STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366448	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stellar Care Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and job description review,the facility failed to ensure professional standards of nursing care were provided when nursing staff did not verify and maintain a valid medical practitioner's order for the resident's clinical record prior to administering a controlled psychotropic medication. Although the dispensing pharmacy had a prescription for the medication, the facility did not have the order available or documented within the resident's medical record and medication administration record at the time of administration of the medication. This affected one resident (Resident #11) of four residents reviewed for medications. The census was 31. Review of Resident #11's medical record revealed an admission date of 08/09/23 and a re-admission date of 03/23/26 with diagnoses including hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side, other schizophrenia, acquired absence of right leg above the knee, acquired absence of left leg above the knee, anxiety disorder and major depressive disorder.Review of Resident #11's physician's orders revealed an order for clonazepam 0.5 milligrams (mg) twice a day as needed with a start date of 09/22/25 and an end date of 12/20/25. This was the only clonazepam order in the medical record.Review of Resident #11's controlled drug sheets for the medication clonazepam 0.5mg revealed the medication was documented on the sheet as given on 01/02/26 at 8:00 P.M., 01/03/26 at 8:00 P.M., 01/04/26 at 8:30 P.M., 01/05/26 at 8:00 P.M., 01/06/26 at 8:00 P.M., 01/09/26 at 8:00 P.M., 01/11/26 at 9:00 P.M., 01/12/26 at 9:00 P.M., 01/15/26 at 9:00 P.M., 01/16/26 at 9:00 P.M., 01/18/26 at 8:30 P.M., 01/19/26 at 8:35 P.M., 01/20/26 at 8:00 P.M., 01/21/26 at 8:00 P.M., 01/23/26 at 8:00 P.M., 01/24/26 at 9:00 P.M., 01/25/26 at 9:00 P.M., 01/26/26 at 9:00 P.M., 01/27/26 at 5:00 A.M., 01/29/26 at 6:00 P.M., 01/30/26 at 5:00 A.M., 03/06/26 at 9:00 P.M., 03/07/26 at 9:00 P.M., 03/08/26 at 9:00 P.M., 03/09/26 at 9:00 P.M., 03/10/26 at 9:00 P.M., 03/13/26 at 9:00 P.M., 03/17/26 at 1:40 A.M., 03/18/26 at 9:00 P.M., 03/28/26 at 9:00 P.M., 03/30/26 at 9:00 P.M., 03/31/26 at 9:00 P.M., 04/03/26 at 9:30 P.M., 04/05/26 at 9:00 P.M. and 04/06/26 at 9:10 P.M. There were no corresponding Medication Administration Record (MAR) entries documenting administration of the medication. Further review of the Narcotic Log revealed there were no doses of the medication documented as administered for the month of February 2026.Review of Resident #11's progress notes on 01/02/26 at 8:00 P.M., 01/03/26 at 8:00 P.M., 01/04/26 at 8:30 P.M., 01/05/26 at 8:00 P.M., 01/06/26 at 8:00 P.M., 01/09/26 at 8:00 P.M., 01/11/26 at 9:00 P.M., 01/12/26 at 9:00 P.M., 01/15/26 at 9:00 P.M., 01/16/26 at 9:00 P.M., 01/18/26 at 8:30 P.M., 01/19/26 at 8:35 P.M., 01/20/26 at 8:00 P.M., 01/21/26 at 8:00 P.M., 01/23/26 at 8:00 P.M., 01/24/26 at 9:00 P.M., 01/25/26 at 9:00 P.M., 01/26/26 at 9:00 P.M., 01/27/26 at5:00 A.M., 01/29/26 at 6:00 P.M., 01/30/26 at 5:00 A.M., 03/06/26 at 9:00 P.M., 03/07/26 at 9:00 P.M., 03/08/26 at 9:00 P.M., 03/09/26 at 9:00 P.M., 03/10/26 at 9:00 P.M., 03/13/26 at 9:00 P.M., 03/17/26 at 1:40 A.M., 03/18/26 at 9:00 P.M., 03/28/26 at 9:00 P.M., 03/30/26 at 9:00 P.M., 03/31/26 at 9:00 P.M., 04/03/26 at 9:30 P.M., 04/05/26 at 9:00 P.M. and 04/06/26 at 9:10 P.M. revealed no documentation the resident had requested the medication or had complaints of anxiety.There was no documentation in the progress notes that the resident received clonazepam during the month of February 2026.Review of Resident #11's behavior monitoring on the treatment (continued on next page)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration record on 01/02/26 at 8:00 P.M., 01/03/26 at 8:00 P.M., 01/04/26 at 8:30 P.M., 01/05/26 at 8:00 P.M., 01/06/26 at 8:00 P.M., 01/09/26 at 8:00 P.M., 01/11/26 at 9:00 P.M., 01/12/26 at 9:00 P.M., 01/15/26 at 9:00 P.M., 01/16/26 at 9:00 P.M., 01/18/26 at 8:30 P.M., 01/19/26 at 8:35 P.M., 01/20/26 at 8:00 P.M., 01/21/26 at 8:00 P.M., 01/23/26 at 8:00 P.M., 01/24/26 at 9:00 P.M., 01/25/26 at 9:00 P.M., 01/26/26 at 9:00 P.M., 01/27/26 at 5:00 A.M., 01/29/26 at 6:00 P.M., 01/30/26 at 5:00 A.M., 03/06/26 at 9:00 P.M., 03/07/26 at 9:00 P.M., 03/08/26 at 9:00 P.M., 03/09/26 at 9:00 P.M., 03/10/26 at 9:00 P.M., 03/13/26 at 9:00 P.M., 03/17/26 at 1:40 A.M., 03/18/26 at 9:00 P.M., 03/28/26 at 9:00 P.M., 03/30/26 at 9:00 P.M., 03/31/26 at 9:00 P.M., 04/03/26 at 9:30 P.M., 04/05/26 at 9:00 P.M. and 04/06/26 at 9:10 P.M. revealed no behaviors were recorded for the resident on those dates.Review of Resident #11's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed but review of the quarterly MDS dated [DATE] revealed the resident had moderate cognitive impairment. Further review of Resident #18's 03/27/26 admission MDS revealed the resident was dependent on staff for toileting hygiene showering/bathing, transfers, and bed mobility, received antipsychotic and antianxiety medications.Review of Resident #11's progress notes revealed a note dated 04/08/26 at 9:01 A.M. written by the Director of Nursing (DON) that read Discussed with pharmacy and ViaQuest nurse practitioner, order was active with an active script the entire time of administration, however, was not active on the EMAR.In an interview on 04/21/26 at 8:32 A.M. the DON stated the progress note dated 04/08/26 at 9:01 A.M. was related to Resident #11's clonazepam medication. The resident's medication was renewed in December of 2025 by the ViaQuest nurse practitioner (NP); however the nurse who received the verbal order did not enter the order for the clonazepam in the medical record or make an entry on the MAR to indicate the administration instructions for the medication. The DON verified this administration, without an active order in the medical record, occurred from 01/02/26 through 04/06/26. The DON verified the pharmacy had a prescription for the medication from ViaQuest. In an interview on 04/22/26 at 12:09 P.M. Registered Nurse (RN) #148 stated she did not recall giving the medication or the medication not being on the MAR. She normally worked upstairs (the facility had a first floor and second floor which both housed residents) however she did know the resident had clonazepam ordered for a long time but did not know if it was scheduled or as needed. The RN said if it was as needed she would look for an