STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366076	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Eastern Star Hlth Care Ctr The	1451 Gambier Road Mount Vernon, OH 43050

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to store food in a sanitary manner and failed to maintain sanitary conditions while serving food. This deficient practice had the potential to affect all residents residing in the facility, who received meals from the kitchen. The facility census was 70.Findings Include:1. An observation on 02/10/26 at 7:57 A.M. revealed in the reach-in freezer there was an opened cardboard box of exposed frozen egg patties in an opened plastic bag, an opened cardboard box of exposed frozen pre-made biscuits in an opened plastic bag, and an opened cardboard box of exposed beef patties in an opened plastic bag. An interview on 02/10/26 at 7:45 A.M. with dietary cook (DC) #208 confirmed the opened cardboard box of exposed frozen egg patties in an opened plastic bag, the opened cardboard box of exposed frozen pre-made biscuits in an opened plastic bag, and the opened cardboard box of exposed beef patties in an opened plastic bag. DC #208 stated the plastic bags should be closed and the box should be closed after being opened for use so as not to expose the food items. Review of the facility's policy titled Food Labeling, Dating, and Expiration, dated 02/28/20, revealed frozen food must be packaged and stored within the freezer in such a way as to protect and preserve the integrity and quality of the food. Food shall be discarded at an earlier date if it is determined that the food quality is compromised in any way. 2. Observation on the [NAME] unit on 02/11/26 at 11:40 A.M. revealed Housekeeper #204 walked into satellite kitchen with a long ponytail and no hairnet; she began standing near the prepared food. Near the door of the kitchen was a sign noting to wear a hairnet in entering kitchen. Interview on 02/11/26 at 11:50 A.M. with Housekeeper #204 confirmed she forgot to put a hairnet on prior to going into kitchen. Review of the undated facility's policy titled, Sanitation and Infection Control Employee Hygiene for Food Safety, revealed all employees will wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, review of menus, and facility policy review, the facility failed to prepare and serve appropriate portions of food during meal service. This deficient practice had the potential to affect all 14 residents residing in the Lily neighborhood. The facility census was 70.Findings Include:Review of the portion size chart kept at each neighborhood serving station revealed the following requirements for portion sizes: 4 oz for fruits, vegetables, regular meats, desserts, and pureed meats with bread worked in; 3 oz for pureed sides, desserts, meats, ground meats, and pureed fruits and veggies; and 5 1/3 oz regular, mech soft, pureed casseroles.Review of the weekly menu revealed there were no portion sizes noted for each food item.An observation on 02/11/26 from 11:30 A.M. to 11:50 A.M revealed Dietary Server (DS) #202 preparing to serve lunch meal for residents in the Lily neighborhood. Per the weekly menu, lunch meal consisted of chipped beef on toast, cooked carrots, cooked green beans, mandarin oranges, and as substitute meal cabbage soup and a tuna salad croissant. DS #202 began serving the mandarin oranges from the container into small dessert bowls using a black plastic tablespoon and placing one to two scoops of the mandarin oranges in each bowl. DS #202 placed serving utensils in each food item container including a 2-ounce (oz) ladle for the cabbage soup, a 1 oz ladle for the chipped beef, 4 oz scoop for the cooked carrots and the green beans, and a black plastic tablespoon for the tuna salad croissant. The lunch meal service began with DS #202 preparing a plate with chipped beef and toast. DS #202 served approximately three scoops of the chipped beef using the 1 oz ladle onto the four pieces of toast. DS #202 then prepared a small bowl of cabbage soup using the 2 oz ladle and placing approximately two scoops of the soup into the bowl, DS #202 prepared a tuna salad croissant using the black plastic tablespoon. DS #202 placed approximately three spoonfuls of the tuna salad on the opened croissant. Lunch service continued until all the residents were served the lunch meal.An interview on 02/11/26 at 12:00 P.M. with Dietary Director (DD) #300 revealed the serving utensils for each food item should include: 4 oz of fruit or vegetables, regular meats and desserts.An interview on 02/11/26 at 12:06 P.M. with DS #202 confirmed the incorrect serving utensils were used when serving the lunch meal. DS #202 stated, I don't measure the portions; I just know what each person eats.Review of the undated facility policy titled Portion Control revealed Individuals will receive the appropriate portions of food as outlined on the menu. Control at the point of service is necessary to assure that accurate portion sizes are served.

