STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365065	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Pavilion Care Center	2171 Harrison Avenue Cincinnati, OH 45211

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and policy review, the facility failed to ensure Resident #03's power-of-attorney (POA) was notified of the resident's change in condition status and transfer to the hospital. This affected one (Resident #03) of three records reviewed for notification. The facility census was 78.Findings include:Review of the medical record revealed Resident #03 was admitted to the facility on [DATE]. Diagnoses included cognitive communication deficit, altered mental status, mood disorder, major depressive disorder, dementia and Alzheimer's disease. The resident had a designated POA listed in the record. Review of Resident #03's progress note dated 10/10/25, revealed the resident's mental status changed from baseline to increased confusion. The resident's vital signs were temperature 97.7 degrees Fahrenheit, blood pressure 136 over 85 millimeters of mercury (mmHg), heart rate 56 beats per minute and oxygen percentage of 96 percent (%). The physician was notified via voicemail, and the nurse was waiting for a response. There was no documented evidence that the resident's POA was notified. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE], revealed Resident #03 had no behaviors, severely impaired cognition, independent with eating, set up for toileting, set up for bathing, and set up for personal hygiene.Review of Resident #03's progress note dated 10/24/25 and authored by Licensed Practical Nurse (LPN) #22, revealed the physician was notified of the resident's mental status changes. The resident continued with confusion, refusal of care, and hallucinations. The resident was awake and restless during the entire night and argumentative with the staff. The resident refused medications and personal care after multiple attempts. The resident continued to wander the unit seated in a wheelchair and attempts of redirection were met with increased agitation. There was no documented evidence that the resident's POA was notified. Review of Resident #03's progress note dated 10/24/25, revealed the physician ordered the resident to be sent to the emergency room (ER) due to delirium. A report was given to University of Cincinnati (UC) Health Main ER. There was no documented evidence that the resident's POA was notified. Review of Resident #03 progress note dated 10/24/25, revealed the resident was transported to UC Hospital at 8:00 A.M. via stretcher due to altered mental status. The resident appeared confused at the time of transfer. The physician was notified. There was no documented evidence that the resident's POA was notified. During an interview on 11/25/25 at 12:20 P.M., LPN Unit Manager #29 stated if a resident was transferred out of the facility, the POA and /or guardian should be notified. During an interview on 11/26/25 at 8:25 A.M., the Director of Nursing (DON) confirmed Resident #03's guardian was not notified when the resident had a change in condition and was transported to the hospital. Review of the policy titled, Change in a Resident's Condition or Status dated 05/2017, revealed, the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when it is necessary to transfer the resident to a hospital/treatment center.This deficiency represents non-compliance investigated under Complaint Number 2622250.

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, policy review, and review of the guidelines from the National Pressure Injury Advisory Panel (NPIAP), the facility failed to adequately assess Resident #09's skin, failed to timely identify the resident's pressure ulcer (a pressure ulcer is a localized injury of the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), until it had reached an advanced stage and failed to timely implement provider ordered interventions to prevent the development of pressure ulcers and/or aid in the healing of existing pressure ulcers. This resulted in Actual Harm to Resident #09, who was admitted without pressure ulcers but was at risk for the development of pressures and subsequently developed an avoidable, facility acquired pressure ulcer. Resident #09 was assessed by Wound Nurse Practitioner (WNP) #60 on 11/04/25 and treatment orders were recommended but not implemented until 11/11/25. On 11/10/25, Resident #09 had red areas to both buttocks with bleeding. Resident #09 was assessed on 11/13/25 by WNP #60 with two pressure ulcers, one of which was first identified as a stage III pressure ulcer (full-thickness skin loss in which adipose [fat] is visible) to the resident's sacrum and a stage II pressure ulcer (partial thickness loss of skin with exposed dermis) to the residents left buttock. This affected one (Resident #09) of three residents reviewed for pressure ulcers. The facility census was 78.Findings include: Review of the medical record of Resident #09 revealed an admission date of 10/20/25. The resident was discharged to the hospital on [DATE] and returned to the facility on [DATE]. Diagnoses included cellulitis, stage III pressure ulcer to sacrum, atrial