order before giving the medication and would assess for symptoms such as anxiety, yelling out, and behaviors that were normal for him such as raising and lowering the head of his bed and saying he was unable to locate the bed control. Review of the Narcotic Control Log provided revealed RN #148 did document doses of the medication for Resident #11.In an interview on 05/13/26 at 10:00 A.M. the DON stated she was made aware of the clonazepam 0.5 mg being given without being on the MAR, on one of the first days that she was working as the DON, when RN # 174 asked her to destroy the medication because there was not an order for it, the DON noted that it had been given recently and investigated to find out why. Her expectation was that the nursing staff would question any medication that was not on the MAR before administering the medication.In an interview on 05/13/26 at 10:10 A.M. RN #174 stated if a medication in the medication cart is not on the MAR and no current order can be seen in the electronic healthcare record (EHR) she would check the completed and discontinued orders to see if it was recently discontinued. If it is not needed for the resident any longer it should be removed from the cart and placed in the return to pharmacy bag. If it is a controlled medication and cannot be returned it remains in the cart and is counted until the DON and another nurse have to destroy the medication. If there is not a place to sign the medication off on the MAR she would not give it. RN #174 further stated there have been instances where the NP has sent a script to the pharmacy and not updated the facility that she/he has extended the order and pharmacy sends the medication and there is not an order. They then have to talk with the pharmacy and the NP to get the correct order in the EHR so that the order is on the MAR. RN #174 stated she always made sure to follow five rights of medication administration the right resident, the right route, the right dose, the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right medication and the right time.In an interview on 05/13/26 at 10:25 AM LPN #144 stated if a medication is in the medication cart but not on the MAR and no order for it is in the EHR she would call the doctor and get the order if the resident needs the medication but would not give any medication that is not on the MAR. She stated she would follow the five rights of medication administration the right resident, the right route, the right dose, the right medication and the right time. Review of the policy titled Physician Orders Policy and Procedure, dated 05/09/24, reviewed 08/2025 revealed the nurse receiving the order would enter it into the electronic healthcare record as soon as practicable.Review of the Facility Assessment, revised 05/14/26, revealed the facility would provide administration of medications that residents needby route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc. and would provide assessment/management of polypharmacy.Review of the Registered Nurse (RN) job description, undated, revealed the RN, when working a shift, would receive and transcribe physician's orders to resident chart, Medication Administration Record (MAR), treatment record and care plan as required, would prepare and administer medications as ordered by the physician and would follow all controlled drug policy and procedures as requiredReview of the Licensed Practical Nurse (LPN) job description, undated, revealed the LPN, when working a shift, would receive and transcribe physician's orders to resident chart, Medication Administration Record (MAR), treatment record and care plan as required, would prepare and administer medications as ordered by the physician and would follow all controlled drug policy and procedures as required. Review of the policy titled Administering Medications, revised 12/2012, revealed medication must be administered in accordance with the orders. Further review of the policy revealed the individual administering the medication was to record in the resident's medical record the date and time the medication was administered, the dosage, the route of administration, any complaints or symptoms for which the drug was administered, any results achieved and when those results were observed.This deficiency represents non-compliance investigated under Master Complaint Number 2992141.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, hospital record review, facility policy review and interview, the facility failed to timely identify a decline in condition and obtain medical intervention for Resident #26 following an injury sustained because of a fall. This affected one (Resident #26) of four residents reviewed for skin conditions.Actual harm occurred on 04/04/26 when Resident #26 complained of pain and had a decline in the ability to transfer. There was no thorough assessment completed to ensure the resident was provided timely and necessary treatment/medical intervention because of this change in condition. On 03/27/26 Resident #26 had sustained an unwitnessed fall. Between 04/04/26 and 04/08/26 the facility failed to complete a comprehensive nursing assessment or physician notification related to the resident's pain and decline in functional status that was identified during this time. On 04/08/26 the resident's family requested an x-ray due to the resident's complaint of pain and decline in functional status. On 04/09/26 the diagnostic test identified a fracture to the left femur neck occurring as result of the fall. The resident was subsequently transferred to the hospital and underwent surgical repair of her left hip fracture on 04/11/26. Findings include: Record review revealed Resident #26 admitted to the facility on [DATE] with diagnoses including weakness and hypertension. Review of a care plan dated 12/19/25 revealed Resident #26 was at risk for or had an activity of daily living self-performance deficit related to fractures of the thoracic vertebra (healed). The goal was for her functional ability to improve throughout the review period. Interventions included but were not limited to being able to transfer from sit to stand with supervision, resident was able to perform chair to bed transfers with supervision, and resident was able to transfer to the toilet with supervision. Review of a care plan dated 12/20/25 revealed Resident #26 was at risk for falls related to having a history of falls, unsteady gait, weakness, and getting on her knees typically at bedside to pray. The goal was to not sustain a