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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on medical record review, observations, staff interviews, review of the mechanical lift manufacturer's instructions, review of the Hoyer sling owner's manual, review of the facility's investigation including witness statements, review of the Emergency Medical Services (EMS) report, review of hospital documentation, review of the death certificate, and review of the facility policies, the facility failed to ensure Resident #96 was transferred safely with a mechanical lift. This resulted in Immediate Jeopardy when Resident #96 suffered serious life-threatening injuries on [DATE] when Resident #96 was transferred using a mechanical lift and the top two straps supporting Resident #96's upper body simultaneously broke. Resident #96 fell approximately five feet from the mechanical lift sling and landed on the back of her head and neck area resulting in a fracture of the second cervical spine (C2), an epidural hematoma, age indeterminate fractures of the first, second, sixth, tenth, and twelfth thoracic spine (T1, T2, T6, T10, T12), and a two centimeter laceration to the posterior scalp that required five staples. These injuries subsequently lead to Resident #96's death on [DATE]. This affected one (#96) of three residents reviewed for utilization of a mechanical lift for transfers. The facility identified a total of 26 current residents (#4, #6, #8, #10, #11, #17, #18, #19, #22, #25, #29, #33, #41, #54, #56, #58, #60, #61, #75, #76, #78, #83, #93, #106, #107, and #108) residing in the facility as requiring the use of a mechanical lift for transfers. The facility census was 89. On [DATE] at 4:30 P.M., the Administrator and the Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at approximately 10:00 A.M., when Certified Nursing Assistant (CNA) #181 and CNA #269 began to transfer Resident #96 from her bed using a mechanical lift and a mesh sling that no longer had a tag attached to it (the tag provides critical safety data required by OSHA [Occupational safety and Health Administration] and ASME [American Society of Mechanical Engineers] B30.9, including the manufacturer's name, rated capacity [load limits] for various hitches [vertical, choker, basket], individual serial number for tracking, and the sling's width, length, and material grade. If missing or illegible, the sling must be removed from service). CNA #269 utilized the blue-colored sling loops on the top two straps near the resident's head and shoulders and the purple-colored sling loops on the bottom two straps near the resident's legs and feet. CNA #269 raised Resident #96 into the air, approximately five feet from the ground. While in the air, the top two blue-colored sling loops broke simultaneously, and Resident #96 fell out of the sling backwards and headfirst. Resident #96 landed on her head/neck sustaining major injuries. Resident #96 was sent to Hospital #1 via EMS where she was diagnosed with a C2 fracture. Resident #96 was transferred to Hospital #2 due to trauma and for a neurosurgery evaluation. On [DATE], Resident #96's advanced directives were changed from Do Not Resuscitate - Comfort Care Arrest (DNR-CCA) to Do Not Resuscitate - Comfort Care (DNR-CC) and Resident #96 was admitted to hospice. On [DATE], (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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #96 died with the immediate cause of death on her death certificate to be complications of blunt impact of injury to head. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: -On [DATE], Resident #96 was discharged to Hospital #1. -On [DATE], the facility obtained written witness statements from the two CNAs (#181 and #269) and Registered Nurse (RN) #213 involved in the incident. -On [DATE], [NAME] Clerk (WC) #127 obtained a photo of the broken sling straps. -On [DATE], WC #127 immediately removed the sling from use by the facility staff. -On [DATE], WC #127 reviewed all slings in the facility and removed one additional sling due to concerns. -On [DATE], WC #127 labeled all slings in the building to identify what sling was used during the incident with Resident #96. -On [DATE], WC #127 ordered six new slings. -On [DATE], the DON implemented a replacement schedule based on manufactures lifespan guidelines and initiated a replacement schedule. -On [DATE], the Administrator and DON developed a policy titled, Mechanical Lift Equipment Safety Policy. The policy was reviewed and approved by the Administrator, DON, Medical Director (MD), and Quality Assurance and Performance Improvement (QAPI) team on [DATE]. -On [DATE] through [DATE], the DON initiated in-service training to all staff on lift equipment integrity checks, sling/pad inspection criteria, failure risk