

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366448	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Stellar Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 47045 Moore Ridge Road Woodsfield, OH 43793	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and interview, the facility failed to ensure required components of the comprehensive assessments were completed as required. This affected one resident (#14) of four residents sampled. The census was 32.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #14 was admitted on [DATE] with diagnoses including quadriplegia, chronic pain, diabetes mellitus, neurogenic bladder, major depressive disorder and peripheral vascular disease.</p> <p>Review of the annual Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed the resident's Cognitive Pattern: Brief Interview for Mental Status and Pain Assessment interview were not completed as required.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed the Pain Assessment interview was not completed as required.</p> <p>On 04/21/25 at 12:25 P.M., interview with Assistant Director of Nursing #85 verified the above.</p> <p>This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00164581.</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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and interview, the facility failed to develop comprehensive care plans as required. This affected two residents (#23 and #33) of four sampled residents. The census was 32.</p> <p>Findings include:</p> <p>1. Closed medical record review revealed Resident #33 was admitted on [DATE] with diagnoses including hypertension, pancreatic disorder and colostomy. The resident was discharged home on 04/15/25.</p> <p>Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #33 was cognitively intact for daily decision-making, denied pain, his overall goal was to return to the community, there was no active discharge plan, no referrals had been made and the local contact agency was unknown. Further review of the record revealed no other MDS assessments were completed for review.</p> <p>a. Review of the Physician Orders dated 03/12/25 revealed Resident #33 was ordered routine Tylenol 650 milligrams three times a day for complaints of pain to the head, neck, trunk and extremities.</p> <p>Review of the electronic Medication Administration Record dated April 2025 revealed Resident #33 was assessed for pain every shift and had complained of mild to moderate pain daily except on 04/05/25, 04/08/25, 04/11/25, 04/12/25, 04/13/25 and 04/15/25.</p> <p>b. Review of the Discharge Planning Review assessment dated [DATE] revealed Resident #33 was discharged home with home health care services.</p> <p>Review of the medical record revealed no evidence of a comprehensive pain care plan or discharge care plan for Resident #33.</p> <p>2. Medical record review revealed Resident #23 was admitted on [DATE] with diagnoses including cirrhosis of liver, diabetes mellitus, diverticulitis and colostomy.</p> <p>Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact for daily decision-making, the resident's overall goal was to return to the community, there was no active discharge plan, no referrals had been made and the local contact agency was unknown.</p> <p>Review of the medical record revealed no evidence a discharge plan of care had been developed.</p> <p>On 04/22/25 at 12:20 P.M., interview with Assistant Director of Nursing #85 verified the above.</p> <p>This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00164581.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, medical record review, policy review, wound dressing guideline review and interview, the facility failed to provide appropriate care and services to treat pressure ulcers. This affected one resident (#14) of one reviewed for wound care. The census was 32.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #14 was admitted on [DATE] with diagnoses including quadriplegia, chronic pain, diabetes mellitus, neurogenic bladder, major depressive disorder and peripheral vascular disease.</p> <p>Review of the annual Minimum Data Set assessment dated [DATE] revealed Resident #14 had no skin impairments.</p> <p>Review of the Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 04/06/25 revealed the resident was at moderate risk for skin breakdown.</p> <p>Review of the nurse practitioner Skin and Wound Initial Evaluation dated 04/08/25 and 04/15/25 revealed three new facility acquired pressure ulcers including an unstageable pressure ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) to the resident's right hip had developed. The treatment for the unstageable right hip pressure ulcer was to cleanse with wound cleanser, apply skin prep to the periwound, apply silver alginate (autolytic debridement with antimicrobial agent) cut to fit the wound bed followed by a bordered gauze. The wound was to be changed daily.</p> <p>Review of the electronic Physician Orders and Treatment Administration Record dated April 2025 revealed Resident #14's right hip pressure ulcer was treated with calcium alginate (autolytic debridement without an antimicrobial agent) between 04/05/25 and 04/17/25.