serious injury from falls through the review date. Interventions included but were not limited to bedside table within reach, call light within reach, floor mat to resident's left side of bed, obtain and monitor lab work as ordered and report abnormalities to provider, offer to assist resident to kneeling position to pray in the morning and evening time, place bed in lowest position when not providing care, place walker next to resident's bed as a visual cue, and therapy to evaluate and treat as ordered and as needed. Resident #26 did not have a plan of care related to pain. Review of the Minimum Data Set (MDS) assessment completed 02/01/26 revealed Resident #26 had mildly impaired cognition, required substantial assistance with bed mobility, required moderate assistance with transfers, was frequently incontinent of bladder, occasionally incontinent of bowel, and had occasional pain. Review of a provider note dated 03/27/26 at 5:03 A.M. by Nurse Practitioner #500 revealed Resident #26 had a fall with no injuries and no signs of trauma. (This was not an in-person assessment by the NP). Review of the unwitnessed fall report dated 03/27/26 at 5:59 A.M., completed on 04/09/26, revealed a statement was received from Licensed Practical Nurse (LPN) #151 once a fracture was identified. An aide (unidentified) said the resident was on the floor. Upon entering the resident's room, the resident was on the floor next to her bed and the aide was with her. The resident stated she went to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	get up out of bed and it was at the lowest level and couldn't push because her legs were not strong enough and slid onto the floor. She said she did not lose consciousness and had no pain or complaints. She said she didn't hit her head. Neuro checks were initiated. Vital signs were within normal limits. Assisted resident to edge of bed and told her she would have neuro checks for the rest of tonight and tomorrow. The resident was asked if she wanted to go to the hospital and she said no, she was fine and would refuse to go anyway. Started neuro paperwork. No environmental factors. Predisposing factors were a fall within the last 30 days. Review of the record revealed no nursing progress notes related to the fall or documentation of an assessment related to the resident's range of motion (ROM) post-fall. There was no documentation post fall through 04/04/26. Review of a nursing note dated 04/04/26 at 1:40 P.M. authored by LPN #144 revealed she was called to Resident #26's room by staff. The resident had four skin tears to the right lower leg and a skin tear to the left upper arm. Wounds were cleansed with in-house wound cleanser, patted dry, and oil emulsion dressings were applied. The physician was notified and family was updated. Resident #26 had a physician order dated 04/04/2026 to cleanse the skin tear to the left upper arm with in house wound cleanser, pat dry, apply oil emulsion dressing and cover with dry dressing every 48 hours and to cleanse the skin tears to the right lower leg with in house wound cleanser, pat dry, apply oil emulsion dressing and cover with a dry dressing every 48 hours. Review of the Medication Administration Record for April 2026 revealed the resident received Tylenol 325 mg two tablets on 04/04/26 at 1:48 P.M. for a pain rated an eight (on a pain scale of 1-10 with one being minimal pain and 10 being the worst pain the resident ever felt) and on 04/06/26 at 6:00 A.M. for a pain rating of 5. There was no further assessment of the resident's pain, including location, description, non-pharmacologic interventions attempted, etc. Follow-up indicated the Tylenol was effective. Review of a nursing note dated 04/06/26 at 5:56 A.M. authored by Registered Nurse (RN) #110 revealed Resident #26 was wet three times this shift, she was put in her chair and was a two person assist as she almost slid to the floor. The aide working was able to pick Resident #26 up and physically place her in bed. Resident #26 had little to no ability to transfer herself and was in a lot of pain and if barely touched, she would moan out in pain. Resident #26 received Tylenol twice this shift and refused to have dressings changed. The dressings were dry and intact and resident stated she just hurt too bad. There was no documentation the physician was notified of Resident #26's condition change related to pain and/or the resident's inability to assist with transfers. Review of a nursing note dated 04/08/26 at 10:59 P.M. by RN #110 revealed the on-call provider was notified of the resident's complaints of pain. Resident #26 had bruising on various places across her body and had skin tears to both upper extremities and right lower extremity. Resident #26 was very sore to the touch and moaned out in pain with the lightest touch. Her biggest complaint of pain seemed to be in the left lower extremity. Resident #26's daughter was at the facility and requested an x-ray and whatever else staff thought she needed after examination. Upon examination, the resident's left leg was more swollen than her right leg. The left leg was warm to the touch. An ultrasound was requested to rule out a deep vein thrombosis and was given the following orders: x-ray of the left hip and knee to rule out fracture and doppler for left lower extremity to rule out deep vein thrombosis. When putting resident to bed, she was unable to stand/pivot transfer as she was able to previously per aides who know her well. Once in bed, the resident also complained of pain to her bottom and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	upon assessment, she had an open area which had increased in size to 10 centimeters (cm) by two cm which was about three times larger than it was two nights prior. The area was also reported to the on-call provider and received an order to clean the wound with wound cleanser daily, apply hydrocolloid/foam dressing per facility procedure, maintain clean, dry and moisturized skin. Monitor for increased drainage, redness and depth, reassess wound weekly or per policy, and notify provider if area worsens or signs of infection appear. Give Tylenol 1000 milligrams (mg) every eight hours as needed for pain. Resident' #26's daughter was notified of new orders; All Stat was called and orders given and stated they would arrive 04/09/26 to complete x-rays and doppler. Review of the MAR for April 2026 revealed Resident #26 had an order for Tylenol 500 mg give two tablets by mouth every eight hours as needed for pain. She received a