STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365618	A. Building B. Wing	12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presidential Post-Acute	524 James Way Marion, OH 43302

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on medical record review, policy review, review of manufacturer instructions, observation, and staff interview, the facility failed to ensure appropriate needles were used during intramuscular medication administration. This affected one (Resident #81) of two residents observed for injectable medications. The facility census was 97. Findings include: Review of the medical record for Resident #81 revealed an admitted [DATE]. Resident #81 had a new diagnoses added on 11/25/24 of urinary tract infection (UTI) and moderate protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #81 was moderately cognitively impaired. Review of the care plan dated 11/17/24 revealed Resident #81 had a UTI. Interventions included to administer antibiotic therapy as ordered and monitor/document for side effects and effectiveness. Review of the physician orders dated 12/12/24 for Resident #81 revealed Ertapenem Sodium intramuscular injection solution reconstituted (antibiotic) one gram every 24 hours for infection for 10 days Observation of medication administration on 12/16/24 at 2:03 P.M. revealed Registered Nurse (RN) #104 was preparing to administer the antibiotic to Resident #81. RN #104 grabbed a BD blunt fill needle-filter to draw up the lidocaine solution and place it into Ertapenem sodium injection powder. The appropriate amount of lidocaine was placed into the Ertapenem injection powder, the blunt needle was removed, and the nurse discarded it in the trash. After a thorough mixing, RN #104 opened up the cart looking for another needle. He was unable to find one, so he went to the storage room and grabbed four more BD blunt fill needle-filters. He said he wanted to use a fresh needle because the previous one would be dull. The nurse then placed a new blunt fill needle-filter onto the syringe and drew up the medication with a five milliliter (ml) syringe, taking 3.2 ml of the solution. The nurse capped off the needle, grabbed an alcohol pad to clean the resident's skin, and locked the cart. RN #104 walked into Resident #81's room where the nurse introduced himself and informed Resident #81 that he would be administering the antibiotic. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #104 walked up to Resident #81 with the syringe in hand, and was approaching the resident to administer the medication. At that point, surveyor intervened prior to administration of the medication. RN #104 confirmed he was going to administer the antibiotic with a BD blunt needle-filter, and explained this was the needle he used for injections. RN #104 was unable to answer what type of needle was used for intramuscular injections. RN #104 proceeded to go through the cart for additional needles and found a 22 gauge, one-inch beveled end needle. This appropriate needle was then used to administer the medication in Resident #81's left deltoid. Interview on 12/16/24 at 2:31 P.M. with the Director of Nursing confirmed when administering intramuscular injections, a blunt fill needle - filter should not be used. The facility does not have any medications currently that would require the usage of a filter needed. He confirmed an 19-23 gauge 1.0 to 1.5 inch should be used. Review of BD blunt fill needle with filter manufactures guidance revealed the BD blunt filter needle includes a five micron filter to remove foreign matter such as glass particles from ampoules, the needle decreases the risk of needle stick due to 10 times higher skin penetration force required. The needle is packaged in a red shield to alter users it is a blunt need. The BD blunt fill needle should not be used for skin injections. Review of Intramuscular Injection Policy dated 04/2011 revealed required supplies are three ml syringe, needle (19 to 23 gauge, 1.0 to 1.5 inch), alcohol swabs, prescribed medication, medication administration record, sharps container and personal protective equipment is required for administration. This was an incidental finding discovered during the course of the complaint investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44070 Based on staff interviews, review of facility policy, and medical record review, the facility failed to ensure the resident's weight loss was timely addressed and recommendations were timely followed through with. This affected one (#100) of three residents reviewed for weight loss. The facility census was 97. Findings include: Review of the medical record for Resident #100 revealed an admitted [DATE] and discharge date of [DATE]. Diagnoses included metabolic encephalopathy, Alzheimer's disease, dementia, dysphasia, chronic obstructive pulmonary disease, and mild protein calorie malnutrition. Review of the plan of care dated 08/07/24 revealed Resident #100 was at risk of malnutrition with related diagnosis of