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	03/23/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, observation, interview, and policy review, the facility failed to ensure medications were not inappropriately crushed per physician order. This affected one (#110) resident of five residents observed for medication administration. The facility census was 89.Findings include:Review of medical record for Resident #110 revealed an admission date of 03/09/26 with diagnoses including but not limited to acute embolism and thrombosis of left axillary vein, dementia, atrial fibrillation, and hypertensive heart disease with heart failure. Review of physician orders revealed metoprolol succinate extended release (ER) 25 milligram (mg) (atrial fibrillation) give one tablet by mouth one time a day (may split- do not crush). Observation on 03/10/26 at 8:40 A.M. of medication pass revealed Licensed Practical Nurse (LPN #132) placed the medications for Resident #110 into a med cup and then into a crush pouch and crushed the medications. Medications included amiodarone 200 mg, escitalopram 10 mg, metoprolol succinate ER 25 mg, pantoprazole 40 mg, furosemide 20 mg, and spironolactone 25 mg. Interview on 03/10/26 at 9:56 A.M with LPN #132 verified that she crushed the metoprolol succinate ER and should not have crushed the medication due to it being extended-release tablet. LPN #132 stated she did not crush the pantoprazole. Review of policy titled, Administering Medications, dated April 2019 revealed medications are administered in accordance with prescriber orders, including required time frame. This deficiency represents non-compliance investigated under Complaint Number 2707817.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to follow physician orders regarding insulin administration. This affected one resident (Resident #23) reviewed for insulin. The facility census was 89. Findings include: Review of the medical record for Resident #23 revealed a re-admission date of 03/03/26 and diagnosis of type two diabetes. Review of Resident #23's entry Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Review of Resident #23's orders on 03/09/26 revealed an order for Insulin Lispro Injection Solution 100 Unit/Milliliters (ML) beginning 03/03/26, to inject 23 units subcutaneously before meals for diabetes. Further review of the order revealed direction to hold the insulin if the blood sugar (BS) is less than 150. Review of Resident #23's Medication Administration Record (MAR) revealed insulin was given 03/05/26 at 11:30 A.M. for a BS of 107, given 03/06/26 at 6:30 A.M. for a BS of 127, given 03/06/26 at 4:30 PM for a BS of 97, and given 03/07/26 at 6:30 A.M. for a BS of 114. Review of Resident #23's blood sugar summary confirmed the blood sugar levels documented in the MAR. Review of Resident #23's progress notes revealed no documentation of physician notification and order to administer the medication outside of parameters. Interview on 03/11/26 at 9:47 A.M. with Licensed Practical Nurse (LPN) #180 confirmed Resident #23 was given insulin outside of physician ordered parameters. LPN #180 confirmed the insulin should have been held when the resident's BS was below 150 unless ordered by the doctor to still administer the medication, which would have been documented in the progress notes. Review of the facility policy titled, Administering Medications, revised April 2019, revealed medication is administered in accordance with prescriber orders. Further review revealed if a dosage was believed to be inappropriate or excessive for the resident's physician or facility's medical director should be contacted to discuss the concerns. This deficiency represents non-compliance investigated under Complaint Number 2707817.