dose on 04/08/26 at 10:24 P.M. for a pain rating of five and on 04/09/26 at 10:31 A.M. for a pain rating of seven. The location of the resident's pain was not identified on the MAR or progress notes. Review of an x-ray dated 04/09/26 revealed there was a mildly reduced femoroacetabular joint space with small marginal osteophyte concerning for mild osteoarthritis, osteopenic changes in the visualized bones, and acute fracture of the neck of the left femur. Review of a nursing note dated 04/09/26 at 2:57 P.M. by LPN #144 revealed Resident #26 was sent to the hospital via squad for an acute left femur neck fracture for surgery consult per physician orders. Family was updated. Review of the facility investigation related to the fracture revealed the following statements:Review of a statement by LPN #143 dated 04/07/26 revealed she worked with Resident #26 on 04/07/26 and resident did state to be careful of her left leg during a transfer to her wheelchair and was worried about the swelling in it. The leg had been swollen on and off to which the physician was aware. (There was no documentation in the medical record on 04/07/26 regarding the resident's status on 04/07/26 including notification to the physician). Review of a statement dated 04/09/26 by Certified Nursing Aide (CNA) #145 revealed on 04/02/26 she worked with Resident #26 with no concerns. She was off on 04/03/26 and came back to work on 04/04/26 when she got report from an agency aide who expressed no concerns. CNA #145 stated she went to get resident up and the resident complained of pain in her left knee. CNA #145 and the nurse, LPN #144, got the resident into her wheelchair and took her to the bathroom. When her pajamas were removed, the resident was sitting down on the toilet and was noted to have four new skin tears down her right leg which had band-aids on them and had discolored areas. LPN #144 checked the chart and found no information regarding the skin issues. LPN #144 left to go get supplies to care for the wounds and after waiting, CNA #145 looked out into the hallway and the housekeeper stated LPN #144 went downstairs to pass medications on the assisted living unit and would be right back. CNA #145 reported the whole time (while on the toilet), the resident was crying in pain about her knee and hip hurting. CNA #145 took off the pajama top to get the resident cleaned up while waiting, then put a blanket over her to stay warm and found an additional skin tear with another band-aid on it to her left upper arm. After waiting about 20 minutes with the resident crying in pain (CNA was unable to stand the resident by herself), she asked housekeeping to contact the nurse for help. The resident's daughter had come in and heard the resident crying and asked, what the hell happened, to which she was instructed to ask the nurse. The resident was assisted back to her room and placed in her recliner. Review of a statement dated 04/09/26 at 5:00 P.M. by LPN #144 revealed she came to work at 6:00 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A.M. on 03/27/26 and was supposed to be oriented on memory care and assisted living units but the nurse orienting her was late. She received report from the nightshift nurse for memory care and he stated Resident #26 had fallen at 4:00 A.M., everyone was notified, and neurochecks had been initiated. After finishing report on memory care, they went down to the assisted living unit for report there and the other dayshift nurse had arrived and stated LPN #144 had an assignment change. Dayshift nurse (LPN #120) asked if the carts were counted and if report was completed, and if anything was going on upstairs. LPN #144 stated she told LPN #120 Resident #26 had fallen at 4:00 A.M. then she went to her assigned hall on the skilled unit. Review of a statement by CNA #127 for 04/03/26 revealed while bathing Resident #26, due to friction of the washcloth and soaking in the tub, the resident's skin reopened from old skin tears on her leg. Review of a statement by LPN #143 revealed on 04/04/26, skin tears were already on Resident #26, they were just bleeding a little so band-aids were applied and she didn't know she needed to do an incident on old areas. There was no additional documentation about the skin tears or how/when they occurred in the resident's medical record. Review of an email dated 04/09/26 at 5:05 P.M. from RN #106 to the Administrator revealed she had collected the following statements related to Resident #26's injury: On 04/08/26 at 11:20 A.M. CNA #145 worked 04/02 and 04/04: She had been rubbing and complaining of that left knee for about a week now. I worked with you, RN #106, on last Thursday and there was nothing on her legs, no bruising, nothing. I came to work early Saturday morning and changed her like always, nothing on her butt. When I got her up that morning to dress her, Oh my RN #106 she had band-aids down her right leg, a band-aid on her left shoulder, bruising on her left knee, a skin tear on her right forearm. That's when LPN #144 sent you the pictures of the band-aids on her leg. On 04/08/26 at 12:00 P.M. RN #166 worked 04/03 dayshift: I helped the aide change her blue jumpsuit, but I did not notice any discoloration on her knee or leg. I did notice the band-aids to her leg. CNA #145 said the next day that she had all of those areas and I wondered if maybe she had fallen but nobody knew anything. On 04/08/26 at 3:00 P.M. LPN #173 worked 04/03 nightshift: I helped the aide, CNA #185, put her to bed and change her. I did not see anything on her. I heard staff talking and thought they said she had fallen, but I am not sure. On 04/09/26 at 9:57 A.M. CNA #163 worked 03/28 nightshift: Resident #26 did not fall the night I worked. I was not told by LPN #151 the night I worked that she had fallen the night prior. On 04/08/26 at 1:30 P.M. LPN #120 worked 03/27 dayshift: I was not aware of any fall on memory care. He told me that everyone upstairs was fine. I did not see any neuro check sheet or any fall papers on the desk. I counted with LPN #144 because she was pulled downstairs to orient. Undated; LPN #144, worked 03/27/26 dayshift: Heard LPN #151 say the resident fell at 4:00 A.M. and everything was taken care of and everyone was notified. I think he started a neuro sheet. The oncoming nurse was LPN #120 and LPN #144 was pulled downstairs to orient and was not sure what LPN #151 told LPN #120. (continued on next page)

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	366448	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stellar Care Center	47045 Moore Ridge Road Woodsfield, OH 43793

