STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365483	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stillwater Skilled Nursing and Rehabilitation	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and review of the facility policy, the facility failed to properly store the resident medications. This had the potential to affect the seven residents with medications stored in the [NAME] Hall cart. The facility census was 46 residents.Findings include: Observation 04/15/26 at 8:20 A.M. of [NAME] Hall medication cart with Licensed Practical Nurse (LPN) #160 revealed there were six loose pills of different sizes, shapes, and colors at the bottom of the cart drawer under the resident medication cards. Interview on 04/15/26 at 8:20 A.M. with LPN #160 confirmed the medication cart drawer had six loose pills at the bottom of the drawer. LPN #160 stated all medications should stored in their original containers and should be discarded if the medication fell to the bottom of the drawer. Review of the facility policy titled Storage of Medications revised April 2019 revealed all drugs and biologicals should be stored a safe, secure, and orderly manner and should be stored in packing, container, or other dispensing systems in which they were received. The nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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 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 medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure a comprehensive person-centered care plan included the resident preferences and refusals of cares/services for laryngectomy tube. This affected one (Resident #8) of two residents reviewed for care plans. The facility census was 46 residents. Findings include: Review of the medical record for Resident #8 revealed an admission date of 01/05/24 with diagnoses including malignant neoplasm of larynx, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and tracheostomy status. Review of the Minimum Data Set (MDS) assessment for Resident #8 dated 01/07/26 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs), and received tracheostomy care. Review of the care plan for Resident #8 dated 06/25/25 which stated the resident had laryngeal tube with a history of cutting edge/lip of the tube, stating it was too long. Interventions included the following: ensure tube ties were secured at all times, suction as necessary, monitor for skin breakdown. Further review of the care plan for Resident #8 revealed it did not include documentation of the resident's refusal of trach ties, the resident's preference to complete laryngeal tube care independently, nor of the resident's refusal to allow staff access to the tube at bedside. Observation on 04/14/26 at 11:37 A.M. of Resident #8 revealed the resident had a a laryngectomy tube in his neck stoma with no trach ties were noted around the tube. Observation revealed Resident #8 removed the laryngectomy tube out of his neck stoma and placed it back independently. There was no replacement tube at the resident's bedside. Interview on 04/14/26 at 11:39 A.M. with Resident #8 confirmed he completed his laryngectomy tube care independently and did not want trach ties around the tube, and he did not have a replacement tube at the bedside. Interview on 04/14/26 at 2:47 P.M. with the Director of Nursing (DON) confirmed Resident #8's care plan for the laryngectomy tube did not have documentation to support the resident completed laryngectomy tube care independently, that the resident refused to allow staff to apply trach ties or allow staff access to laryngectomy tube at bedside. Review of the facility policy titled Care planning- Interdisciplinary Team (IDT) revised September 2013 revealed the facility IDT was responsible for the development of an individual comprehensive care plan for each resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to ensure a replacement laryngectomy tube (used to keep neck stoma open and to provide a permanent, total airway separation) was at the resident's bedside or easily accessible for staff use. This affected one (Resident #8) of one facility-identified resident with laryngectomy tube. The facility census was 46 residents.Findings include: Review of the medical record for Resident #8 revealed an admission date of 01/05/24 with diagnoses including malignant neoplasm of larynx, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and tracheostomy status. Review of the Minimum Data Set (MDS) assessment for Resident #8 dated 01/07/26 revealed the resident was cognitively intact, required staff assistance with activities of daily living (ADLs), and received tracheostomy care. Review of the physician's orders for Resident #8 revealed an order dated 11/10/25 to remove the laryngectomy tube from the stoma and cleanse the stoma site with normal saline and to clean and replace the tube every shift and as needed. Observation on 04/14/26 at 11:37 A.M. of Resident #8 revealed the resident had a a laryngectomy tube in his neck stoma and the removed the laryngectomy tube out of his neck stoma and placed it back independently. There was no replacement tube at the resident's bedside. Interview on 04/14/26 at 11:39 A.M. with Resident #8 confirmed he completed his laryngectomy tube care independently and he did not have a replacement tube at the bedside. Interview on 04/14/26 at 11:16 A.M. with Licensed Practical Nurse (LPN) # 146 confirmed Resident #8 did not have a replacement laryngectomy tube at bedside nor did the staff have a tube available to use if needed. LPN #146 stated nursing staff assist the resident with setting up cleaning supplies for laryngectomy tube care and the resident was able to complete the task independently and refused to allow staff to complete the task. Interview on 04/14/26 at 11:40 A.M. with the Director of Nursing (DON) confirmed Resident #8 had a laryngectomy tube in his locked box at the bedside but staff were not able to get into the locked box. Review of the facility policy titled Tracheostomy Care revised August 2013 revealed a replacement tube must be available at the bedside at all times.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on medical record review, staff interview, and review of the facility policy, the facility failed to ensure residents did not receive unnecessary medications. This affected one (Resident #22) of five residents reviewed for unnecessary medications. The facility census was 46 residents.Findings include: Review of the medical record for Resident #22 revealed an admission date of 10/24/25 with diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and malignant neoplasm of bronchus and lung. Review of the physician's orders for Resident #22 revealed an order dated 10/27/25 for Azithromycin 250 milligram (mg) one tablet by mouth on Monday, Wednesday, and Friday for infection. Review of the care plan for Resident #22 dated 11/13/25 revealed the resident had signs and symptoms of respiratory infection/COPD exacerbation and was on long term antibiotic for COPD. The goal was for the resident to be free from signs and symptoms of pneumonia /respiratory infection after completion of antibiotics, administer antibiotics as ordered. Review of the pharmacist's recommendation for Resident #22 dated 11/23/25 revealed the pharmacist recommended a stop date on the Azithromycin. The physician's assistant refused the recommendation because the pulmonologist had written the order for the medication. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 02/13/26 revealed the resident was cognitively intact. Review of the progress note for Resident #22 dated 03/04/26 revealed the resident developed pneumonia and the physician gave orders start Augmentin and Doxycycline twice daily for five days and to hold Azithromycin for seven (7) days. Review of the after-visit summary for Resident #22 dated 03/10/26 revealed the resident saw the pulmonologist for mucopurulent chronic bronchitis and COPD and the pulmonologist gave an order to continue the Azithromycin tablet on Monday, Wednesday, and Friday. Interview on 04/14/26 at 2:45 P.M. with the Director of Nursing (DON) confirmed the facility staff had not called the pulmonologist to review the use of Azithromycin three times weekly for COPD and ask for a possible stop date for the medication. The DON also confirmed the facility Infection Preventionist (IP) had not monitored or evaluated the long-term use of Azithromycin for Resident #22 nor had the IP suggested a possible dose reduction or stop date for the medication to the attending physician or pulmonologist since the 11/23/25 pharmacy recommendation. Review of the facility policy titled Infection Prevention and Control Program dated December 2023 revealed the facility would monitor antibiotic use and evaluate. The facility would provide feedback to practitioners regarding review of antibiotic use. Review of the facility policy titled Antibiotic Stewardship dated December 2016 revealed the facility staff would monitor antibiotic use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to ensure a medication error rate of five percent (%) or lower. The medication error rate was 7.4% based on two errors out of 27 medication opportunities. This affected one (Resident #34) of the four residents observed for medication administration. The facility census was 46 residents.Findings include: Review of the medical record for Resident #34 revealed an admission date of 07/26/24 with diagnoses including hypertension, atherosclerotic heart disease, asthma, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment for Resident #34 dated 01/31/26 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the physician's orders for Resident #34 dated April 2026 revealed orders for the following 12 morning medications: Eliquis, Claritin, Norco, Lasix- hold if blood pressure less than 120/80, Wellbutrin, amlodipine besylate-hold for blood pressure less than 120/80, allopurinol, clonidine-hold if systolic blood pressure less than 110, spironolactone, aspirin, pantoprazole. Observation on 04/15/26 between 8:02 A.M. of medication administration for Resident #34 per Licensed Practical Nurse (LPN) #160 revealed the nurse prepared 10 medications for administration: allopurinol, aspirin, Claritin, Lasix, pantoprazole, spironolactone, Wellbutrin, clonidine, Eliquis, and Norco. LPN #160 confirmed Resident #34's medication cup contained 10 medications. At 8:16 A.M. LPN #160 checked the resident's blood pressure and noted it was 150/88. LPN #160 administered the 10 medications to Resident #34, washed her hands, and exited the resident's room. Interview on 04/15/26 at 8:19 A.M. LPN #160 confirmed she had not administered Resident #34's amlodipine besylate or carvedilol as ordered. LPN #160 confirmed that Resident #34 should have had 12 medications administered with the morning medication pass. Review of the facility policy titled Administering Medications revised April 2019 revealed medications should be administered in a safe and timely manner, and as prescribed. The policy stated medications were to be administered in accordance with prescriber orders, including required timeframe.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on medical record review, staff interview, and review of the facility policy, the facility failed to implement the antibiotic stewardship plan and failed to properly monitor antibiotic use. This affected one (Resident #22) of five residents reviewed for unnecessary medications. The facility census was 46 residents.Findings include: Review of the medical record for Resident #22 revealed an admission date of 10/24/25 with diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and malignant neoplasm of bronchus and lung. Review of the physician's orders for Resident #22 revealed an order dated 10/27/25 for Azithromycin 250 milligram (mg) one tablet by mouth on Monday, Wednesday, and Friday for infection. Review of the care plan for Resident #22 dated 11/13/25 revealed the resident had signs and symptoms of respiratory infection/COPD exacerbation and was on long term antibiotic for COPD. The goal was for the resident to be free from signs and symptoms of pneumonia /respiratory infection after completion of antibiotics, administer antibiotics as ordered. Review of the pharmacist's recommendation for Resident #22 dated 11/23/25 revealed the pharmacist recommended a stop date on the Azithromycin. The physician's assistant refused the recommendation because the pulmonologist had written the order for the medication. Review of the Minimum Data Set (MDS) assessment for Resident #22 dated 02/13/26 revealed the resident was cognitively intact. Review of the progress note for Resident #22 dated 03/04/26 revealed the resident developed pneumonia and the physician gave orders start Augmentin and Doxycycline twice daily for five days and to hold Azithromycin for seven (7) days. Review of the after-visit summary for Resident #22 dated 03/10/26 revealed the resident saw the pulmonologist for mucopurulent chronic bronchitis and COPD and the pulmonologist gave an order to continue the Azithromycin tablet on Monday, Wednesday, and Friday. Interview on 04/14/26 at 2:45 P.M. with the Director of Nursing (DON) confirmed the facility staff had not called the pulmonologist to review the use of Azithromycin three times weekly for COPD and ask for a possible stop date for the medication. The DON also confirmed the facility Infection Preventionist (IP) had not monitored or evaluated the long-term use of Azithromycin for Resident #22 nor had the IP suggested a possible dose reduction or stop date for the medication to the attending physician or pulmonologist since the 11/23/25 pharmacy recommendation. Review of the facility policy titled Infection Prevention and Control Program dated December 2023 revealed the facility would monitor antibiotic use and evaluate. The facility would provide feedback to practitioners regarding review of antibiotic use. Review of the facility policy titled Antibiotic Stewardship dated December 2016 revealed the facility staff would monitor antibiotic use.