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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 interview, medical record review, and policy review, the facility failed to notify the physician when Resident #15 missed doses of medication and failed to notify the family/power of attorney (POA) and physician of Resident #74's transfer to the hospital. This affected two residents (#15 and #74) of 20 records reviewed. The facility census was 70.Findings include: 1. Review of Resident #15's medical record revealed an admission date of 07/17/24 with diagnoses including acute respiratory failure with hypoxia, type two diabetes mellitus, major depressive disorder, unspecified dementia, insomnia, and cognitive communication deficit. Review of Resident #15's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Review of Resident #15's physician order dated 11/05/24 revealed an order for Brillinta 90 milligrams (mg) twice a day. Review of Resident #15's Medication Administration Record for 02/01/26 to 02/11/26 revealed Brillinta was not administered on 02/09/26 for either scheduled doses due to being unavailable. On 02/10/26 the 'upon rising' dose was administered late at 3:37 P.M. because it had been unavailable and the pharmacy had to send it. Review of Resident #15's progress notes revealed no evidence the physician was notified of Resident #15's missing medication. Interview on 02/11/26 at 1:35 P.M. with Registered Nurse (RN) #109 revealed she had been the nurse who called the pharmacy over the missing medication. She verified there was no evidence the physician had been notified of the missing doses. 2. Review of Resident #74's medical record revealed admission date 05/10/23 and discharge date [DATE] with diagnoses including but not limited to gastrointestinal hemorrhage, heart failure, and type two diabetes. The resident was a Full Code. Review of Resident #74's quarterly minimum data set (MDS) dated [DATE] revealed intact cognition with a Brief Interview Mental Status (BIMS) score of 14 out of possible 15. Review of Resident #74's care plan dated 09/27/25 revealed Resident #74 had ineffective breathing patterns related to shortness of breath at times. Review of Resident #74's physician orders revealed an order dated 11/23/25 for a 2-view chest Xray. Review of Resident #74's progress note dated 11/23/25 at 2:30 P.M revealed Resident #74's family was visiting when Resident #74 was noted to have increased confusion and complaining of left sided lung pain at times. An Xray was ordered with the results revealing Resident #74 had shallow breathing (hypoaeration of the lungs) and right atelectasis (partial or complete collapse of lung lobes). The facility's Certified Nurse Practitioner (CNP) #310 was notified of the Xray results and ordered an antibiotic. Resident #74's power of attorney (POA) was notified and did not want Resident #74 sent to (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital. Review of Resident #74's progress note dated 11/23/25 at 11:18 P.M. revealed Resident #74 was noted to be heard calling out for assistance. Registered Nurse (RN) #115 assessed Resident #74 with vital sign results including respirations 38 breaths per minute (normal ranges from 12 to 20 breaths per minute), heart rate 138 beats per minute (bpm) (normal ranges from 60 to 100 bpm), blood pressure 88/73 millimeters of Mercury (mmHg) (normal ranges around 120/80 mmHg), and temperature 97.6 degrees Fahrenheit (F) (normal ranges from around 97 degrees F to 99 degrees F). Emergency Medical Services (EMS) was notified for the transfer of Resident #74 to the hospital for further evaluation. The progress notes revealed no evidence the resident's family/POA or physician were notified of the hospitalization. An interview on 02/12/26 at 10:07 A.M. with Licensed Practical Nurse Unit Manager (LPN UM) #15 confirmed there was no notifications documented for Resident #74's family/POA or the on-call physician when Resident #74 was transferred to the hospital on [DATE] at 11:18 P.M. LPN UM #15 stated even in an emergency the physician and family were to be notified, and the notifications were to be documented in the progress notes. Review of the facility's undated policy titled, Procedure for notification of changes for resident, revealed the facility shall promptly notify the resident and/or the resident representative and his or her physician or delegate of changes in the resident's condition or status to obtain orders for appropriate treatment and monitoring and promote the resident's right to make choices about treatment and care preferences.