STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366483	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Trail Health Campus	10460 Progress Way Harrison, OH 45030

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure staff accurately documented when medications were held from being administered and the rationale for holding the medication, which affected 1 (Resident #2) of 5 residents reviewed for unnecessary medications. The facility census was 54.Findings included:An Resident Face Sheet indicated the facility admitted Resident #2 on 04/01/2024. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of ST elevation myocardial infarction of unspecified site (heart attack) permanent atrial fibrillation, hypertensive heart disease with heart failure, end stage renal disease, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/04/2026, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment.Resident #2's Care Plan revealed a problem statement initiated on 04/04/2024, that indicated the resident was at risk for cardiovascular distress related to diagnoses of hypotension, atrial fibrillation, myocardial infarction, and hypertension. Interventions directed staff to obtain vital signs as ordered and to administer medications as ordered (initiated 04/04/2026).Resident #2's physician Orders included an active order, dated 12/28/2025, for midodrine (a miscellaneous cardiovascular agent) 5 milligrams (mg), one tablet by mouth twice a day, with instructions to hold the medication if the resident's systolic blood pressure (SBP; the top number in a blood pressure reading) was greater than 130 millimeters of mercury (mmHg). The Orders also included an active order, dated 12/27/2025, for metoprolol tartrate (a beta blocker) 25 mg tablet, one half tablet (12.5 mg) by mouth twice a day, with instructions to Hold for SBP less than 100 HR [heart rate] less than 55.Resident #2's December 2025 Medications Administration History revealed staff documented that midodrine 5 mg was administered to the resident when the resident's SBP was greater than 130 mmHg on the following dates and times: - 12/06/2025- 6:00 AM to 10:00 AM- Licensed Practical Nurse (LPN) #3 documented the medication was administered; the resident's SBP was documented as 133 mmHg.- 12/15/2025- 6:00 AM to10:00 AM- LPN #3 documented the medication was administered; the resident's SBP was documented as 144 mmHg.- 12/15/2025- 6:00 PM to10:00 PM- LPN #7 documented the medication was administered; the resident's SBP was documented as 131 mmHg. - 12/17/2025- 6:00 PM to 10:00 PM- LPN #7 documented the medication was administered; the resident's SBP was documented as 145 mmHg.- 12/30/2025- 6:00 PM-10:00 PM- LPN #7 documented the medication was administered; the resident's SBP was documented as 133 mmHg.Resident #2's December 2025 Medications Administration History revealed staff documented metoprolol tartrate 12.5 mg was administered when the resident's SBP was less than 100 mmHg or their heart rate was less than 55 beats per minute (bpm) on the following dates and times:- 12/01/2025- 6:00 AM to 10:00 AM, LPN #3 documented the medication was administered; the resident's SBP was documented as 98 mmHg.Resident #2's January 2026 Medications Administration History revealed staff documented that midodrine 5 mg was administered to the resident when the resident's SBP was greater than 130 mmHg on the following dates and times: - 01/01/2026- 6:00 AM to 2:00 PM- LPN #7 documented the medication was administered; the resident's SBP was documented as 135 mmHg. - 01/16/2026- 6:00 PM to 10:00 PM- LPN #7 documented the medication (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was administered; the resident's SBP was documented as 131 mmHg.- 01/30/2026- 6:00 PM to 10:00 PM- LPN #7 documented the medication was administered; the resident's SBP was documented as 131 mmHg.Resident #2's February 2026 Medications Administration History revealed staff documented that midodrine 5 mg was administered to the resident when the resident's SBP was greater than 130 mmHg on the following dates and times:- 02/04/2026- 6:00 PM to 10:00 PM- LPN #7 documented the medication was administered; the resident's SBP was documented as 131 mmHg. - 02/11/2026- 6:00 PM to 10:00 PM- LPN #7 documented the medication was administered; the resident's SBP was documented as 131 mmHg.Resident #2's record revealed no evidence of the medications being held on the dates and times referenced.During an interview on 02/26/2026 at 10:00 AM, LPN #7 stated she checked the resident's blood pressure when there were parameters given. She stated that if the medication had to be held, then she took it out of the packaging and discarded it. LPN #7 stated she was familiar with Resident #2 and knew the resident's medications well. LPN #7 stated she worked fast and sometimes clicked the prep button and forgot to go back and change it to indicate that it was not given. During an interview on 02/26/2026 at 10:50 AM, LPN #3 stated she checked Resident #2's blood pressure and looked at parameters to see if medications were to be given. She stated that if a medication was held, it would be documented on the medication administration record (MAR). LPN #3 stated she was very familiar with Resident #2, and she worked with the resident at least once a week. She stated that sometimes she accidentally hit prepped and signed it out but forgot to go back to document the medication was not given.During an interview on 02/26/2026 at 11:25 AM, the Director of Health Services (DHS) stated she expected the nurses to follow the parameters in the order. She stated if a medication should be held, then staff held it and notified the doctor as ordered. The DHS stated she expected medication with blood pressure readings outside the parameters to be marked as not given in the electronic medical record.