underweight, significant weight loss and a need for mechanically altered diet. Interventions included providing adequate time for meal consumption as the resident was a slow eater, assist with meals and fluids as needed, cueing at meals to encourage consumption, food in bowls of finger foods with meals to promote increased oral intake, monitor meal intake, monitor weight per protocol, and provide diet and supplements per physician order. Resident #100 was hospitalized from 09/07/24 to 09/11/24 due to altered mental status and increased sodium levels. Review of Resident #100's weight dated 09/12/24 revealed upon readmission to the facility, Resident #100 weighed 92.0 lbs. This indicated Resident #100 had a weight loss of 9.8 percent (%) weight loss in one month and 8.9% in one week. Review of Registered Dietitian (RD) #80's progress note dated 09/12/24 revealed she spoke with the resident's family regarding Resident #100's food preferences. Resident #100 pocketed foods and would not always allow someone to help her with meals. The weight change found an 8.9% weight loss within one week with a request for a reweight pending. The resident's diet changed to moist and minced from puree. Will resume mighty shake (high calorie nutritional supplement with meals and medication pass 2 .0 (high calorie nutritional supplement) and add a blue plate to promote increased intake for dementia. Meal intakes ranged 25-75% and will monitor re-weights. The facility had no documentation of Resident #100 being re-weighed per RD recommendations dated 09/12/24. Review of the physician orders revealed Resident #100 had dietary supplements including medication pass 2. 0 ordered once daily for underweight dated 09/11/24 and a house supplement with meals (three times daily) for inconsistent intakes dated 09/12/24 and Mirtazapine tablet (Remeron) (can increase appetite) 7.5 milligrams (mg) for one tablet at bedtime dated 09/11/24. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #100 was cognitively impaired and was independent with eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nutritional Risk assessment dated [DATE] revealed a goal weight to maintain/gain without significant changes. Resident #100 accepted medication pass well and had other nutritional supplements (ONS) in the room (the family provided) for ad lib consumption. The RD progress note dated 09/23/24 revealed Resident #100 had been started on mirtazapine with increased oral intake to 50-75%. Resident #100's weight on 09/30/24 dropped to 90.0 for a weight loss of 6.25% in one week and 10.71% weight loss in about one month. On 10/15/24, there was a physician order to start an electrolyte drink to provide once daily for hydration needs. The next documentation from RD #80 was 17 days later on 10/17/24. The progress dated 10/17/24 revealed Resident #100 had additional weight loss. Resident #100 had a recent COVID diagnosis with interventions for an electrolyte drink and a new recommendation to increase medication pass 2.0 from once daily to twice daily. This was 17 days after significant weight loss was identified. Interviews on 12/17/24 at 4:30 P.M. with RD #80 stated she was present at the facility twice weekly. She stated she monitored intakes and weights that would be flagged for any significant weight loss to review for supplements and interventions and for re-weights. RD #80 confirmed the facility did not have evidence of re-weight for Resident #100 from when she recommended it on 09/12/24. RD #80 confirmed the facility had no documentation or evidence of follow up after Resident #100 had a significant weight loss on 09/30/24 and the weight loss was not addressed until over two weeks later. Interview on 12/18/24 at 11:30 A.M. with the Administrator revealed the facility had access to notify RD #80 of any resident's weight loss/ The Administrator verified any issues of weight loss such as interventions or assessments should be followed up with immediately. Review of the facility policy titled, Weight Assessment and Intervention, dated 03/2022 revealed resident weights shall be monitored for undesirable or unintended weight loss of gain. Any weight change of 5% or more since the last weight assessment shall be retaken the next day for confirmation and notify the RD immediately in writing. The weight loss threshold was a loss of 5% in under one month, 7.5% in three months and 10% in six months. Resident weight changes shall be evaluated by the treatment team. Review of facility policy titled, Dietician, dated 11/2022 revealed facility shall have a qualified Dietician to oversee the food and nutrition services in the facility. They shall oversee the food and nutrition services provided to residents. The Dietician was responsible for assessing nutritional needs, developing and evaluating therapeutic diets, developing person centered programs involving food and nutrition services, and food preparation service and storage. This deficiency represents non-compliance investigated under Complaint Number OH00160137.