STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305063	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presidential Oaks	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to implement Enhanced Barrier Precautions (EBP) in 2 of 2 residents reviewed for pressure ulcers (Resident Identifiers are #55 and #30). The facility failed to follow hand hygiene policy with 1 of 1 dressing change observation (Resident identifier is #55). The facility failed to follow identified interventions for water management: legionella prevention and update Infection Prevention Policies annually.Findings include: Resident #30 Review on 1/30/26 of Resident #30's wound note, dated 1/29/26, revealed a stage II pressure ulcer to the left heel and a stage II pressure ulcer to the sacrum. Review of Resident #30's physician orders did not indicate the resident was on EBP was in place. Observation on 1/30/26 at approximately 9 a.m. of Resident #30's room revealed no signage indicating EBP usage. Review on 1/30/26 of Resident #30's January 2026 Treatment Administration Record revealed an active order for Wound to Sacrum: Apply hydrogel to the wound bed. Apply foam dressing. Change daily. dated 1/8/26. Further review of Resident #30's January 2026 TAR revealed: Wound orders Left heel, apply skin prep to the peri wound, collagen sheet to wound bed, and cover with bordered foam dressing. Change Tuesday, Thursday, Saturday, and PRN. Interview on 1/30/26 at approximately 10:45 a.m. with Staff A (Unit Manager) confirmed that Resident #30 did have pressure ulcers and EBP should have been in place. Interview on 1/30/26 at approximately 10:50 a.m. with Staff B (Director of Nursing) confirmed that Resident #30 did have pressure ulcers EBP should have been in place. Resident #55 Review on 1/29/2026 of Resident #55's provider orders revealed a daily dressing change for a stage 2 pressure injury. Observation on 1/29/2026 at approximately 12:00 p.m. of Resident #55's room revealed no sign for EBP and no cart available for personal protective equipment. Review on 1/29/2026 of Resident #55's care plan for pressure injury care revealed no indication for enhanced barrier precautions to be followed during high contact care activities. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 1/30/26 of facility policy titled Enhance Barrier Precautions Policy and Procedure dated 10/10/2025 revealed Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of the transmission of multidrug-resistant organisms (MDROs).High-contact resident activities include: Dressing bathing/showering transferring providing hygiene changing linens changing briefs or assisting with toileting.wound care: any skin opening requiring a dressing.Wound.pressure ulcers.Procedure:.2. Post clear signage on the door or wall outside the resident room.a. Signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves.6. Enhanced barrier precautions should be used for the duration of a resident's stay in the facility or until resolution of the wound. Interview on 1/30/2026 at approximately 11:30 a.m. of Staff E (Infection Preventionist) confirmed that Resident #55 should have been on EBP for pressure ulcers. Observation on 1/30/2026 at approximately 9:30 a.m. of Staff F (Licensed Practical Nurse (LPN)) completing Resident #55's dressing change revealed Staff F changed his/her gloves between dirty and clean tasks but did not complete hand hygiene with glove removal after removing old dressing and prior to applying new gloves to clean the wound. Interview on 1/30/26 at approximately 9:40 a.m. with Staff F (LPN) above observation. Review on 1/30/26 of facility policy titled Hand Hygiene Policy undated revealed Policy: It is the policy of [facility name omitted] to ensure that appropriate preventative measures are taken to prevent the spread of infection. Procedure: 1. Appropriate hand washing must be used under the following conditions:.After removing gloves.6. An alcohol-based solution may be used unless hands are visibly soiled. Interview on 1/30/2026 at approximately 11:30 a.m. with Staff E (Infection Preventionist) confirmed hand hygiene should be done with glove removal. Review on 1/30/2026 of facility Water Management Plan revealed identified risk areas and interventions to be the faucets: run 5-6 minutes and toilets flushed; the water heater: monitored and logged weekly. Aerators: visually inspected weekly, removed and disinfected annually. Eye wash stations: visually inspected, taken down and disinfected quarterly. Further review revealed no documentation that preventative interventions were performed. Interview on 1/30/2026 at approximately 10:00 a.m. with Staff G (Maintenance Director) revealed that the facility was unable to provide evidence of any interventions being completed. Further interview confirmed there had been no actions taken to prevent legionella. Review on 1/30/2026 of facility Infection Prevention policies revealed a policy titled Antibiotic Stewardship Program undated, Infection Surveillance dated 9/12/24, Antibiotic Use Assessment and Documentation dated 7/11/24, all not within the past year. Interview on 1/30/2026 at approximately 8:30 a.m. with Staff E (Infection Preventionist) confirmed policies had not reviewed annually per requirement.