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 04/09/26 at 2:54 P.M. LPN #151: I know I filled out the papers and documented the fall in the chart. I don't know, they came up missing. I got ahold of on-call too. She was found sitting by her bed in her room by the aide. I grabbed her vitals, she denied hitting her head, her bed was in low position. I helped her get back in bed and she said her mind was not real good because she can't remember things. RN #106 worked 04/02/26 dayshift: Resident was acting per her usual. She had no areas on her legs, no discoloration to her left knee/leg during my shift. She had sat in her recliner and was in her wheelchair in the lobby with the other residents. No complaints of pain and CNA #145 was able to transfer her to the toilet with no issues. Review of a hospital record dated 04/11/26 revealed Resident #26 presented on 04/09/26 with left hip pain since a fall on 03/27/26, she had been unable to bear weight on the leg, and she was admitted for left femoral neck fracture. She had a known deep vein thrombosis (DVT) in her left lower extremity from January 2026 and was on Eliquis. She was admitted and orthopedics was consulted and a left hip bipolar hemiarthroplasty was completed on 04/11/26. Resident #26 had post-operative hypoxic and hypercarbic respiratory failure and required a BiPap post-operatively for several hours and was able to eventually wean off the BiPap. She also had post-operative acute on chronic anemia and had two units of blood on 04/12/26 with improvement in hemoglobin. During an interview on 04/22/26 at 10:21 A.M., Resident #26's daughter stated she came to visit the resident on 04/04/26 and the aide had her in the shower room on the commode. Resident #26's daughter revealed her mom was naked, freezing, and screaming, oh, help me, help me. The daughter said the resident was in major pain. It took the nurse a while to come to the shower room and the daughter asked if the resident could be put back in her wheelchair and when she was, the pain eased some. The resident leaned to her side when in her chair because of hip pain. The resident's daughter also stated she requested an x-ray for the resident due to her complaints of pain and she had a broken hip and went to the hospital. Lastly, the resident's daughter shared the surgeon in the hospital said the resident's hip was broken for about two weeks prior to her surgery. During an interview on 04/22/26 at 3:24 P.M., Regional Nurse #191 confirmed the MAR for March 2026 revealed Resident #26 had not taken any as needed Tylenol, but on the MAR for April 2026, she received a dose of Tylenol 325 mg two tablets on 04/04/26 for a pain of eight, on 04/06/26 for a pain of five, then received Tylenol 500 mg two tablets on 04/08/26 for pain of five, and 04/09/26 for pain of seven. Regional Nurse #191 confirmed no x-ray was ordered until 04/08/26 which resulted in a delay in the resident's care because a new onset of resident pain was not addressed timely. She stated she would try to find out why there was a delay. However, no additional information was provided during the survey related to the delay in care or notification with the resident's complaints of pain in conjunction with the resident's functional decline. During an interview on 04/23/26 at 10:47 A.M. with CNA #142 revealed she worked with Resident #26 on 03/31/26 and she was complaining about her leg and hip hurting, she was having a hard time moving in bed. The CNA stated the complaints of pain were reported to the nurse but she could not recall which nurse. During an interview on 04/23/26 at 3:25 P.M. with CNA #145 confirmed the incidents in her statement regarding 04/04/26 were accurate and she provided the same information during the interview. During an interview on 04/23/26 at 2:02 P.M. with RN #110 revealed she worked agency and was not (continued on next page)

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	366448	A. Building B. Wing	05/15/2026

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F 0684 Level of Harm - Actual harm Residents Affected - Few	in the facility a whole lot. RN #110 stated Resident #26's family stopped her and asked her to assess the resident upon the start of her shift so she completed an assessment (on 04/08/26). The resident was complaining of pain and favoring one leg so she called the on-call providers and received orders for a doppler to rule out deep vein thrombosis and an x-ray to check for fracture. RN #110 stated the resident did have a fracture and was sent out. RN #110 stated no one knew what had happened but she was having quite a lot of pain, then during the investigation they found out an agency nurse (identified as LPN #151) did not know how to complete a change in condition (fall). The RN stated when she and the aide tried to assist her to bed, she couldn't stand (this was documented in the 04/06/26 progress note). The aides stated normally she could, but an aide lifted her into bed. Resident #26 was moaning with any movement and when barely touched. She was complaining of pain to the inside of her leg but couldn't rate it due to dementia. Resident #26 also had some swelling around her hip. An interview on 04/24/26 at 10:53 A.M. with Physician #501 revealed he completed Resident #26's hip surgery. He stated the injury did not look fresh because as you continue to go with an unaddressed fracture, the bone fragments rub together and grind down a bit so it wasn't a crisp break like a new fracture would be. Physician #501 estimated the fracture happened one to three weeks prior to surgery. Review of a policy titled Change in a Resident's Condition dated 08/2023 revealed the facility shall notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition. The nurse will notify the resident's physician when there has been a change in condition. Unless otherwise instructed by the resident, the nurse will notify their representative. Except in medical emergencies, notifications will be made timely of a change occurring in the resident's medical/mental health condition or status and regardless of the resident's current mental of physical condition, the nursing supervisor will inform the resident of any changes in their medical care or nursing treatments. The nursing supervisor will record in the resident's medical record information related to changes in the resident's medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Numbers 2960434 and 2806419.