</p> <p>On 04/17/25 between 2:19 P.M. and 2:58 P.M., observation revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Licensed Practical Nurse (LPN) #33 gathered supplies to complete Resident #14's unstageable right hip pressure ulcer including saline, derma wound cleaner, calcium alginate 2 x 2 gauze and a 4 x 4 border gauze. There was a sign posted on the door upon entering the resident's room indicating enhanced barrier precautions (EBP) and a three drawer container observed directly outside of the resident's room in the hallway. LPN #33 and Assistant Director of Nursing (ADON) #85 entered the room without donning personal protective equipment (gown), washed their hands, applied gloves and explained the procedure to the resident. ADON #85 assisted the resident to his left side and LPN #33 removed the dressing and dropped it into the trash can. The soiled dressing was observed to have thick cloudy drainage with an odor. LPN #33 applied wound cleanser onto a 4 x 4 inch gauze and proceeded to wipe across the width of the wound multiple times in a back and forth motion then in a circular motion around the perimeter of the wound, then back across the wound bed again with the same gauze. LPN #33 placed the gauze in the trash can, removed her gloves, washed her hands and donned new gloves. LPN #33 reached into her pocket and removed bandage scissors. Without cleaning the scissors, LPN #33 cut a piece of calcium alginate and placed the scissors on the barrier. The calcium alginate was placed on the resident's wound but it extended over the wound at which time LPN #33 removed the calcium alginate, used the same bandage scissors to cut the dressing that had touched the wound and then placed the bandage scissors back on the barrier with the other clean supplies. LPN #33 was placing the calcium alginate onto the wound when it fell on the bed. LPN #33 picked up the calcium alginate dressing from the bed, discarded it into the trash can, picked up the bandage scissors without cleaning them and cut a new piece of calcium alginate. LPN #33 placed the calcium alginate in the wound and covered it with a border gauze. LPN #33 removed her gloves, washed her hands and cleaned her bandage scissors with alcohol prior to placing them back in her pocket.</p> <p>On 04/17/25 at 2:50 P.M., interview with ADON #85 verified LPN #33 did not complete the treatment as ordered and appropriate infection control practices including EBP protocols were not implemented.</p> <p>On 04/17/25 at 3:00 P.M., interview with LPN #33 verified the above observation made during Resident #14's dressing change.</p> <p>On 04/21/25 at 10:25 A.M., interview with ADON #85 revealed the resident always had an odor, verified LPN #33 had not transcribed the wound treatment correctly as silver alginate versus calcium alginate, and it was not discovered until 04/17/25 during this current survey.</p> <p>Review of the undated policy: Pressure Injury Treatment revealed residents with pressure injuries will be treated with consistent treatment protocols to aid in the healing process. In addition, residents with pressure injuries will have an individualized treatment program that provides the appropriate treatment to facilitate health and that assesses and addresses comorbid conditions in a systematic manner.</p> <p>Review of the policy: Wound Care revised August 2022 revealed the following procedure included the use of gloves when the dressing was removed, pull the glove over the dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly or use a hand sanitizer and complete treatments as ordered.</p> <p>Review of The Wound Pros: Wound Dressings dated 2025 revealed the primary difference between calcium alginate and silver alginate lies in the presence of silver ions in the latter. While both dressings work by gelling in response to wound exudate, silver alginate dressing also delivers antimicrobial action. This makes it particularly useful for wounds that are infected or at risk of infection.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00164581.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>28704</p> <p>Based on observation, record review, policy review and interview, the facility failed to ensure the resident environment remained free of accident hazards when medication carts and treatment carts were left unlocked and unattended. This had the potential to affect seven residents (#26, #27, #28, #29, #30, #31 and #32) residing on the locked memory care unit. The census was 32.</p> <p>Findings include:</p> <p>Medical record reviews revealed Resident #26, #27, #28, #29, #30, #31 and #32 were all severely impaired for daily decision-making and resided on the locked, memory care unit.</p> <p>On 04/21/25 at 8:07 A.M., observation with Licensed Practical Nurse (LPN) #76 revealed the medication cart and treatment cart were unsupervised and unlocked at the nurses' station upon arrival to the memory care unit. Certified nurse assistant (CNA) #78 was observed in the dining room serving breakfast trays, and the medication and treatment carts were not within view of the CNA. There was no nurse or staff observed at the nurses' station at the time of the observation. Interview with LPN #76 at the time of the observation verified the carts were unlocked and stated the night shift nurse had already left leaving only CNA #78 on the unit to supervise the residents while LPN #76 was downstairs administering medications. LPN #76 stated Residents #26, #27, #28, #29, #30, #31 and #32 were independent with ambulation and/or could independently self-propel themselves in a wheelchair. LPN #76 verified all seven residents' wandered throughout the unit, would be capable of opening the drawers of the medication and/or treatment carts and a code/key (depending on use of stairs or the elevator) was needed to get on and off the unit.