indicators, proper equipment reporting, and emergency response protocols. -On [DATE], the DON in-serviced all staff on lift equipment integrity checks, sling/pad inspection criteria, failure risk indicators, proper equipment reporting, and emergency response protocols. -On [DATE], the DON conducted a root cause analysis. -Starting on [DATE], the DON or designee would conduct weekly random audits of ten slings/pads to ensure each pad is appropriately labeled, inspections have been conducted, and replacement schedule has been reviewed for four weeks and then monthly for two months. -On [DATE] through [DATE], the DON and/or WC #127 completed annual competency validations for mechanical lift use and equipment safety assessments on all CNAs. -On [DATE], WC #127 purchased 81 new slings for the facility and they were delivered on [DATE]. -On [DATE], the facility held an ad-hoc meeting at approximately 9:30 A.M. with the Administrator, DON, Medical Director (MD), RN Unit Manager #161, Minimum Data Set (MDS) RN #141, Social Services Assistant (SSA) #148, Housekeeping Supervisor (HS) #144, RN Unit Manager #261, Maintenance Director #163, WC #127, and Staffing Coordinator (SC) #220 to discuss the incident, the plan for ordering new slings, reviewed new policy, and discussed staff education. -On [DATE], WC #127 removed all old slings from use in the facility. New slings were labeled and put into use for the facility. -On [DATE], all systemic changes will be reviewed monthly for three months by the QAPI team. -On [DATE], the DON in-serviced all therapy staff, CNAs, and nurses on the policy/procedure and/or protocol related to not moving/dragging a resident after a fall, which could contribute to further injuries. -On [DATE], the DON reassessed all residents that were currently utilizing mechanical lift devices to ensure the proper lift was being utilized and/or necessary and the appropriate number of staff needed for assistance were identified. Care plans were updated to reflect resident needs. Residents #4, #6, #8, #10, #11, #17, #18, #19, #22, #25, #29, #33, #41, #54, #56, #58, #60, #61, #75, #76, #78, #83, #93, #106, #107, and #108's physicians orders were updated to reflect the use of a mechanical lift which required two person assistance. The task section in the medical charts of Residents #4, #6, #8, #10, #11, #17, #18, #19, #22, #25, #29, #33, #41, #54, #56, #58, #60, #61, #75, #76, #78, #83, #93, #106, #107, and #108 was updated to reflect the use of a mechanical lift which required two-person assistance. The care plans of Residents #4, #6, #8, #10, #11, #17, #18, #19, #22, #25, #29, #33, #41, #54, #56, #58, #60, #61, #75, #76, #78, #83, #93, #106, #107, and #108's were also updated to reflect the use of a mechanical lift which required two-person assistance. -Starting on [DATE], the DON or designee will conduct random visual observations of mechanical lift transfers on ten random residents weekly, to ensure proper personnel in place, proper mechanics and proper sling usage for four weeks and then ten random observations monthly for two months. -The DON or designee will report monitoring plan results to the QAPI committee monthly. The QAPI committee will monitor on an ongoing basis until sustained compliance is achieved, with quarterly reviews to assess effectiveness and make necessary adjustments to the monitoring plan (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	frequency based on demonstrated compliance rates. -Observation on [DATE] at 9:48 A.M. of a mechanical lift transfer for Resident #78 completed by CNA #209 and CNA #226 revealed no concerns regarding a safe mechanical lift transfer. -Review of two additional medical records for Residents #08 and #22, reviewed for Hoyer lift transfers, revealed no concerns. -On [DATE], interviews with CNA #226, CNA #209, RN #213, CNA #269, and CNA #181, revealed they received education on Hoyer lift transfers, equipment, and falls. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level two (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #96's medical record revealed an initial admission date of [DATE] and a re-entry date of [DATE]. Diagnoses included hypertensive heart disease without heart failure, unspecified dementia, muscle weakness, unspecified protein calorie malnutrition, unspecified osteoarthritis, and stiffness of the right and left knees. Review of Resident #96's annual MDS assessment dated [DATE] revealed Resident #96 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of two. Furthermore, Resident #96 was dependent upon staff for bed to chair and chair to bed transfers, toileting hygiene, shower and bathing, and personal hygiene. Review of Resident #96's physician orders with a start date of [DATE] revealed an order for a Hoyer lift for all transfers with instructions for every