fibrillation, and hemiparesis and hemiplegia to right dominant side. Review of the admission care plan initiated on 10/21/25, revealed Resident #09 was at risk for altered skin integrity and pressure ulcers related to bowel and bladder incontinence, limited mobility, decreased ADL self-performance, medical diagnoses, and overall medical conditions. Interventions included a pressure reduction device to bed (low air loss mattress with bolsters). Review of the Braden Scale for Predicting Pressure Sore Risk dated 10/21/25, revealed Resident #09 was at high risk for developing pressure ulcers.Review of the physician order dated 10/21/25, revealed Resident #09 was ordered to receive house barrier cream applied to peri-area buttocks after each incontinent episode and as needed (PRN) to prevent skin breakdown.Review of the progress note dated 11/04/25 at 2:38 P.M. and authored by Wound Nurse Practitioner (WNP) #60, revealed Resident #09 returned from the hospital and had incontinent associated dermatitis to the right buttock that measured 3.0 centimeters (cm) in length by 2.0 cm in width by 0.1 cm in depth. Treatment orders were to cleanse area with normal saline, apply Venelex (topical cream to promote the healing of skin ulcers and wounds) to base of the wound, leave open to air every shift and as needed and provide turning and repositioning per protocol for pressure prevention. Review of November 2025 Treatment Administration Record (TAR) for Resident #09 from 11/04/25 through 11/10/25, revealed no documented treatments per WNP #60's treatment orders on 11/04/25. Review of the Five-Day Medicare Minimum Data Set (MDS) assessment for Resident #09 dated 11/07/25, revealed the resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 99. This resident was dependent on staff for activities of daily living (ADL). Section M (skin conditions) revealed the resident did not have a pressure ulcer but was at risk.Review of the skilled nurse's note dated 11/09/25, revealed Resident #09's skin appearance was within normal limits with no new changes to skin integrity. Review of the progress note dated 11/10/25 at 7:52 A.M., revealed the staff noted red areas to Resident #09's bilateral buttocks with minimal bleeding. Resident #09 made groaning and moaning noises when the area was cleaned. Resident #09's sister and other parties were notified. Review of the physician order dated 11/11/25, revealed Resident #09 was ordered to have his right buttocks cleansed with normal saline, Venelex applied, and leave open to air every shift. This order was originally supposed to be implemented on 11/04/25 per WNP #60's treatment orders. Review of the progress note dated 11/13/25 at 9:39 A.M. and authored by WNP #60, revealed Resident #09 had the following skin concerns: right buttock had incontinence associated dermatitis which measured 5.5 cm in length by 4.0 cm in width by 0.2 cm in depth with 80 percent (%) granulation (new tissues) and 20 % slough (peeling skin), sacrum had a stage III pressure ulcer which measured 3.0 cm in length by 1.5 cm in width by 0.3 cm in depth with 90 % granulation and 10 % slough, and left buttock had a stage II pressure ulcer which measured 2.5 cm in length by 3.5 centimeters in width by 0.1 cm in depth with 100% epithelial tissue. New treatment orders were recommended including a low air loss (LAL) mattress. Review of the physician order dated 11/13/25

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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, staff interviews, review of pharmacy records, and policy review, the facility failed to ensure residents were free from significant medication errors. This affected one (Resident #45) of three resident reviewed for medication administration. The facility census was 78.Findings include:Review of the medical record for Resident #45 revealed an admission date of 03/19/24. Diagnoses included hyperosmolality and hypernatremia, major depressive disorder, and pressure ulcer of the sacral region.Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #45 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10. Review of the physician order dated 11/11/25, revealed Resident #45 was ordered Meropenem (antibiotic) Intravenous (IV) Solution Reconstituted one gram (gm), use one gram intravenously every eight hours for infected sacral wound for 14 days.Review of the Pharmacy Delivery Receipt dated 11/11/25, revealed Resident #45 received 24 bags (an 8-day supply) of Meropenem IV solution.Review of the November 2025 medication administration record (MAR), revealed Resident #45 did not receive IV Meropenem IV solution on 11/14/25 at 9:00 P.M., 11/15/25 at 5:00 A.M., 1:00 P.M., and 9:00 P.M., 11/16/25 at 5:00 A.M., 1:00 P.M., and 9:00 P.M., and 11/17/25 at 5:00 A.M.Review of the pharmacy progress note dated 11/15/25 at 4:55 A.M., revealed Resident #45 did not receive Meropenem IV solution because the medication was on order.Review of the pharmacy progress note dated 11/15/25 at 11:09 P.M., revealed Resident #45 did not receive Meropenem IV solution because the medication was on order. Review of the pharmacy progress note dated 11/16/25 at 5:11 A.M., revealed Resident #45 did not receive