</p> <p>On 04/21/25 at 1:05 P.M., interview with Assistant Director of Nursing #85 verified medication and treatment carts were to be locked at all times especially on the memory care unit since all seven residents (#26, #27, #28, #29, #30, #31 and #32) had cognitive impairment.</p> <p>Review of the undated policy: 1.0 Medication Dispensing System revealed medication carts were to always be locked when out of sight or unattended.</p> <p>This deficiency represents an incidental finding of non-compliance investigated under Complaint Number OH00164581.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on medical record review and interview, the facility failed to ensure colostomy care was provided as ordered. This affected two residents (#23 and #33) of four residents sampled. The census was 32.</p> <p>Findings include:</p> <p>1. Closed medical record review revealed Resident #33 was admitted on [DATE] with diagnoses including hypertension, pancreatic disorder and colostomy. The resident was discharged home on 04/15/25.</p> <p>Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #33 was cognitively intact for daily decision-making and had a surgical wound.</p> <p>Review of the Physician Orders dated 02/11/25 revealed colostomy care was to be provided once a shift.</p> <p>Review of Resident #33's Treatment Administration Records (TAR) revealed the following:</p> <p>a. Dated February 2025 revealed colostomy care was completed on 18 of 35 opportunities.</p> <p>b. Dated March 2025 revealed colostomy care was completed on 53 of 62 opportunities.</p> <p>c. Dated April 2025 revealed colostomy care was completed on 24 of 30 opportunities.</p> <p>Review of the care plan: Alteration in gastrointestinal status related to colostomy dated 02/10/25 revealed to change ostomy appliance as ordered.</p> <p>2. Medical record review revealed Resident #23 was admitted on [DATE] with diagnoses including cirrhosis of liver, diabetes mellitus, diverticulitis and colostomy.</p> <p>Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #23 was cognitively intact for daily decision-making.</p> <p>Review of the electronic Physician Orders dated 03/12/25 revealed ostomy care was to be completed every shift.</p> <p>Review of the TAR dated April 2025 revealed ostomy care was provided on 28 of 30 opportunities.</p> <p>Review of the undated care plan: Alteration in gastro-intestinal status related to colostomy revealed colostomy care was to be provided as ordered by the physician.</p> <p>On 04/22/25 at 1:05 P.M., interview with Assistant Director of Nursing #85 verified ostomy care was not completed as ordered for Resident #23 or #33.</p> <p>(continued on next page)</p>

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00164581.

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to ensure the facility's medication error rate was not 5 percent or greater. This affected two residents (#19 and #30) of three residents observed for medication administration with seven errors out of 26 opportunities resulting in an error rate of 26.9%. The census was 32.</p> <p>Findings include:</p> <p>1. Medical record review revealed Resident #19 was admitted on [DATE] with diagnoses including chronic atrial fibrillation, cerebrovascular disease, hypertension, congestive heart failure and diabetes mellitus.</p> <p>Review of the electronic Physician Orders dated April 2025 revealed Resident #19 was ordered the following medications to be administered at 9:00 A.M.: glipizide (diabetes) 5 milligrams (mg), metformin 500 (mg), Eliquis 2.5 (mg) and Metoprolol tartrate 25 (mg).</p> <p>On 04/17/25 between 10:22 A.M. and 10:50 A.M., observation revealed Registered Nurse (RN) #100 prepared and administered glipizide (diabetes), metformin (diabetes), Eliquis (anticoagulant) and Metoprolol (blood pressure) to Resident #19. At the time of the observation RN #100 verified he administered the medications outside of the required timeframe stating it was his first time on that hallway and was behind.</p> <p>2. Medical record review revealed Resident #30 was admitted on [DATE] with diagnoses including unspecified dementia, diabetes mellitus, hypertension, anxiety disorder and major depressive disorder.</p> <p>Review of the electronic Physician Orders dated April 2025 revealed Resident #30 was ordered medications including aspirin (ASA) chewable 81 (mg), buspar 10 (mg) two tablets and Effexor (antidepressant) 37.5 (mg) three tablets.</p> <p>On 04/21/25 between 8:10 A.M. and 8:34 A.M., observation revealed Licensed Practical Nurse (LPN) #76 prepared Resident #30's medications including ASA enteric coated 81 (mg), buspar 10 (mg) one tablet and Effexor 37.5 (mg) one tablet. At 8:34 A.M., the surveyor asked LPN #76 regarding dosage of buspar and Effexor and LPN #76 verified she was administering the wrong doses of buspar and Effexor to Resident #30 and dispensed the additional tablets into the medication cup after reviewing the order.