shift. Review of Resident #96's care plan with a revision date of [DATE] revealed Resident #96 required assistance with Activities of Daily Living related to weakness, acute illnesses, functional decline, or generally not feeling well with interventions that included a Hoyer lift for all transfers and requiring the assistance of two people for dressing, personal hygiene, and bathing. Review of Resident #96's Medication and Treatment Administration Records (MAR and TAR) for the month of [DATE] revealed an order for Hoyer lift for transfers every shift and they had been signed by the nurse each shift except for one shift on [DATE]. Review of the witnessed fall incident report dated [DATE] at 10:00 A.M. revealed Resident #96 was being transferred from her bed to her wheelchair via mechanical lift. CNA #181 and CNA #269 were present in the room for the transfer. While the lift was being moved from the bed to the wheelchair, the top two blue sling loops ripped, and Resident #96 fell to the floor on her left side. The nurse was immediately notified and 911 was called. Resident #96 had an approximately two centimeters by one centimeter laceration to the back of her head. Resident #96's head was laying on the mechanical lift leg, so staff stabilized her head and removed the mechanical lift. Pressure was applied to the bleeding area on the back of her head until EMS arrived. Review of the EMS run report dated [DATE] revealed EMS arrived at Resident #96 at 10:31 A.M. Resident #96 was lying on her left side with a staff member holding gauze on the left side of her head. The laceration on her head was not able to be seen due to the resident's hair. The nurse stated she was in the mechanical lift, and the straps broke, resulting in Resident #96 falling about five feet and hitting her head on the legs of the lift. Resident #96 was complaining of chest and head pain. A C-collar was placed, and Resident #96 was transported to Hospital #1 with no lights or sirens. Review of Resident #96's Hospital #1's Emergency Department (ED) documentation dated [DATE] revealed Resident #96 presented to Hospital #1 for a fall to the ground, landing on her back and hitting her head on the mechanical lift after the mechanical lift strap broke. Resident #96 was found to have a C2 fracture, multiple thoracic compression fractures - age indeterminate on Computed Tomography (CT) scan, acute hypoxic respiratory failure - CT of chest with extensive mucous plugging and a concern for aspiration or pneumonia, a pulmonary embolism - moderate nonocclusive thrombus of the right main artery, an epidural hematoma, and a scalp laceration. Resident #96 was transported to Hospital #2 due concerns related to trauma. Review of Resident #96's Hospital #2's documentation dated [DATE] through [DATE] revealed a C2 fracture, high attenuation along the dorsum of the [NAME] measuring two millimeters in thickness and could represent epidural hematoma versus venous engorgement, age indeterminate fractures of the first, second, sixth, tenth, and twelfth thoracic spine (T1, T2, T6, T10, T12), a pulmonary embolism that was incidentally found on CT scan, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	acute respiratory failure, and a scalp laceration that required five staples. On [DATE], Resident #96's advanced directives were changed from Do Not Resuscitate - Comfort Care Arrest (DNR-CCA) to Do Not Resuscitate - Comfort Care (DNR-CC) and Resident #96 was admitted to hospice. Resident #96 discharged from the hospital to another Nursing Facility for hospice/palliative care. Review of Resident #96's death certificate revealed a date of death of [DATE] with the immediate cause of death to be complications of blunt impact of injury to the head with underlying causes including atherosclerotic heart disease, dementia, and atrial fibrillation. Review of the witness statement dated [DATE], written by CNA #269, revealed prior to lifting Resident #96 in the mechanical lift sling, he inspected the sling per company protocol. There were two CNAs present in the room and during the transfer, the mechanical lift sling unexpectedly snapped, causing Resident #96 to fall to the floor. The other CNA ran to get a nurse while CNA #269 stayed with the resident until the charge nurse arrived.^ Review of the witness statement dated [DATE], written by CNA #181, revealed a co-worker already had Resident #96 in the mechanical lift sling and hooked up to the mechanical lift when she was asked to assist with the transfer. CNA #181 was behind the wheelchair while her co-worker operated the lift. Resident #96 was turned towards the chair and as the mechanical lift was turned, both top straps broke and Resident #96 fell.