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to maintain Resident #56's privacy when a video monitor, monitoring his room, was kept in the common area. This affected one resident (#56) of one resident reviewed for privacy. The facility census was 70.Findings include: Review of Resident #56's medical record revealed an admission date of 01/03/26 with diagnoses including fracture of right pubis, unspecified dementia, severe protein-calorie malnutrition, depression, anxiety disorder, chronic kidney disease, and repeated falls. Review of Resident #56's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Review of Resident #56's physician order dated 01/04/26 revealed a video monitoring device was to be in place for fall prevention.Observation on 02/10/26 at 9:16 A.M. of Resident #56's unit revealed when entering the unit through the door there was a main common area with several recliners facing the television. The television was on a wall with open windows into the dining room. A monitor was observed sitting on the ledge of the window on the left. On this monitor Resident #56 could be observed sitting in his chair in his room.Observation on 02/10/26 at 9:35 A.M. revealed the monitor remained in the same location, Resident #56 was observed sitting in his room. There were residents in the common area.Interview on 02/10/26 at 9:35 A.M. with Certified Nurse Assistant (CNA) #22 verified the observation. She reported they had a 'baby monitor' for Resident #56 due to his falls. She verified it could be seen by anyone in the common area. CNA #22 reported it could not be at the nurse's station because the distance was too far for the monitor to pick up. Observation on 02/11/26 at 10:05 A.M. revealed the monitor remained in the same location, there were two residents in the common area. Observation at 10:55 A.M. revealed Resident #56 could be observed in his bed on the monitor.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** Based on interview and record review, the facility failed to ensure fall prevention strategies were in place for Resident #15 prior to a fall. This affected one resident (#15) of three residents reviewed for falls. The facility census was 70.Findings include: Review of Resident #15's medical record revealed an admission date of 07/17/24 with diagnoses including acute respiratory failure with hypoxia, type two diabetes mellitus, major depressive disorder, unspecified dementia, and cognitive communication deficit.Review of Resident #15's fall event dated 10/14/24 revealed she had a fall while transferring off the commode.Review of Resident #15's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition and required partial to moderate assistance with toileting hygiene and supervision or touching assistance with toilet transfers. Review of Resident #15's plan of care dated 07/10/25 revealed the resident was at risk for falls, accidents, and injury related to admitted from hospital due to fall at home diagnoses, and getting up and walking without asking for assistance. Interventions included keeping bed at safe height and walker near reach, offer to toilet in early morning and assist as needed, keeping bathroom door closed while elder is in room to not tempt her to go herself, personal items in reach and return to bed after meals.Review of Resident #15's progress note dated 07/11/25 revealed the resident was heard calling out for help. The resident was found by the nurse lying on the bathroom floor with blood to her posterior head. The resident stated they fell backwards losing balance and injuring her head. Direct pressure was applied to the area and the resident was assessed. The call light was not utilized prior to her fall, the resident indicated she forgot. The staff reported Resident #15 and their neighbor were both attempting to use the restroom unassisted after they visited each other. They assisted Resident #15 on to the commode with her walker and call light in reach and went to her neighbor to assist them. This is when the resident fell. The resident was sent to the hospital.Review of Resident #15's fall report dated 07/11/25 and closed 07/25/25 revealed the resident had an unwitnessed fall in the bathroom. The resident had been at the sink unsupervised after she had transferred herself off of the commode and not utilizing the call light. The resident reported a pain of six to her buttocks and back of the head. The staff were educated to stay with the resident even if she was using the commode due to the elder not utilizing the call light. Review of Resident #15's plan of care dated 12/30/25 revealed the resident was at risk for falls, accidents, and injury related to admitted from hospital due to fall at home diagnoses, and getting up and walking without asking for assistance. Interventions included keeping bed at safe height and walker near reach, offer to toilet in early morning and assist as needed, keeping bathroom door closed while elder is in room to not tempt her to go herself, personal items in reach, return to bed after meals, and added on 07/11/25 staff were educated to stay with the resident while using the commode due to the resident not utilizing the call light when in reach.Interview on 02/12/26 at 8:41 A.M. with Certified Nursing Assistance (CNA) #23 revealed staying with a resident while they were on the toilet depended on many factors including cognition and level of assistance. If they were a fall risk they would need someone to stay with them. They might stand outside the bathroom door with it cracked to give them privacy, but they would stay nearby.Interview on 02/12/26 at 11:00 A.M. with the Chief Executive Officer (CEO) verified the resident had been left alone on the toilet prior to her fall.