</p> <p>On 04/21/25 at 11:05 A.M., interview with LPN #76 verified she administered enteric coated ASA to Resident #30 instead of chewable stating there wasn't any chewable ASA available in the medication cart but was able to get some from the supply cabinet.</p> <p>Review of the undated policy: 3.0 Medication Administration Times revealed medications were to be administered as ordered and within 60 minutes before or after the facility's dosing schedule, except before or after meals orders and non-routine time ordered medications. Medication administration pass may begin 60 minutes before the scheduled times of administration but may not exceed 60 minutes after the scheduled times of administration.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigated under Complaint Number OH00164581.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28704</p> <p>Based on observation, medical record review, policy review and interview, the facility failed to maintain appropriate infection control practices during a wound treatment. This affected one resident (#14) of one observed for a dressing change. The census was 32.</p> <p>Findings include:</p> <p>Medical record review revealed Resident #14 was admitted on [DATE] with diagnoses including quadriplegia, diabetes mellitus, neurogenic bladder and peripheral vascular disease.</p> <p>Review of the electronic Physician Orders dated 04/17/25 revealed Resident #14 was receiving daily treatments including pressure ulcer treatments to an unstageable right hip pressure ulcer. The resident had an indwelling urinary catheter and was ordered enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organism that involves the use of a gown and gloves during high-contact resident care activities i.e. residents with wounds or indwelling medical devices).</p> <p>On 04/17/25 between 2:19 P.M. and 2:58 P.M., observation revealed the following:</p> <p>Licensed Practical Nurse (LPN) #33 gathered supplies to complete Resident #14's unstageable right hip pressure ulcer including saline, derma wound cleaner, calcium alginate 2 x 2 gauze and a 4 x 4 border gauze. There was a sign posted on the door upon entering the resident's room indicating enhanced barrier precautions (EBP) and a three drawer container observed directly outside of the resident's room in the hallway. LPN #33 and Assistant Director of Nursing (ADON) #85 entered the room without donning personal protective equipment (gown), washed their hands, applied gloves and explained the procedure to the resident. ADON #85 assisted the resident to his left side and LPN #33 removed the dressing and dropped it into the trash can. The soiled dressing was observed to have thick cloudy drainage with an odor. LPN #33 applied wound cleanser onto a 4 x 4 inch gauze and proceeded to wipe across the width of the wound multiple times in a back and forth motion then in a circular motion around the perimeter of the wound, then back across the wound bed again with the same gauze. LPN #33 placed the gauze in the trash can, removed her gloves, washed her hands and donned new gloves. LPN #33 reached into her pocket and removed bandage scissors. Without cleaning the scissors, LPN #33 cut a piece of calcium alginate and placed the scissors on the barrier. The calcium alginate was placed on the resident's wound but it extended over the wound at which time LPN #33 removed the calcium alginate, used the same bandage scissors to cut the dressing that had touched the wound and then placed the bandage scissors back on the barrier with the other clean supplies. LPN #33 was placing the calcium alginate onto the wound when it fell on the bed. LPN #33 picked up the calcium alginate dressing from the bed, discarded it into the trash can, picked up the bandage scissors without cleaning them and cut a new piece of calcium alginate. LPN #33 placed the calcium alginate in the wound and covered it with a border gauze. LPN #33 removed her gloves, washed her hands and cleaned her bandage scissors with alcohol prior to placing them back in her pocket.</p> <p>On 04/17/25 at 2:50 P.M., interview with ADON #85 verified LPN #33 did not complete the treatment as ordered and appropriate infection control practices including EBP protocols were not implemented</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/17/25 at 3:00 P.M., interview with LPN #33 verified the above.</p> <p>Review of the policy: Wound Care revised August 2022 revealed the following procedure included the use of gloves when the dressing was removed, pull the glove over the dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly or use a hand sanitizer and complete treatments as ordered.</p> <p>Review of the policy Enhanced Barrier Precautions (EBP) dated 04/01/24 referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities including the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP was indicated for residents with wounds and indwelling medical devices.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00164581.</p>