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	366448	A. Building B. Wing	05/15/2026

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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 record review, interview, observations, and policy review, the facility failed to ensure residents did not exit the facility unsupervised, had elopement assessments completed as appropriate and fall interventions were in place. This affected three residents (Resident #5, #26 and #32) of three residents reviewed for accidents. The census was 31. Findings include: 1.Record review revealed Resident #32 admitted to the facility on [DATE] with diagnoses including dementia and diabetes.Review of a Minimum Data Set (MDS) Assessment completed on 02/01/26 revealed Resident #32 had severely impaired cognition, wandered one to three days during the assessment period, and was able to walk 150 feet with supervision or touching assistance.Review of a care plan dated 02/25/26 revealed Resident #32 resided on a secured unit. The goal was to wander safely within her environment. Interventions included but were not limited to administer medications as ordered, ask resident to discuss how they feel about placement, elopement assessments as ordered and as needed, and redirection as needed.Review of a provider note dated 03/17/26 by Certified Nurse Practitioner (CNP) #502 revealed Resident #32 would be moving out of the memory care unit to make room for another resident who needed the bed.Review of assessments revealed there was no elopement assessment completed prior to moving off the secured unit but the resident was at risk for elopement.Review of a nursing note dated 03/19/26 at 1:20 P.M. by Registered Nurse (RN) #174 revealed she noticed staff running down the hallway, when further investigating, realized that resident had wheeled herself to the front door of the building, left her wheelchair at the front door and walked outside the facility and into the roadway. Staff rushed to her and assisted her back to safety in the building. Assessment was performed to check for injury and obtain information about the incident. Vital signs were within normal limits. There were no injuries noted and all supervisors, family and the provider were notified of the incident. Wander guard immediately placed to resident's right ankle and checked for functioning. Staff were alerted to monitor resident closely. Resident continued to wander around the facility and exit seek. Redirection was somewhat effective. Resident was currently resting in her chair with a call light in reach.Review of a nursing note dated 03/19/26 by RN #174 revealed Resident #32 was displaying exit seeking behaviors around the front door, wander guard was in place to the right ankle, supervisor, provider and representative were aware of behaviors.Review of an order dated 03/19/26 revealed Resident #32 had a wander guard placed on her right ankle, check placement and function every shift.Review of a provider note dated 03/19/26 by Medical Director (MD) #503 revealed Resident #32 was being seen for a regulatory visit and she could not recall a recent incident in which she left her wheelchair at the front door and was observed running down the street. Resident #32 then denied any intention to elope stating she valued her life.Review of a nursing note dated 03/20/26 at 2:49 P.M. by RN #413 revealed Resident #32 was being moved back to the memory care unit related to exit seeking behaviors and her spouse was aware. Interview on 04/20/26 at 12:51 P.M. with RN #174 revealed she had been at the nurses' station and was able to see staff running down the halls due to camera monitors at the desk. Stated she did not actually see where resident had made it to, but it was reported she was walking down the road and someone on a motorcycle had stopped her and someone else had called the facility to tell staff.Interview on 04/21/26 at 9:06 A.M. with Certified Nursing Assistant (CNA) #107 revealed Resident #32 moved off the secure unit to accommodate another resident. Resident #32 had been wandering and confused. CNA #107 stated she was in a room with other staff caring for a resident and when she exited the room, a visitor walked in and stated a woman was walking out in the road, and CNA #107 and two other staff sprinted out the door. CNA #107 stopped at the door to grab the wheelchair while the other staff ran ahead. CNA #107 stated she almost made it to the next road to the left but a guy on a motorcycle had stopped in the road and distracted her until we could get there. (continued on next page)

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	366448	A. Building B. Wing	05/15/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/21/26 at 9:42 A.M. with CNA #125 revealed she was upstairs and received a phone call which stated a resident was out in the road walking down the street. The nurse, Licensed Practical Nurse (LPN) #120 took off running down the stairs while CNA #125 stayed with the residents on memory care.Interview on 04/21/26 at 9:47 A.M. with CNA #116 revealed Resident #32 had been exit seeking earlier on 03/19/26 and was redirected twice, which was reported to RN #174. No interventions were implemented. CNA #116 stated she was with CNA #107 in a room providing care and when she came out someone had told them a resident was down the road. CNA #116 stated she took off running and resident was not too far down the road, on the right ride. There was a man on a motorcycle who stopped and was talking to the resident. CNA #116 stated she was concerned because there was no interventions in place during the adjustment period after moving off the secure unit. CNA #116 stated residents with dementia get confused with a change in environment and their routine and a move off the unit could have triggered that.Interview on 04/21/26 at 10:12 A.M. with Administrator confirmed there was not an investigation. Administrator stated Resident #32 had lived on the secured unit and they moved her off the unit because she was not having behaviors. Administrator confirmed the secured unit was for memory care, not a behavioral unit. Administrator stated a change in environment for someone with dementia could cause more confusion but she did not feel resident was more confused. Administrator also confirmed a wander guard and elopement assessment was not completed prior to the resident moving off the secured unit.2.Record review revealed Resident #5 admitted to the facility on [DATE] with diagnoses including dementia and depression.Review of an MDS completed 02/15/26 revealed Resident #5's cognition was moderately impaired and she had no behaviors.Review of the census line revealed Resident #5 moved from the memory care unit on 03/20/26 to the first floor.Review of assessments revealed an elopement assessment was not completed until 04/03/26.Interview on 04/23/26 at 1:05 P.M. with Administrator confirmed Resident #5 did not have an elopement assessment completed prior to moving off the secured memory care unit. 3.Observational tour completed on 04/24/26 at 12:19 P.M. with Maintenance Director (MD) #140 revealed while walking with a wander guard in hand, surveyor was able to walk through the front entrance of the assisted living facility three times without the door locking or alarming. The facility was connected to the AL and residents were able to access the AL through open double doors from the nursing home dining room to the AL facility. MD #140 confirmed findings.4.Record review revealed Resident #26 admitted to the facility on [DATE] with diagnoses including anxiety disorder and weakness.Review of a care plan dated 12/20/25 and revised on 03/16/26 revealed Resident #26 was at risk for falls related to having history of falls, unsteady gait, weakness, resident gets on her knees typically at bedside to pray. The goal was to not sustain serious injury from falls through review date. Interventions included but were not limited to floor mat to left of bed.Observation on 04/21/26 at 9:45 A.M. revealed Resident #26's fall mat was not to the left of her bed, but was against the wall with a laundry basket on it.Interview on 04/21/26 at 11:37 A.M. with CNA #102 confirmed the floor mat was not in place. This deficiency represents non-compliance investigated under Master Complaint Number 2992141 and Complaint Number 2960434.