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to maintain appropriate infection control practices while providing suprapubic (SP) catheter care to 1 (Resident #5) of 2 residents observed for suprapubic catheter care. The facility census was 54.Findings included:A facility policy titled, Suprapubic Catheter Care, dated 12/16/2024, revealed, Overview: To prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. The policy revealed, 3. To perform the procedure: a. Cleanse around the catheter site (Note: If the resident has a drainage sponge around the stoma [a surgically created opening on the abdomen where a tube is placed to divert urine outside the body] site, remove the drainage sponge before washing,) Wash the outer part of the catheter tube.During an interview on 02/26/2026 at 1:09 PM, the Infection Preventionist (IP) stated the procedure and standard practice for cleaning a stoma was to start at the stoma site and clean in a circular motion away from the stoma. She also stated that the procedure and standard practice for cleaning the catheter tubing was to hold the base of the tubing at the stoma site and clean by moving the washcloth down the tubing away from the stoma site. A Resident Face Sheet revealed the facility admitted Resident #5 on 02/20/2026. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of acute cystitis without hematuria, obstructive and reflux uropathy, urinary tract infection, benign prostatic hyperplasia without lower urinary tract symptoms, and the need for assistance with personal care.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/02/2026, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for toileting hygiene (which included wiping the opening of an ostomy/stoma) and had an in-dwelling catheter (which included a suprapubic catheter) during the assessment look-back period. Resident #5's Care Plan included a focus area initiated on 02/23/2026, that indicated the resident had an active diagnosis of Urinary Tract Infection (UTI). Interventions directed staff to use proper infection control precautions as indicated and per policy when providing toileting, incontinence care, or catheter care (initiated 02/23/2026).Resident #5's Physician Order Report for orders dated 01/01/2026 through 02/24/2026, revealed an active order dated 02/20/2026 to provide suprapubic catheter care which included cleansing with soap and water with activity of daily living care, twice a day.During an observation of suprapubic catheter care on 02/25/2026 at 11:22 AM, Registered Nurse (RN) #9 and RN #6 stopped outside Resident #5's room, donned personal protective equipment (PPE) including a gown and gloves, and entered the room. The observation revealed that the resident was sitting in a wheelchair and RN #9 asked the resident if it was okay for them to provide catheter care while the resident was sitting in the wheelchair, and the resident agreed. The observation revealed that RN #9 wet a washcloth in a basin of warm water, added body wash to the cloth, and cleansed the stoma site for the suprapubic catheter by wiping back and forth (in an up and down scrubbing motion) over the stoma site. RN #9 then wet a clean cloth and rinsed the stoma site in the same up/down scrubbing motion, then proceeded to dry the stoma with a clean, dry cloth in the same manner. RN #9 then held onto the base of the tubing and wiped up and down the tubing, starting at the insertion site, going down the tubing approximately three inches and back up the tubing toward the stoma. RN #9 then wet a clean washcloth, rinsed the tubing with the same back and forth motion, and used a dry cloth to pat the tubing dry. During an interview on 02/26/2026 at 10:12 AM, RN #9 stated that the process was to use a soapy cloth to clean around the stoma site and tubing and use the same process for rinsing and drying. RN #9 stated that she was supposed to clean near the stoma site then outward. For the tubing, RN #9 stated that she was supposed to hold the tubing and clean down the tube, away from the insertion site. She stated she usually liked to have Resident #5 positioned in the bed for suprapubic catheter care. However, RN #9 stated that the resident was already in a wheelchair, and the resident was really hard to transfer. RN #9 said she tried to go under the catheter (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as well as she could; however, she stated that it was not done correctly and stated the resident should have been in bed for better positioning. During an interview on 02/26/2026 at 1:09 PM, the IP stated it was never okay to clean urinary catheter tubing by wiping a washcloth up and down the tubing. She stated RN #9 did not use the correct procedure for cleaning Resident #5's stoma site and tubing. During an interview on 02/26/2026 at 10:51 AM, the Director of Health Services (DHS) stated the procedure for cleaning a stoma site was to start from the inside. Per the DNS, staff should clean the tubing by going from the insertion site down the tubing away from the patient. She stated it was not appropriate to scrub up and down over the stoma site. During an interview on 02/26/2026 at 11:03 AM, the Interim Administrator stated that he did not know the catheter care policy verbatim, but knew there was a right way to provide catheter care. He stated he expected the nurses to provide catheter care per facility policy.