| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365618 | A. Building<br>B. Wing | 10/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Presidential Post-Acute | 524 James Way<br>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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a self-reported incident (SRI), record review, facility investigation, policy review, and resident and staff interviews, and radiologist interview, the facility failed to ensure Resident #7 received proper assistance during transfers to prevent accidents. Actual Harm occurred on 07/11/25 when Resident #7 sustained a left rib fracture following an improper transfer by facility staff. This affected one (#7) of six residents reviewed for accidents. The facility census was 91.Findings include: Review of Resident #7's medical record revealed an admission date of 04/08/25. Diagnoses included chronic obstructive pulmonary disease, weakness, spinal stenosis of the lumbar region with neurogenic claudication, and adult failure to thrive. Review of Resident #7's care plan dated 04/08/25 revealed Resident #7 was at risk for falls related to functional decline, weakness, and bedbound status. Interventions included to assist with two staff members for transfers (implemented 04/09/25), and assistance with locomotion on and off the unit (implemented 04/09/25). The care plan was updated on 10/16/25 for staff education to lock wheelchair brakes. The nursing note dated 07/11/25 at 8:41 A.M. revealed Resident #7 complained of left rib pain and requested an X-ray due to pain with inhalation, exhalation, and movement. The nurse notified the nurse practitioner, and an order for an X-ray was obtained. Review of the X-Ray results dated 07/11/25 at 10:07 P.M. revealed the findings included a new acute nondisclosed left tenth rib fracture. The results were reported on 07/12/25 at 7:53 A.M. from mobilex after being reviewed by Radiologist #700. A progress note dated 07/12/25 revealed the nurse practitioner was updated on X-ray results. Review of the facility's SRI Control Number 262699, dated 07/12/25, revealed a report of Resident #7 sustaining a left rib fracture during a transfer. Licensed Practical Nurse (LPN) #494's written statement revealed on 07/11/25, Resident #7 reported left rib pain during morning care. The nurse performed a head-to-to-toe assessment. Resident #7 stated, I think the aide squeezed me too hard and broke my rib, but was unable to recall the name of the staff member or the exact date the incident. Resident #7 stated it may have been a couple of days ago. LPN #494 notified the provider and obtained an order for a chest X-ray. The X-ray, completed on 07/12/25, revealed a new acute nondisplaced left tenth rib fracture. The physician was notified of the results. Administration completed additional training to the facility staff regarding pivot transfers to ensure appropriate transfer technique was provided to the residents. A progress note dated 07/13/25 revealed a new order for a lidocaine patch to the left rib as needed. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, indicating her cognition remained intact and continued to be dependent on staff for transfers. The nursing note dated 10/13/25 at 10:55 A.M. revealed a certified nursing assistant (CNA) reported she had to lower Resident #7 to the floor during a transfer from bed to chair because one of the wheelchair brakes was not locked, causing the wheelchair to move. The nurse was immediately notified, and a head-to-toe assessment was completed. The resident denied pain, and no injuries were noted at that time. The progress note dated 10/13/25 at 12:14 P.M. revealed Resident #7 complained of left hip pain following another transfer. An X-ray was ordered for her left knee, hip, and elbow. The X-Ray results dated 10/14/25 revealed Resident #7's left elbow, knee, and hip had no acute osseous findings, and the left hip is in alignment with mild osteoarthritis of the left hip with no fracture or dislocation seen. Interviews conducted on 10/16/25 at 11:18 A.M. with Resident #7 revealed she could not recall the name of the CNA who transferred her in July but stated the CNA performed the transfer alone. Resident #7 stated the aide squeezed too tight, and she immediately felt pain, telling the CNA, I think you broke my rib. Resident #7 stated she informed the nurse of her pain, but she could not recall the nurse's name. She stated she was crying in pain, and the transfer that caused the rib fracture occurred the same day she reported the injury. At 12:20 P.M., Resident #7 stated for the transfer in July, only one CNA performed the transfer. She reported that a mechanical lift (Hoyer lift) had not been used for some time but could not recall when it was last used. Resident #7 also stated only one CNA performed the transfer on 10/13/25 and she had to be lowered to the ground. An interview conducted on 10/16/25 at 1:10 P.M. with LPN #466 identified CNA #353 reported having to lower Resident #7 to the floor due to the wheelchair not being locked. LPN #466 stated she believed CNA #353 was working alone during the transfer, but this was never confirmed. An interview conducted on 10/16/25 at 1:45 P.M. with Director of Nursing (DON) revealed CNA #353 involved in the October transfer was verbally educated on ensuring wheelchair brakes were locked prior to transfer. The DON stated there was no documentation of written education or retraining for the aide |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, review of Centers for Disease Control and Prevention (CDC) guidance, and facility policy review, the facility failed to implement enhanced barrier precautions (EBP) as physician ordered during wound care for Resident #67. This affected one (#67) of three residents reviewed for wounds. The facility identified 13 residents who had EBP in place. The facility census was 91. Findings include:Review of Resident #67's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included congestive heart failure, chronic kidney disease, diabetes mellitus, and morbid obesity. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #67 had impaired cognition and required assistance from staff with transfers, bed mobility, and bathing.<br><br>Review of Resident #67's care plan dated 05/07/24 revealed a care plan focus of EBP. Resident #67 required EBP during high-contact resident care activities due to the presence of wounds. Interventions included to utilize personal protective equipment (PPE) (gown and gloves, face-shield as indicated) during high contact resident care activities (e.g. Brief changes, toileting assistance, device care and wound care).<br><br>Review of Resident #67's physicians orders dated 10/01/25 revealed orders to assist for EBP during high contact resident care every shift and a wound care treatment order to the sacrum/right buttocks every shift.<br><br>Observation of wound care on 10/16/25 at 9:45 A.M. revealed Nurse #494 and Wound Nurse #474 provided wound care to Resident #67's sacrum/right buttocks and they did not wear gowns during the wound care.<br><br>Interview on 10/16/25 at 10:05 A.M. with Wound Nurse #474 confirmed Resident #67 was on EBP for the wounds and confirmed Nurse #494 and Wound Nurse #474 did not wear a gown during wound care. Wound Nurse #474 confirmed a gown should have been worn by the nurse during wound care.<br><br>Review of the facility's EBP policy dated March 2024 revealed EBP involves the use of gowns and gloves during high-contact resident care activities, in addition to standard precaution and staff should don appropriate PPE before engaging in high-contact resident care activities.<br><br>Review of the CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP is an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00166290 (1373764). |