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	366448	A. Building B. Wing	05/15/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to ensure weights were obtained as ordered. This affected one (#26) of one resident reviewed for edema. The facility census was 31.Findings include: Record review revealed Resident #26 admitted to the facility on [DATE] with diagnoses including weakness and hypertension.Review of a care plan dated 12/19/25 revealed Resident #26 had altered cardiovascular status related to hypertension, congestive heart failure (CHF), and myocardial infarction. The goal was to be free from signs and symptoms of complications related to cardiac problems through the review date. Interventions included but were not limited to give cardiac medications as ordered, monitor for edema and note extent/report to provider, and weight monitoring as ordered and as needed.Review of a Minimum Data Set, dated [DATE] revealed Resident #26 had mildly impaired cognition, had no behaviors, had a diagnosis of CHF, and had a weight gain while not on a physician prescribed weight-gain regimen.Review of orders revealed an order dated 03/24/26 to weigh Resident #26 daily starting on 03/25/26, if the weight gain is three pounds or more, call the provider. After seven days, weigh Resident #26 daily or follow physician's order and call physician if weight gain of three or more pounds in one day or five or more pounds in one week for CHF.Review of weights revealed Resident #26 was weighed on 03/26/26 and was 97 pounds (lbs).Review of weights revealed Resident #26 weighed 97.6 pounds on 04/02/26.Review of a nursing note dated 04/06/26 at 4:18 A.M. by Registered Nurse (RN) #110 revealed Resident #26 refused to be weighed.Review of a nursing note dated 04/07/26 at 4:19 A.M. by RN #148 revealed Resident #26 refused to be weighed.Review of a nursing note dated 04/08/26 at 4:01 A.M. by RN #110 revealed resident #26 refused to be weighed and stated she preferred dayshift. Review of the medical record revealed Resident #26 discharged to the hospital on [DATE] and returned to the facility on [DATE] for a left displaced femoral neck fracture.Review of weights revealed Resident #26 weighed 113.6 lbs on 04/14/26.Review of weights revealed Resident #26 weighed 113.8 lbs on 04/18/26.Review of weights revealed Resident #26 weighed 99.2 lbs on 04/19/26.Review of weights revealed Resident #26 weighed 116.4 lbs on 04/20/26.Review of weights revealed Resident #26 weighed 117.8 lbs on 04/22/26.There was no additional information in the medical record related to Resident #26's daily weights or refusals.Interview on 04/23/26 at 10:15 A.M. with Director of Nursing confirmed missing daily weights for 03/25/26, 03/27/26-04/01/26, 04/03/26-04/05/26, 04/15/26-04/17/26, and 04/21/26 and lack of notification to physician related to weight fluctuations or refusals to be weighed.Review of a policy titled Weight Management Program and Weight Gain/Loss Policy dated 08/2024 revealed all resident will have their weight and nutritional status monitored and addressed as indicated. All residents will be weighed monthly and as ordered. Their weights will be reviewed by the dietician and nursing management monthly and as needed. This deficiency represents non-compliance investigated under Complaint Number 2960434.