^ Review of the witness statement dated [DATE], written by RN #213, revealed she was called by the CNAs and found Resident #96 on the floor in between the mechanical lift legs. The CNAs explained what happened. Vitals were taken and an assessment was completed. Bleeding was noted from the back of Resident #96's head. Resident #96 was complaining of shoulder and neck pain. Resident #96's head was supported, and the mechanical lift was removed. Resident #96 was then slid out into the hallway for better access for the EMS. Family was updated and EMS arrived and placed a C-collar on Resident #96. Interview on [DATE] at 1:25 P.M. with the Administrator and the DON revealed the Administrator was notified Resident #96 had fallen from the mechanical lift on [DATE] at 10:30 A.M. Immediately, corrective action was put into place to ensure the safety of all other residents in the facility who required the use of mechanical lifts. The Administrator and DON verified no other residents have had injuries related to mechanical lifts since the incident occurred. Interview on [DATE] at 2:06 P.M. with CNA #269 revealed on [DATE] around 10:00 A.M. he had given Resident #96 a bed bath and gotten her dressed. CNA #269 stated he placed the mechanical lift sling underneath Resident #96 and hooked the sling up to the mechanical lift. CNA #269 stated he saw CNA #181 walking in the hallway and asked if she would assist him in transferring Resident #96. CNA #181 stood behind the wheelchair while CNA #269 stood behind the mechanical lift. CNA #269 stated he did not see anything concerning about the sling that he could remember prior to using the sling for Resident #96. CNA #269 raised Resident #96 into the air and began to push the mechanical lift toward the wheelchair. CNA #269 stated they were close to the wheelchair when both blue straps on the sling broke and Resident #96 fell out of the sling backwards, headfirst, and hit her head/neck area on the mechanical lift leg. Immediately, CNA #269 yelled for the nurse and for help. CNA #269 stated RN #213 came into the room and assessed the resident as someone else had been directed by RN #213 to call 911. CNA #269 stated himself, RN #213, and CNA #181 pulled the resident into the hallway so EMS could get to the resident easier. CNA #269 stated Resident #96 was stating her chest hurt. EMS arrived shortly and took her to the hospital. Interview on [DATE] at 2:16 P.M. with CNA #181 revealed she was walking down the hall when CNA #269 asked her to assist in a mechanical lift transfer for Resident #96. CNA #181 stated CNA #269 had already been bathed and dressed and just needed a second person to assist in the transfer. CNA #181 stated she stood behind the wheelchair to assist in pulling her up once she got to the wheelchair. CNA #269 raised Resident #96 into the air and began the transfer when both blue straps on the sling broke, and Resident #96 fell to the floor hitting her head/neck area on the mechanical lift's legs. CNA #181 noted CNA #269 applied pressure to the back of Resident #96's head as she was bleeding from somewhere on the back of her head. RN #213 was immediately in the room after yelling for someone to call 911 and assessed the resident. RN #213 stated they needed to move her out of the room, so CNA #269 stabilized Resident (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#96's head and shoulders and RN #213 and CNA #181 grabbed the resident under her body and moved her from the bedroom into the hallway. The EMS were there shortly after and applied a C-collar to transport her to the hospital. Interview on [DATE] at 9:40 A.M. with RN #213 revealed she was in another resident's room when she heard yelling. She made sure the resident she was with was safe and went running to find what the yelling was about. RN #213 stated she got to Resident #96's room and saw her lying in the fetal position with no obvious injuries at that moment. She ran to grab supplies to take vital signs. RN #213 noted the resident had blood coming from the back of her head and had CNA #269 hold pressure on the wound with an ABD pad. Following assessment of Resident #96, RN #213 told another staff member to call 911. Due to Resident #96's head laying on the mechanical lift, they stabilized her head and removed the mechanical lift. Due to concerns about room for EMS, RN #213 told the staff to assist in moving her to the hallway. RN #213 stated she was concerned Resident #96 had a head/neck/spine injury and you would not normally move a resident with a potential head/neck/spine injury. RN #213 stated she wanted to move her so EMS would be able to get to the resident when they arrived. RN #213 stated four to six people assisted in dragging Resident #96 out into the hallway. RN #213 stated EMS was not going to put a C-collar on Resident #96 prior to transfer, but she told them to put one on and they did. Resident #96 was then transported to Hospital #1. Observation on [DATE] at 9:48 A.M. of a mechanical lift transfer for Resident #78 completed by CNA #209 and CNA #226 revealed no concerns regarding a safe mechanical lift transfer. Observation on [DATE] at 10:43 A.M. revealed all mechanical lift slings in the laundry room and throughout the facility revealed no holes, fraying, or concerns regarding the integrity of the slings that were currently in use at the facility. Observation on [DATE] at 9:28 A.M. of the sling used to transfer Resident #96 revealed the sling was very worn. There was no tag present on the sling, and it was undated.