Meropenem IV solution because the medication was on order. Review of the pharmacy progress note dated 11/16/25 at 4:15 P.M., revealed Resident #45 did not receive Meropenem IV solution because the medication was on order. Review of the pharmacy progress note dated 11/16/25 at 8:41 P.M., revealed Resident #45 did not receive Meropenem IV solution because medication on order at pharmacy.Review of the pharmacy progress note dated 11/17/25 at 4:52 A.M., revealed Resident #45 did not receive Meropenem IV solution because the medication was on order. Review pf the pharmacy delivery receipt dated 11/18/25, revealed Resident #45 received 21 bags (a seven-day supply) of Meropenem IV solution.During an interview on 11/26/25 at 8:07 A.M., Pharmacy Representative (PR) #100, stated an order was submitted on 11/11/25 for Meropenem IV solution. PR #100 reported a seven-day supply (24 bags) was sent on 11/11/25. PR #100 also reported a seven-day supply (21 bags) was sent on 11/18/25.During an interview on 11/26/25 at 9:27 A.M., the Director of Nursing (DON) verified Resident #45 missed doses of Meropenem on 11/14/25, 11/15/25, 11/16/25, and 11/17/25.During an interview on 11/26/25 at 1:05 P.M., the DON stated Resident #45 was not given IV Meropenem on the above days because an agency nurse was working and didn't ask where the IV medications were stored.Review of the facility policy titled, Administering Medications, revised April 2019, revealed medications were administered in a safe and timely manner, and as prescribed. Medications were administered within one hour of their prescribed time, unless otherwise specified.This deficiency represents non-compliance investigated under Complaint Number 2639823.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to ensure dishware was clean prior to serving pureed meal service. This affected one (Resident #11) of one resident who the facility identified as receiving pureed diets. The facility census was 78.Findings include:Record of the medical record for Resident #11 revealed an admission date of 05/06/24. Diagnoses included dysphagia, epilepsy, mood disorder, and hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of three. Review of the physician order dated 11/21/25, revealed Resident #11 was ordered a regular diet, pureed texture, regular thin consistency.Observation on 11/25/25 at 11:46 A.M., revealed [NAME] #110 obtained a divided plate, which had food particles from previous meal on plate. [NAME] #110 went to sink and rinsed with water and then placed pureed pasta onto that divided plate.During an interview on 11/25/25 at 11:50 A. M. [NAME] #110 verified the divided plate was not clean and had food on it from previous meal. [NAME] #110 verified she rinsed off the plate with water and placed pureed pasta and placed onto lunch tray to be served.Review of the facility policy titled, Food Preparation and Service, revised October 2017 revealed food and nutrition services employees shall prepare and serve food in a manner that complied with safe food handling practices. Areas for cleaning dishes and utensils were located in a separate area from the food service line to ensure that a sanitary environment was maintained.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, and policy review, the facility failed to ensure infection control measures were implemented during wound care. This affected one (Resident #09) of three residents reviewed for wound care. The facility census was 78.Findings include:Review of the medical record of Resident #09 revealed an admission date of 10/20/25. Diagnoses included cellulitis, stage three pressure ulcer to sacrum, atrial fibrillation, and hemiparesis and hemiplegia to right dominant side.Review of the Five-Day Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #09 had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 99. This resident was assessed to require dependent with toileting, bathing, dressing, and transfers.Review of the physician order dated 11/20/25, revealed Resident #09 was ordered to have right buttocks cleansed with normal saline, skin prep to peri-wound, and covered with border foam one time a day for wound care.During an observation of wound care for Resident #09 on 11/26/25 at 10:05 A.M., by Licensed Practical Nurse (LPN) #23 with the assistance of Certified Nursing Assistant (CNA) #13, revealed LPN #23 did not remove her soiled gloves and perform hand hygiene after removing the old dressing from Resident #09. LPN #23 wore the same gloves for the entirety of the dressing change.During an interview on 11/26/25 at 10:26 A.M., LPN #23 verified she did not remove her soiled gloves after removing Resident #09's old dressing. LPN #23 verified she should have removed her soiled gloves and performed hand hygiene prior to cleaning and placing a new dressing to Resident #09's wound.Review of the facility policy titled, Wound Care revised October 2010, revealed the purpose was to provide guidelines for the care of wounds to promote healing. Wash and dry hands thoroughly and put on gloves. Loosen tape and remove dressing. Pull gloves over the dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. Put on gloves and continue treatment.