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interview, and facility policy review, the facility failed to properly store medications for Resident #9. This affected one resident (#9) out of two residents reviewed for pain management and had the potential to affect two of fifteen residents the facility noted as independently ambulatory. The facility census was 70.Findings include:Review of Resident #9's medical record revealed an admission date of 07/27/24. Diagnoses included unspecified dementia, low back pain, unspecified chronic back pain, poly-osteoarthritis and type II diabetes with diabetic chronic kidney disease.Review of Resident #9's quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) of 05 indicating impaired cognition. Review of Resident #9's physician orders revealed an order for Tramadol (an opioid medication) 50 milligrams (mg) four times a day due upon rising, at noon, afternoon, and at bedtime.Review of the Resident #9's comfort care plan dated 01/19/26 revealed Resident #9 experienced low back pain, pain and had osteoarthritis with a goal that Resident #9 would voice comfort through the target date. Interventions included to administer medications per physician orders and monitor for side effects, report unrelieved complaints of pain and signs of discomfort to physician for adjustments in medication management, monitor for nonverbal signs of discomfort, and monitor for complaints of pain.Observation on 02/09/26 at 6:28 P.M. revealed a white pill in a medication cup sitting on the medication cart laptop keyboard. No nurse was noted on unit at time of observation.Interview on 02/09/26 at 6:31 P.M. with Licensed Practical Nurse (LPN) #123 confirmed the medication was sitting on keyboard of the medication cart and Registered Nurse (RN) #117 was supposed to administer the medication to Resident #9 prior to leaving. LPN #123 confirmed the medication was Resident #9's Tramadol.Review of Resident #9's Tramadol narcotic sheet confirmed Tramadol 50 mg was removed from the locked cabinet at 4:34 P.M on 02/09/26.Review of Resident #9's Medication Administration Record (MAR) revealed a note by RN #117 for the afternoon Tramadol on 02/09/26 at 4:35 P.M. that stated Not administered: administered at 6:30 P.M. by another nurse.Review of the facility's policy titled, Medication Administration dated 10/14/24 revealed a procedure to administer medication and remain with the resident while the medication is swallowed, never leave a medication in a resident's room without orders to do so. It noted staff were to return to the medication cart and document medication administration with initials on the MAR immediately after administering medication to each resident.

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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, observation, interview, and facility policy review, the facility failed to maintain infection control during wound care for Resident #50, failed to implement Enhanced Barrier Precautions (EBP) for two residents. These deficient practices affected one resident (Resident #50) out of four residents reviewed for pressure ulcers and affected two residents (Residents #56 and #78) out of five residents reviewed for transmission based precautions. The facility census was 70.Findings Include: 1. Review of Resident #50's medical record revealed an admission date of 07/15/25 with diagnoses including but not limited stage four (IV) sacral pressure ulcer with osteomyelitis, type two diabetes mellitus, high blood pressure, and chronic pain. Review of Resident #50's quarterly Minimum Data Set (MDS) dated [DATE] revealed cognitive impairment with a Brief Interview Mental Status (BIMS) score of 10 out a possible 15 and required staff assistance with self-care and mobility. Review of Resident #50's physician orders revealed an order for wound treatment for a Stage IV sacral pressure ulcer including daily dressing changes with Silvercel rope packed in the wound and covered with a sacral foam dressing. An observation on 02/11/26 at 9:24 A.M. revealed the Director of Nursing (DON) completing the sacral wound dressing change for Resident #50. The DON removed the Silvercel sheet from the package and used scissors, removed from her scrubs pocket, to cut the amount of Silvercel required to pack Resident #50's sacral wound. The DON did not clean or sanitize the scissors prior to cutting the clean Silvercel sheet. The DON took the piece of Silvercel and packed Resident #50's wound and covered with a sacral foam dressing. An interview on 02/11/26 at 9:30 A.M. with the DON confirmed the scissors were not cleaned prior to cutting the Silvercel sheet for packing of Resident #50's sacral wound. Review of the facility's policy tilted Infection Control Policy revised March 2024 revealed environmental cleaning and disinfection including cleaning/disinfection of resident care equipment, including shared equipment. 