ˆThe green band that goes all the way around the sling was worn so much it was missing small parts of the green band in a couple places. Review of the undated Joerns Hoyer User Instruction Manual revealed prior to use, examine slings for fraying or other damage. Do not use any sling if damaged or if the sling shows signs of wear. Review of the undated Invacare Reliant 450 lift manufacturers guidelines revealed to check for wear, damage, and secure locking. Review of the Drive User Instruction Manual revealed to never use a sling which is frayed or damaged. Review of the Direct Supply Panacea Slings Owner's Manual revealed anticipated usable product life is based on normal use with proper maintenance, cleaning, and storage. Slings should be inspected, monitored, and cared for as described in the owner's manual as the product may need to be replaced sooner than anticipated in particular situations. Direct supply anticipated usable product life was six months. Review of the facility policy with a last revision date of [DATE] titled, Lifting Machine, Using a Mechanical, revealed staff should ensure all necessary equipment including slings are on hand and in good condition. Review of the facility policy with a last revision date of [DATE] titled, Assessing Falls and their Causes, revealed if there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview, and review of the facility policy, the facility failed to ensure a homelike environment. This affected four (#53, #4, #8, and #90) residents reviewed for physical environment and had the potential to affect all residents. The facility census was 89.Observation on 03/09/26 at 9:37 A.M. of Resident #53's bedroom revealed behind the bed a large, discolored area behind the bed frame with chipped paint. Further observation of Resident #4's bedroom revealed a wall with pealing wallpaper and chipped paint. Additional observation of Resident #8's bedroom revealed a large area on the wall with dry wall chipped and missing paint. Additional observation of Resident #90's bedroom revealed two holes in the wall behind the bed with visible paint chipping.Observation on 03/09/26 at 10:00 A.M. revealed throughout the facility there were areas in the hallways with chipped paint.Interview on 03/12/26 at 9:07 A.M. with the Maintenance Director (MD) #163 revealed currently the facility was not fixing issues in the resident rooms. MD #163 confirmed that Resident #53's bedroom had a large, discolored area behind the bedframe with chipped paint, Resident #4's bedroom wall had pealing wallpaper and chipped paint, Resident #8's bedroom had a large area on the wall with dry wall chipped and missing paint. DM #163 further confirmed the areas throughout the hallways missing paint were previously repaired but never painted. When asked when bedrooms in the facility have cosmetic repairs DM #163 stated he waited till residents were discharged to fix any areas of concern.Review of the facility policy titled, Resident Environmental Quality dated 2024, revealed preventative maintenance schedules, for the maintenance for the building should be followed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure Resident #49's dignity was maintained when her exposed body could be observed from the hallway during colostomy care. This affected one resident (#49) of one resident reviewed for dignity. The facility census was 89.Findings include:Review of Resident #49's medical record revealed an admission date of 10/13/25 with diagnoses including encounter for attention to colostomy, dysphagia, hypertension, anxiety disorder, spinal stenosis, depression, diaphragmatic and umbilical hernia, and overactive bladder. Review of Resident #49's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. Review of Resident #49's plan of care dated 11/20/25 revealed the resident had a colostomy and was at risk for complications related to skin integrity. Interventions included maintaining privacy while providing care.Observation on 03/09/26 at 9:36 A.M. revealed Resident #49 could be observed from the hallway. She was laying in her bed with her stomach, brief, and legs exposed, the curtain had been pulled enough that Resident #49's head, arms, and chest could not be