

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365483	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/23/2026
NAME OF PROVIDER OR SUPPLIER  Stillwater Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  75 Mote Drive Covington, OH 45318	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, staff interview, review of Self-Reported Incident (SRI), review of the incident log, review of police statement, review of staff drug screening results, and policy review, the facility failed to ensure resident's controlled substances were not misappropriated. This affected four (#18, #31, #50 and #78) of five residents reviewed for misappropriation. The facility census was 49. Findings include: Review of the medical record for Resident #18 revealed an admission date of 09/29/23 with diagnoses including chronic obstructive pulmonary disease, type two diabetes, and vascular dementia. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #18 is cognitively intact. Review of the physician orders revealed Resident #18 had an active order for Oxycodone. Review of the medical record for Resident #31 revealed an admission date of 12/26/24 with diagnoses including type two diabetes and inflammatory spondylopathy cervical region. Review of the MDS dated [DATE] revealed Resident #31 is cognitively impaired. Review of the physician orders revealed Resident #31 had an active order for Oxycodone. Review of the medical record for Resident #50 revealed an admission date of 09/26/25 with diagnoses including type two diabetes and chronic pain. Review of the MDS dated [DATE] revealed Resident #50 is cognitively intact. Review of the physician orders revealed Resident #50 had an active order for Oxycodone. Review of the medical record for Resident #78 revealed an admission date of 08/13/25 with diagnoses including chronic kidney disease and type two diabetes. Review of the MDS dated [DATE] revealed Resident #78 was cognitively intact. Review of the physician orders revealed Resident #78 had an active order for Oxycodone. Review of the incident log from 11/23/25 to 02/23/26 revealed Resident #18, #31, #50, and #78 had an alleged incident involving misappropriation of controlled substances on 02/05/26. Review of the facilities SRI dated 02/05/26 revealed on 02/05/26, Director of Nursing (DON) #100 noted an alteration in medication packaging involving controlled substances during a routine narcotic count. Bubble packaging had nicks and tears on the backside of the cards for multiple controlled substance. While popping the medications for waste, it was noted that the medication was an unstamped white pill that was not consistent with manufacture markings of the pills in the rest of the narcotic pills. Each narcotic card with compromised packaging was identified as Oxycodone 5 milligrams (mg) tablets. Medication administration activities were immediately stopped and medication carts were secured. Audits of medication were started with 11 cards of Oxycodone being affected totaling 42 unstamped pills being identified. Four current residents were identified as potentially affected and were immediately assessed and interviewed. All nurses with access to the medication were directed to submit a urine drug screen and all nurses complied. The urine sample for Licensed Practical Nurse (LPN) #89 did not meet temperature requirements and was transported to complete a full-panel drug screen, that was pending at the time of the SRI investigation. Local law enforcement was notified of the incident. During an interview with LPN #89 she admitted</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 365483	If continuation sheet Page 1 of 2

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>to responsibility for the drug discrepancy and diversion of controlled substances. LPN #80 verified that she replaced Oxycodone 5 mg tablets with Melatonin 1 mg tablets in all 11 packages. LPN #89 verified that the diversion started within the last month. The facilities investigation revealed misappropriation was substantiated. Review of the police statement written by LPN #89 dated 02/05/26 verified that she was replacing narcotics with a medication that looked similar to imitate the narcotic. Review of the facilities drug screen for LPN #89 dated 02/05/26 at 9:00 A.M. revealed that the temperature of the urine sample was not between 90-100 degrees. Review of the observed drug screen completed on 02/05/26 revealed LPN #89 tested positive for cocaine, opiates, and oxycodones. Interview on 02/23/26 at 10:25 A.M. with DON #100 verified that she found the alterations in the narcotic packaging. DON #100 verified that LPN #89 confessed to diverting the narcotic medication. All residents were assessed with no concerns found. All residents had their medications replaced. DON #100 confirmed four (#18, #31, #50 and #78) residents were affected by the misappropriation. Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021, revealed residents have a right to be free from abuse, neglect, misappropriation and exploitation. The deficient practice was corrected on 02/05/25 when the facility implemented the following corrective actions: On 02/05/26 at from 7:43 A.M., DON #100 identified packages of narcotics with impaired package integrity. On 02/05/26 from 7:45 A.M. to 9:00 A.M. a full narcotic audit of all medication carts was conducted. 11 Oxycodone 5 mg cards for 5 residents with a total of 42 unstamped white pills were found in place of the oxycodone. On 02/05/26 between 9:00 A.M. and 7:00 P.M. drug testing of all nursing staff was completed. On 02/05/26 at 10:22 A.M the Medical Director, Chief Medical Director, Nurse Practitioner and Pharmacist were notified. On 02/05/26 at 10:56 A.M. the facility notified law enforcement and State Survey Agency of suspected drug diversion. On 02/05/26 at 11:00 A.M. DON #100 and Pharmacy Consultant completed the following audits: all current narcotics sheets, Electronic Medication Administration Records, Pyxis/Omniceil reports, shift-to-shift count documents, and waste documents. No additional discrepancies were found. On 02/05/26 at 11:00 A.M. the facility provided the following education to all staff: controlled substance handling, narcotic procedures, waste witnessing requirements, reporting discrepancies immediately, abuse/neglect and misappropriation policy. On 02/05/26 at 12:27 P.M. the facility had a QAPI meeting regarding narcotic discrepancy and abatement plan. On 02/05/26 at 7:40 P.M. the facility notified Ohio Board of Nursing suspected drug diversion. On 02/05/26 Social Services Director interviewed all cognitively intact residents. All residents denied concerns about receiving proper medication or knowledge of misappropriation. On 02/05/26 DON #100 interviewed all cognitively intact residents. All residents denied unmanaged pain or inadequate pain control. On 02/05/26 DON #100 assessed all cognitively impaired residents for presence of pain. All residents presented absent of abnormal findings. On 02/05/26 DON #100 began daily audits of medication storage and narcotic sheets. This deficiency represents non-compliance investigated under Complaint Number 2744451.</p>		