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, it was determined that the facility failed to implement a system to monitor antibiotic use use for 3 of 5 resident's reviewed in a final sample of 18 residents (Resident identifiers are #11, #57, and #7).Findings include:Review on 1/30/2026 of facility policy titled Antibiotic Stewardship Program undated revealed .Policy Interpretation and Implementation.to improve the use of antibiotics in an effort to decrease antibiotic resistant organisms. The center shall follow McGeer criteria for identifying the presence of infections.nursing partners will be active in the Quality Assurance program to enhance the use of antibiotics and for following approved guidelines established by this center based on the McGeer Criteria.Review on 1/30/2026 of facility antibiotic line list for November 2025, December 2025, and January 2026 revealed the log was missing infection symptoms and no there documentation that the antibiotics were appropriate and it McGeer's criteria.Resident #11Review on 1/30/26 of Resident #11's provider orders revealed an order dated 11/19/2025 for ertapenem 500mg, IV [intravenous] daily for 7 days.Review on 1/30/2026 of November 2025 antibiotic line list revealed antibiotic treatment was for a Urinary Tract Infection (UTI) with symptoms for treatment being GI [gastrointestinal] complaints and pain.Review on 1/30/2026 of antibiotic worksheet provided by the facility with McGeer's Criteria definitions undated revealed the definition for treatment of a UTI must fulfill both 1 AND 2. 1.At least one of the following sign or symptom: Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate. 2.At least one of the following microbiologic criteria: equal to or more than 100,000 cfu [colony forming units]/ml [milliliter] of no more than 2 species of organisms in a voided urine sample or equal to or more than 100 cfu/ml of any organism(s) in a specimen collected by an in-and-out catheter.Interview on 1/30/2026 at approximately 12:00 p.m. with Staff E (Infection Preventionist) confirmed there was no assessment completed of McGeer's criteria or antibiotic appropriateness for Resident #11's antibiotic.Resident #57Review on 1/30/2026 of Resident #57's provider orders revealed an order dated 12/12/2025 for Augmentin 875mg-125mg orally every 12 hours for 7 days.Review on 1/30/2026 of December 2025 antibiotic line list revealed antibiotic treatment was for a Urinary Tract Infection with symptoms for treatment not noted.Interview on 1/30/2026 at approximately 12:00 p.m. with Staff E confirmed there was no assessment completed of McGeer's criteria or antibiotic appropriateness for Resident #57's antibiotic.Resident #7Review on 1/30/26 of Resident #7's provider orders revealed an order dated 1/12/2026 for nitrofurantoin 50mg orally every day. Review on 1/30/2026 of January 2026 antibiotic line list revealed antibiotic treatment was for a Urinary Tract Infection with symptoms for treatment noted to be altered mental status, fatigue, malaise.Review on 1/30/2026 of facility provided McGeer's Criteria worksheet for Resident #7's antibiotic treatment dated 1/13/2026 revealed a blank worksheet.Interview on 1/30/2026 at approximately 12:00 p.m. with Staff E confirmed there was no assessment completed of McGeer's criteria or antibiotic appropriateness for Resident #7's antibiotic.Interview on 1/30/2026 at approximately 8:15 a.m. with Staff E revealed he/she has not tracked antibiotic treatments that do not fit McGeer's criteria. Further interview revealed there is no reporting or discussion in Quality Assurance Performance Improvement (QAPI) regarding infections that are treated outside of the criteria or for prophylactic (preventative) treatment.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview and record review, it was determined that the facility failed to ensure that residents were provided with a private space for a resident group to meet on a regular basis, make residents aware of upcoming meeting and to make prompt efforts to resolve resident and group grievances, keep residents apprised of the progress towards resolution, and maintain evidence demonstrating the response and rationale for the response for 6 residents out of a facility census of 71 (Resident identifiers are #6, #14, #26, #30, #41 and #54).Findings include:Interview on 1/28/26 at approximately 8:15 a.m. with Staff D (Administrator in Training) revealed that the Resident Council president was not a long term resident. Staff D revealed resident group consists of the organization's long term and their other facilities (independent living and assisted living) and the Resident President is from the independent living. Observation and interview on 1/28/26 at approximately 1:00 p.m. during a Resident Group Meeting revealed that five of the six residents (Resident #14, #26, #30, #41 and #54) in attendance were not aware of a Resident Council group meeting. Resident #54 was not aware that they could elect a President for the Resident Council for SN and LTC, he/she stated that the president was for the entire building. Resident #6 was admitted to the facility in October 2025 and was never told about a monthly meeting where residents would come to discuss issues they were having or seeing in the facility. He/she would have attended. Resident #41 stated that he/she had not been asked to attend group meeting until today. He/she would like to attend moving