seen. Certified Nursing Assistant (CNA) #114 could be observed providing colostomy care. Interview on 03/09/26 at 9:42 A.M. with CNA #114 revealed she did not realize Resident #49 had been exposed. She thought she had pulled the curtain far enough to provide her with privacy. CNA #114 verified the curtain should have been pulled far enough to hide Resident #49 from view.Interview on 03/09/26 at 10:43 A.M. with Resident #49 revealed she was very self-conscious of her ostomy. She expected staff to close the curtain during care and did not want to be seen during care.Review of facility policy, ?Dignity,' dated 2001 revealed, staff were to promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the witnessed fall investigation, and policy review, the facility failed to report an incident of potential neglect to the state agency. This affected one resident (#96) of three residents reviewed for Self-Reported Incidents (SRI). The facility census was 89. Findings include:Review of Resident #96's medical record revealed an initial admission date of 10/15/21 and a re-entry date of 12/24/22. Diagnoses included hypertensive heart disease without heart failure, unspecified dementia, muscle weakness, unspecified protein calorie malnutrition, unspecified osteoarthritis, and stiffness of the right and left knees. Review of Resident #96's annual MDS assessment dated [DATE] revealed Resident #96 had severely impaired cognition with a Brief Interview for Mental Status (BIMS) score of two. Furthermore, Resident #96 was dependent for bed to chair and chair to bed transfers, toileting hygiene, shower and bathing, and personal hygiene. Review of Resident #96's physician orders with a start date of 05/07/24 revealed an order for a Hoyer lift for all transfers with instructions for every shift. Review of Resident #96's care plan with a revision date of 02/13/26 revealed Resident #96 required assistance with Activities of Daily Living related to weakness, acute illnesses, functional decline, or generally not feeling well with interventions that included a Hoyer lift for all transfers and requiring the assistance of two people for dressing, personal hygiene, and bathing. Review of the witnessed fall incident report dated 02/08/26 at 10:00 A.M. revealed Resident #96 was being transferred from her bed to her wheelchair via mechanical lift. CNA #181 and CNA #269 were present in the room for the transfer. While the lift was being moved from the bed to the wheelchair, the top two blue sling loops ripped and Resident #96 fell to the floor on her left side. The nurse was immediately notified and 911 was called. Resident #96 had approximately two centimeter by one centimeter laceration to the back of her head. Resident #96's head was laying on the mechanical lift leg, so staff stabilized her head and removed the mechanical lift. Pressure was applied to the bleeding area on the back of her head until EMS arrived. Review of the facility's SRIs revealed no SRI was initiated. Interview on 03/12/26 at 9:28 A.M. with the Director of Nursing and the Administrator verified they did not submit an SRI because they did not feel abuse, neglect, or misappropriation occurred. Review of the facility policy with a last revised date of September 2022 titled, Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating revealed if abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown source is suspected, the administrator immediately reports his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility.

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	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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on resident record review, interview, and policy review, the facility failed to ensure care plans were person-centered and reflected the residents' current status. This affected three residents (#01, #23, and #49) of 25 residents reviewed for care planning. The facility census was 89.Findings include: 1. Review of the medical record for Resident #01 revealed a re-admission date of 02/09/26 and diagnosis of Post Traumatic Stress Disorder (PTSD) Review of Resident #01's care plan dated 02/06/26 revealed a focus for trauma informed care identifying the resident as being at risk for decreased psychosocial well-being, adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing related to PTSD. Review of the interventions and goals associated with the focus revealed no mention of Resident #01's history related to the PTSD diagnosis nor any triggers the resident has. Interview on 03/11/26 at 1:55 P.M. with the Director of Nursing (DON) revealed residents with a PTSD diagnosis should have information related to their triggers and trauma history included in their care plans. The DON further confirmed Resident #01 did not have their triggers or trauma history included in their care plan. 2. Review of the medical record for Resident #23 revealed a re-admission date of 03/03/26 and diagnoses of schizoaffective disorder and bipolar disorder. Review of Resident #23's orders revealed an order beginning 03/03/26 for behavior monitoring every shift. Review of Resident #23's care plan revealed no goals or interventions related to the resident's mental health diagnoses. Interview on 03/11/26 at 1:55 P.M. with the DON revealed a resident's mental health diagnoses should be included in their care plan. The DON further confirmed Resident #23's care plan did not address his mental health diagnoses. 