

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Presidential Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Pleasant Street Concord, NH 03301	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, it was determined that the facility failed to complete a thorough investigation of an alleged violation for 1 of 6 residents reviewed for alleged abuse. (Resident identifier is #1). Findings include: Review on 10/2/25 of Resident #1's nursing progress note dated 9/22/25 at 10:41 a.m. revealed, . Lnas [Licensed Nursing Assistants] reported that [Resident #1] appeared to be in pain and had swelling/redness to [left lower extremity], upon examination this writer noticed a reddened area just above the ankle on the left leg, the area was warm, red, and tender to the touch. [Resident #1] also had swelling of the lower left leg and foot. The [Advanced Practice Registered Nurse] was notified and ordered an x-ray which revealed a spiral fracture of the mid [middle part of a bone] to distal tibia.</p> <p>Review on 10/2/25 of Resident #1's radiology report dated 9/22/25 revealed: minimally displaced spiral oblique fracture of the mid] to distal left tibial diaphysis.</p> <p>Interview on 10/2/25 at 10:20 a.m. with Staff C (Licensed Nursing Assistant) revealed that he/she had taken care of Resident #1 on 9/20/25 and 9/21/25. Staff C revealed that on 9/20/25 that Resident #1 said Ow during a stand pivot transfer. Staff C revealed that on 9/21/25 that Resident #1 was kept in bed that morning due to complaints of leg pain and that the Resident #1 would hold their left leg during incontinence care. Staff C revealed that he/she had not been interviewed or asked to make a statement by the facility regarding Resident #1 above injury on 9/22/25.</p> <p>Interview on 10/2/25 at 2:10 p.m. with Staff D (Director of Nursing) revealed that he/she did not interview any LNA who worked with Resident #1 on 9/20/25 and 9/21/25 regarding Resident #1's fracture and did not identify a cause of the fracture.</p> <p>Review on 10/2/25 of the facility's undated policy titled Resident Abuse and Reporting Policy revealed, .It is the policy of [the Facility] to. investigate. alleged abuse, neglect, mistreatment. 3. The facility will investigate all allegations and prevent further potential abuse while the investigation is ongoing. Definitions. Injuries of unknown source: Source of the injury was not observed and could not be explained by the resident; and the injury is suspicious because: the extent of seriousness of the injury. Policy. Investigating &dash; The Administrator or Director of Nursing will conduct an investigation of alleged abuse. The DON will . c. Interview all nursing department witnesses/suspects and record their statements. The Administrator will. c. Review the Nursing report, suspect interview, witness interview(s), and Social Services interview, and other investigative documentation.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Presidential Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Pleasant Street Concord, NH 03301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on interview and record review, it was determined that the facility failed to implement interventions in accordance with the resident's assessed needs that address the identified limitations in the resident's ability to perform transfers in 1 of 5 residents reviewed in a final sample of 6 residents (Resident identifier is #1). Findings include: Review on 10/2/25 of Resident #1's Physical Therapy (PT) notes revealed the following;</p> <p>On 8/15/25 a Treatment Encounter Note that revealed, . Educated aide that pt [patient] would be appropriate to hoier [mechanical lift]. Staff is using various techniques including bear hugging pt which is unsafe for both pt and staff. To avoid injury to pt and staff a hoier lift would be appropriate. Unit Manager notified about this and that pt should be a hoier. This was signed by Staff A (Physical Therapy Assistant) and Staff E (Physical Therapist) on 8/15/25.</p> <p>On 8/29/25 a Treatment Encounter Note that revealed . pt is essentially D [dependent] for xfers [transfers]. Does not participate in xfers, unable to bear weight through LE [lower extremities]. Again recommend pt be a hoier for pt and staff safety. [Nursing] notified. This was signed by Staff A on 8/29/25.</p> <p>On 9/12/25 a Treatment Encounter Note that revealed .Nsg [nursing] notified that hoier should be utilized . This was signed by Staff A and Staff E.</p> <p>Interview on 10/2/25 at 10:20 a.m. with Staff C (Licensed Nursing Assistant) revealed that he/she had taken care of Resident #1 on 9/20/25 and 9/21/25 and that on 9/20/25 they had done a stand-pivot of 1 person to place Resident #1 back into bed after lunch. Staff C revealed that it was their understanding that Resident #1 could be transferred by a stand pivot and that a mechanical lift could be used if needed. Staff C revealed that Resident #1 said Ow during this transfer and during incontinence care and the nurse was made aware. Staff C revealed that on 9/21/25 that Resident #1 was kept in bed that morning due to complaints of pain and holding his/her left leg and that the Resident would hold their left leg during incontinent care on 9/21/25.</p> <p>Review on 10/2/25 of Resident #1's nursing progress note dated 9/22/25 at 10:41 a.m. revealed, . Lnas [Licensed Nursing Assistants] reported that [Resident #1] appeared to be in pain and had swelling/redness to [left lower extremity], upon examination this writer noticed a reddened area just above the ankle on the left leg, the area was warm, red, and tender to the touch. [Resident #1] also had swelling of the lower left leg and foot. The [Advanced Practice Registered Nurse] was notified and ordered an x-ray which revealed a spiral fracture of the mid [middle part of a bone] to distal tibia.</p> <p>Rev/iew on 10/2/25 of Resident #1's radiology report dated 9/22/25 revealed results minimally displaced spiral oblique fracture of the mid [middle] to distal left tibial diaphysis.</p> <p>Review on 10/2/25 of Resident #1's Activities of Daily Living Care Plan revised intervention date of 9/16/25 revealed TRANSFER: The resident requires 2 staff hoier transfer assist to move between surfaces as necessary.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Presidential Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Pleasant Street Concord, NH 03301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/2/25 at 9:45 a.m. with Staff A (Physical Therapy Assistant) confirmed that he/she had been providing physical therapy to Resident #1 and that the resident should be transferred via a mechanical lift for both the Resident's and Staff's safety. Staff A confirmed that they had communicated Resident #1's transfer status verbally to nursing staff since 8/15/25.</p>		