2. Review of Resident #78's medical record revealed an admission date of 01/27/26 with diagnoses including but not limited to gastrostomy, dysphagia, adult failure to thrive, and depression. Review of Resident #78's admission minimum data set (MDS) assessment dated [DATE] revealed Resident #78 received 51% or more of nourishment from enteral feeding. Review of Resident #78's physician orders revealed orders to check the percutaneous endoscopic gastrostomy (PEG) tube placement every shift before medications and as needed (PRN), and an order to clean around the PEG tube site with gentle soap and water, pat dry daily and as needed. There was no evidence of orders related to Enhanced Barrier Precautions (EBP) or personal protective equipment (PPE) requirements. Review of Resident #78's care plan revealed a care plan dated 02/02/26 for enteral feeding via PEG (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tube. There was no evidence of a care plan related to EBP or PPE requirements. An observation on 02/10/26 at 10:15 A.M. revealed there was no notification sign for EBP or PPE available outside of Resident #78's room for use by staff while caring for Resident #78. An interview on 02/10/26 at 10:35 A.M. with Licensed Practical Nurse (LPN) #150 confirmed Resident #78 did not have EBP notification sign and PPE outside of the room and there was no order for EBP, or a care plan developed for Resident #78 related to having a PEG tube in place. Review of the EBP notification sign revealed providers and staff are to wear gloves and gown for the following high-contact resident care activities including device care or use: central line, urinary catheter, feeding tube, tracheostomy. 3. Review of Resident #56's medical record revealed an admission date of 01/03/26 with diagnoses including fracture of right pubis, unspecified dementia, severe protein-calorie malnutrition, depression, and anxiety disorder. Review of Resident #56's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. Resident #56 had moisture associated skin damage (MASD). Review of Resident #56's plan of care dated 01/26/26 revealed he had open MASD to the coccyx. Review of Resident #56's physician order dated 01/09/26 revealed an order to apply zinc cream to an Abdominal pad (sterile dressing) and apply the pad to open MASD on the coccyx every shift. Observation on 02/10/26 at 9:16 A.M. and on 02/11/26 at 10:05 A.M. and 1:35 P.M. revealed Resident #56 did not have Enhanced Barrier Precautions (EBP) in place. Interview on 02/11/26 at 1:35 P.M. and 1:51 P.M. with RN #109 verified Resident #56 did not have EBP in place. She reported this was because his wound was not a pressure wound. Interview on 02/11/26 at 3:36 P.M. with MDS Nurse #120 revealed the facility did not have an EBP policy. Review of the CDC webpage 'Implementation of Personal protective equipment use in nursing homes to prevent spread of multidrug-resistant organisms' dated 04/02/24, and obtained at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html revealed nursing home residents with wounds were considered especially high at risk of the acquisition and colonization of multi-drug resistant organisms. The use of both gown and gloves for high-contact resident care activities was indicated. Review of the facilities posted sign 'Enhanced Barrier Precautions' revealed everyone must perform hand hygiene when entering the room. Additionally, staff providing high contact care activities were to wear a gown and gloves while in the room. High contact care activities included: dressing, bathing, transferring, changing bed linens, brushing teeth, shaving, assisting with toileting, device care, wound care, and collecting soiled clothing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility policy, and review of McGeer's criteria, revealed the facility failed to follow antibiotic stewardship for two residents (#10 and #15) of seven residents reviewed for infection control. The facility census was 70.Findings include:1. Review of Resident #15's medical record revealed an admission date of 07/17/24 with diagnoses including acute respiratory failure with hypoxia, type two diabetes mellitus, major depressive disorder, unspecified dementia, and cognitive communication