3. Review of Resident #49's medical record revealed an admission date of 10/13/25 with diagnoses including encounter for attention to colostomy, dysphagia, hypertension, anxiety disorder, spinal stenosis, depression, diaphragmatic and umbilical hernia, and overactive bladder. Review of Resident #49's plan of care on 03/11/26 revealed it did not comprehensively address her activity of daily living (ADL) needs. It did not address her assistance needs for bed mobility, toileting, eating, ambulation, dressing, grooming, bathing, and personal hygiene. Interview 03/11/26 at 1:33 P.M. with MDS Coordinator #141 revealed staff of different specialties enter in information to the care plan. MDS Coordinator #141 confirmed activities of daily living (ADL) goals should always be in the care plan. MDS Coordinator #141 confirmed the ADL goals were not in Resident #49's care plan. Interview 03/11/26 at 1:40 P.M. with Registered Nurse (RN) Manager #261 revealed upon admission a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' code status, pain, ADLs, and skin issues are triggered for the care plan. RN Manager #261 confirmed ADLs for Resident #49 were not in their care plan. Interview 03/11/26 at 1:55 P.M. with the DON revealed the admitting nurse is responsible for putting a residents' ADLs into the care plan and any further needs are added to the care plan as they arise. The DON reported the admitting nurse is not the same individual for all admissions. The DON confirmed Resident #49 did not have ADL needs documented in their care plan. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed the comprehensive, person-centered care plan should describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Further review of the facility policy also revealed care plan interventions are chosen with consideration between the resident's problem areas and their causes.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure vision and hearing services were arranged for Resident #49. This affected one resident (#49) of one resident reviewed for communication and sensory. The facility census was 89.Findings include:Review of Resident #49 revealed an admission date of 10/13/25 with diagnoses including encounter for attention to colostomy, dysphagia, hypertension, anxiety disorder, spinal stenosis, depression, diaphragmatic and umbilical hernia, and overactive bladder. Review of Resident #49's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. Review of Resident #49's medical record revealed no evidence she had been asked to sign a consent for ancillary services or had seen an audiologist or optometrist. Interview on 03/09/26 at 10:43 A.M. with Resident #49 revealed she wanted to see the audiologist about hearing aids. Additionally, she reported in the past she had surgery to her right eye and it was causing problems again and she wanted to see the doctor about it.Interview on 03/10/26 at 10:48 A.M. with Activities Director #142 revealed residents should be given consent for ancillary services once they become long term care residents. She verified Resident #49 was a long term care resident and she had not spoken to her about receiving ancillary services.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide colostomy care as ordered for Resident #49. This affected one resident (#49) of one resident reviewed for constipation and diarrhea. The facility census was 89.Findings include: Review of Resident #49's medical record revealed an admission date of 10/13/25 with diagnoses including encounter for attention to colostomy, dysphagia, hypertension, anxiety disorder, spinal stenosis, depression, diaphragmatic and umbilical hernia, and overactive bladder. Review of Resident #49's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition. Review of Resident #49's plan of care dated 11/20/25 revealed the resident had a colostomy and was at risk for complications related to skin integrity. Interventions included keeping the ostomy site covered, encouraging the resident to express feelings and concerns, keeping the pouch emptied routinely, maintaining privacy while providing care, observing for signs and symptoms of complications