forward.Review on 1/28/26 of the Resident Council meeting minutes revealed the following:On 10/28/25, LTC residents had concerns with activities, nursing care, and food. On 12/30/25, LTC residents had concerns with missing items.Interview on 1/30/26 at approximately 2:00 with Staff D confirmed the above findings and that there was no response to the LTC residents' concerns. Review on 1/30/26 of the facility policy Resident Council Meetings not dated, revealed: Resident Council is the political voice of the individuals who reside in the facility. Many of the residents are unable to voice their opinions and/or concerns and need to rely on the residents who are capable and interested in facility events to speak for them. 6. Activity staff and nursing staff be responsible for inviting and encouraging appropriate residents from third and second floors to attend, 9. Activity staff will document any issues or concerns not resolved at the meeting with a Department Response Form to the specific department. Forms with be put in each Director's mailbox within forty-eight hours (48) hours. 10. Once the issue has been resolved, the Director will return the completed Departments Response Form to the Activity Director within 10 (ten) days. 11. These issues will be brought up at the following meeting and documented as resolved.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview and record review, it was determined that the facility failed to notify the physician of medications not administered to the residents for 1 of 4 residents reviewed for hospitalizations in a final sample of 18 residents (Resident Identifiers is #71).Findings include:Review on 1/30/26 of Resident #71's January 2026 Medication Administration Record (MAR) revealed physician's orders for the following:Aspirin 81 oral tablet delayed release, give one tablet my mouth at bedtime related to Paroxysmal Atrial Fibrillation. Further review revealed that Resident #71 refused the medication on 1/1/26, 1/2/26, 1/3/26, and 1/4/26.-sosorbide Dinitrate oral tablet 5 milligrams (mg), give two tablets by mouth at bedtime related to Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Further review revealed that Resident #71 refused the medication on 1/1/26, 1/2/26, 1/3/26, and 1/4/26.Losartan Potassium oral tablet 50 mg, give one tablet by mouth one time a day related to Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Further review revealed that Resident #71 refused the medication on 1/3/26,and 1/4/26.Verapamil HCl ER oral tablet extended release 120 mg, give 1 tablet by mouth two times a day related to Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Further review revealed that Resident #71 refused the medication on 1/1/26 and 1/2/26 at 8:00 p.m. and 1/3/26 and 1/4/26 at 9:00 a.m. and 8:00 p.m.Interview on 1/30/26 at 1:39 p.m. with Staff B (Director of Nursing) confirmed the above finding. Staff B revealed that there was no documentation the provider was notified of the refused medications prior to 1/5/26. Review on 1/30/26 of Resident #71's provider note, dated 1/5/26, revealed that Resident #71 had been refusing their hypertensive medication and had severe chest pain. Resident agreed to go to the hospital for further evaluation.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, it was determined that the facility failed to follow its grievance policy for generating grievances, investigating, and resolution of grievances for 1 of 1 resident reviewed abuse in a final sample of 18 residents. (Resident identifier is #46).Findings include:Review on 1/30/26 of the facility's policy Grievance Process undated revealed, .2. Staff member receiving the concern generates a grievance form and completes the top section of the form (date of grievance/concern, received by, resident name, room number, name of person reporting concern, relationship to resident, and description of concern). 3. Staff member receiving the concern delivers the form to the Director of Social Services. 4. Director of Social Services logs the grievance/concern, assigns a person to investigate/take action on the grievance/concern, scans the grievance/concern form, and emails the person(s) assigned to investigate/take action on the grievance/concern with cc to Acting Administrator and Director of Nursing . *Resident, family members, or responsible party does not need to formally ask for a grievance/concern to be filed. The grievance/concern form should be generated by any concerns. Resident, family member, or responsible party should not be given the form to complete themselves, the staff learning of the concern or hearing the concern should generate the form.Interview on 1/28/26 at 10:15 a.m. with Resident #46 revealed that he/she felt staff were busy and rushed her during incontinence care. Resident #46 stated that he/she told a staff member recently about how he/she felt but nothing was done.Review on 1/30/26 of Resident #46's progress note, dated 1/5/26, revealed that Staff C (Licensed Practical Nurse) spoke with Resident #46 about a licensed nursing assistant (LNA) on duty. Review further revealed that Resident #46 felt rushed and sometimes staff were not nice to him/her.Interview on 1/30/26 at 12:43 p.m. with Staff D (Administrator in Training) revealed that Resident #46's concerns did not generate a grievance and no investigation was done.