deficit.Review of Resident #15's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition.Review of Resident #15's progress note dated 01/09/26 revealed the nurse assessed a skin issue to the residents' right inner thigh. The area was hard to the touch, large in measurement, and raised with no discoloration. Resident #15 only reported pain in the area when it was touched. An additional progress note on 01/09/26 revealed the Certified Nurse Practitioner (CNP) gave a new order to start Cephalexin 500 milligrams (mg) one capsule twice a day for seven days for cellulitis.Review of Resident #15's infection tracker dated 01/09/26 revealed most questions were left unanswered including the type of infection, if the surveillance definition was met, if it was a reportable infection, her history, symptoms, onset date, and diagnostic testing. The only areas completed were responsible party notifications, new orders, and attached progress notes. The evaluation notes stated the resident remained with a lump however the antibiotic was completed and a Doppler and ultrasound were completed and negative for a deep vein thrombosis. The final question on the form was if the symptoms resolved and treatment was completed, to which there was a check mark and the answer, no.Review of Resident #15's physician orders dated 01/09/26 to 01/16/26 revealed an order for Cephalexin 500 mg one capsule twice a day. To start with bedtime dose on 01/09/26 and end upon rising on 01/16/26.Interview on 02/12/26 at 9:23 A.M. with MDS Nurse #120 revealed the facility was supposed to follow McGeer's criteria for infections. She verified Resident #15 did not meet McGeer's criteria for antibiotics and that there was no evidence the physician was notified of this. Review of the McGeer's criteria checklist for cellulitis, soft tissue or wound infections, dated 11/05/24, revealed at least one criterion must be met: either pus at the wound, skin, or soft tissue site; at least four of the following new or increasing signs or symptoms, heat (warmth) at affected site, redness (erythema) at affected site, swelling at affected site, tenderness or pain at affected site, serous drainage at the affected site; or at least one of the following: fever, leukocytosis, acute changed in mental status, or acute functional decline. 2. Review of Resident #10's medical record revealed an admission date of 09/25/19 with diagnoses including type two diabetes mellitus, major depressive disorder, hemiplegia and hemiparesis affecting left non-dominant side, and osteoarthritis.Review of Resident #10's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had intact cognition.Review of Resident #10's progress note dated 02/06/26 revealed the resident had an open area from Moisture Associated Skin Damage (MASD) on her right buttock. The nurse also noted the resident's right index finger was reddened around the cuticle and slightly swollen at the end of the fingernail. Hospice was made aware and gave orders for Clindamycin.Review of Resident #10's infection tracker dated 02/06/26 revealed the resident had a soft tissue infection of the right buttock and suspected cellulitis of the right index finger. Symptoms included her right buttock was extremely red and excoriated and her right index finger was red and slightly swollen. No other symptoms were indicated and no other diagnostics were performed.Review of Resident #10's physician order dated 02/07/26 to 02/16/26 revealed an order for Clindamycin 300 milligrams (mg) three times a day.Interview on 02/12/26 at 9:23 A.M. with MDS Nurse #120 revealed the facility was supposed to follow McGeer's criteria for infections. She verified Resident #10 did not meet McGeer's criteria for antibiotics and that there was no evidence the physician was notified of this. Review of the McGeer's criteria checklist for cellulitis, soft tissue or wound infections, dated 11/05/24, revealed at least one (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366076	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Eastern Star Hlth Care Ctr The	1451 Gambier Road Mount Vernon, OH 43050

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	criterion must be met: either pus at the wound, skin, or soft tissue site; at least four of the following new or increasing signs or symptoms, heat (warmth) at affected site, redness (erythema) at affected site, swelling at affected site, tenderness or pain at affected site, serous drainage at the affected site; or at least one of the following: fever, leukocytosis, acute changed in mental status, or acute functional decline. Review of the policy ?Antibiotic Stewardship/infection Control' revealed it was facility policy to implement an antibiotic stewardship program that promoted appropriate use of antibiotics while optimizing treatment of infections and reducing the possible adverse events associated with antibiotics.