related to colostomy and notifying physician of abnormal findings, providing ostomy care as ordered, and education and emotional support as needed.Review of Resident #49's physician order from 10/18/25 to 01/20/26 revealed an order to change colostomy appliance as needed for leakage change and at least every three days.Review of Resident #49's Medication Administration Record (MAR) from 11/01/25 to 11/30/25 revealed her colostomy appliance was only changed on 11/15/25 and 11/29/25. Review of the MAR from 12/01/25 to 12/31/25 revealed it was only completed on 12/08/25.Review of Resident #49's physician order dated 02/11/26 revealed an order to change colostomy appliance every three days on night shift.Review of Resident #49's MAR for February 2026 revealed it was not completed as scheduled for 02/11/26.Review of Resident #49's progress notes from 10/18/25 to 02/11/26 revealed no documented reason for not replacing her colostomy appliance.Interview on 03/09/26 at 10:43 A.M. with Resident #49 revealed she was not always receiving colostomy care on schedule.Interview on 03/11/26 at 1:18 P.M. with Registered Nurse (RN) #161 verified there was no evidence Resident #49's colostomy appliance was changed as ordered for the above dates. A policy for colostomy's was requested and not received.

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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.

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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.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interviews, staff interviews, and policy review the facility failed to ensure residents understood arbitration agreements prior to signing them. This affected four (#7, #55, #62, and #68) of six residents reviewed for arbitration agreements. The facility census was 89.Findings include:1.Review of medical record for Resident #55 revealed an admission date of 01/22/26 with diagnoses including but not limited to dementia.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment.Review of Arbitration Agreement revealed the agreement was signed by the resident on 01/23/26.Interview on 03/11/26 at 1:57 P.M. with Resident #55 revealed the resident did not know what an arbitration agreement was. Resident #55 could not remember if she ate lunch today or what was for lunch. Resident #55 could not answer questions.2.Review of medical record for Resident #68 revealed an admission date of 01/08/26 with diagnoses including but not limited to contusion and laceration of cerebrum without loss of consciousness, encephalopathy, cognitive communication deficit, and nonrheumatic mitral valve insufficiency.Review of the MDS assessment dated [DATE] revealed a BIMS score of zero which indicated severe cognitive impairment.Review of the Arbitration Agreement revealed the agreement was signed by the resident on 02/23/26 during a readmission to the facility.Interview on 03/11/26 at 3:35 P.M. with admission Assistant (AA #144) revealed the arbitration agreement is signed on admission. AA #144 stated all admission paperwork is done electronically and is on an iPad that the resident initials and signs each page. AA #144 stated she informs the residents' the arbitration agreement is voluntary and if they have a dispute with the facility, it would be heard through arbitration and not a judge and jury. AA #144 stated she looked at the BIMS scores completed by Speech Therapy to determine the cognitive status of residents prior to having them sign admission paperwork including the arbitration agreement. AA #144 stated she also looked to see if a resident had a guardian, responsible party, or POA. AA #144 stated the admission paperwork could be emailed to the guardian, responsible party, or POA to be signed if they could not come to the facility.Interview on 03/12/26 at 9:37 A.M. with AA #144 verified Resident #68 had a BIMS of zero and signed her own arbitration agreement. AA #144 also verified Resident #55 had a BIMS of three and signed her own arbitration agreement. AA #144 verified that both residents should not have signed their own arbitration agreements.Review of policy titled, Binding Arbitration Agreements, dated November 2023 revealed the terms and conditions of a binding arbitration agreement are explained to the resident in a form and manner that he or she understands, taking into consideration the resident's language, literacy and stated preference for learning. After the terms and conditions of the agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before being asked to sign the document. A signature alone is not sufficient acknowledgement of understanding. The resident or representative must verbally acknowledge understanding, and the verbal acknowledgement documented by the staff member who explains the agreement.