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	366448	A. Building B. Wing	05/15/2026

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview the facility failed to ensure the daily posted nursing staff information was current. This had the potential to affect all 31 residents residing in the facility. The census was 31.Findings include: On 04/20/26 at 9:40 A.M. during the initial tour an observation revealed the required daily nurse staff posting was dated 04/18/26. No other posting of the daily nurse staffing was observed during the tour.In an interview on 04/20/26 at 9:45 A.M. Activities Director #103 confirmed the observed posting was dated 04/18/26 and was not current.This is an incidental finding discovered during the course of the complaint investigation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and policy review the facility failed to ensure residents did not receive psychotropic medications without an active order in the medical record. This affected one resident (Resident #11) of four residents reviewed for medication use. The facility census was 31.Findings include: Review of Resident #11's medical record revealed an admission date of 08/09/23 and a re-admission date of 03/23/26 with diagnoses including hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side, other schizophrenia, acquired absence of right leg above the knee, acquired absence of left leg above the knee, anxiety disorder and major depressive disorder.Review of Resident #11's physician's orders revealed an order for clonazepam 0.5 milligrams (mg) twice a day as needed with a start date of 09/22/25 and an end date of 12/20/25. This was the only clonazepam order in the medical record.Review of Resident #11's controlled drug sheets for the medication clonazepam 0.5mg revealed the medication was documented on the sheet as given on 01/02/26 at 8:00 P.M., 01/03/26 at 8:00 P.M., 01/04/26 at 8:30 P.M., 01/05/26 at 8:00 P.M., 01/06/26 at 8:00 P.M., 01/09/26 at 8:00 P.M., 01/11/26 at 9:00 P.M., 01/12/26 at 9:00 P.M., 01/15/26 at 9:00 P.M., 01/16/26 at 9:00 P.M., 01/18/26 at 8:30 P.M., 01/19/26 at 8:35 P.M., 01/20/26 at 8:00 P.M., 01/21/26 at 8:00 P.M., 01/23/26 at 8:00 P.M., 01/24/26 at 9:00 P.M., 01/25/26 at 9:00 P.M., 01/26/26 at 9:00 P.M., 01/27/26 at 5:00 A.M., 01/29/26 at 6:00 P.M., 01/30/26 at 5:00 A.M., 03/06/26 at 9:00 P.M., 03/07/26 at 9:00 P.M., 03/08/26 at 9:00 P.M., 03/09/26 at 9:00 P.M., 03/10/26 at 9:00 P.M., 03/13/26 at 9:00 P.M., 03/17/26 at 1:40 A.M., 03/18/26 at 9:00 P.M., 03/28/26 at 9:00 P.M., 03/30/26 at 9:00 P.M., 03/31/26 at 9:00 P.M., 04/03/26 at 9:30 P.M., 04/05/26 at 9:00 P.M. and 04/06/26 at 9:10 P.M. There were no corresponding Medication Administration Record (MAR) entries documenting administration of the medication. Further review of the Narcotic Log revealed there were no doses of the medication documented as administered for the month of February 2026.Review of Resident #11's progress notes on 01/02/26 at 8:00 P.M., 01/03/26 at 8:00 P.M., 01/04/26 at 8:30 P.M., 01/05/26 at 8:00 P.M., 01/06/26 at 8:00 P.M., 01/09/26 at 8:00 P.M., 01/11/26 at 9:00 P.M., 01/12/26 at 9:00 P.M., 01/15/26 at 9:00 P.M., 01/16/26 at 9:00 P.M., 01/18/26 at 8:30 P.M., 01/19/26 at 8:35 P.M., 01/20/26 at 8:00 P.M., 01/21/26 at 8:00 P.M., 01/23/26 at 8:00 P.M., 01/24/26 at 9:00 P.M., 01/25/26 at 9:00 P.M., 01/26/26 at 9:00 P.M., 01/27/26 at5:00 A.M., 01/29/26 at 6:00 P.M., 01/30/26 at 5:00 A.M., 03/06/26 at 9:00 P.M., 03/07/26 at 9:00 P.M., 03/08/26 at 9:00 P.M., 03/09/26 at 9:00 P.M., 03/10/26 at 9:00 P.M., 03/13/26 at 9:00 P.M., 03/17/26 at 1:40 A.M., 03/18/26 at 9:00 P.M., 03/28/26 at 9:00 P.M., 03/30/26 at 9:00 P.M., 03/31/26 at 9:00 P.M., 04/03/26 at 9:30 P.M., 04/05/26 at 9:00 P.M. and 04/06/26 at 9:10 P.M. revealed no documentation the resident had requested the medication or had complaints of anxiety.There was no documentation in the progress notes that the resident received clonazepam during the month of February 2026.Review of Resident #11's behavior monitoring on the treatment administration record on 01/02/26 at 8:00 P.M., 01/03/26 at 8:00 P.M., 01/04/26 at 8:30 P.M., 01/05/26 at 8:00 P.M., 01/06/26 at 8:00 P.M., 01/09/26 at 8:00 P.M., 01/11/26 at 9:00 P.M., 01/12/26 at 9:00 P.M., 01/15/26 at 9:00 P.M., 01/16/26 at 9:00 P.M., 01/18/26 at 8:30 P.M., 01/19/26 at 8:35 P.M., 01/20/26 at 8:00 P.M., 01/21/26 at 8:00 P.M., 01/23/26 at 8:00 P.M., 01/24/26 at 9:00 P.M., 01/25/26 at 9:00 P.M., 01/26/26 at 9:00 P.M., 01/27/26 at 5:00 A.M., 01/29/26 at 6:00 P.M., 01/30/26 at 5:00 A.M., 03/06/26 at 9:00 P.M., 03/07/26 at 9:00 P.M., 03/08/26 at 9:00 P.M., 03/09/26 at 9:00 P.M., 03/10/26 at 9:00 P.M., 03/13/26 at 9:00 P.M., 03/17/26 at 1:40 A.M., 03/18/26 at 9:00 P.M., 03/28/26 at 9:00 P.M., 03/30/26 at 9:00 P.M., 03/31/26 at 9:00 P.M., 04/03/26 at 9:30 P.M., 04/05/26 at 9:00 P.M. and 04/06/26 at 9:10 P.M. revealed no behaviors were recorded for the resident on those dates.Review of Resident #11's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was not assessed but review of the quarterly MDS dated [DATE] revealed the resident had moderate (continued on next page)

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	366448	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stellar Care Center	47045 Moore Ridge Road Woodsfield, OH 43793

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive impairment. Further review of Resident #18's 03/27/26 admission MDS revealed the resident was dependent on staff for toileting hygiene showering/bathing, transfers, and bed mobility, received antipsychotic and antianxiety medications.Review of Resident #11's progress notes revealed a note dated 04/08/26 at 9:01 A.M. written by the Director of Nursing (DON) that read Discussed with pharmacy and ViaQuest nurse practitioner, order was active with an active script the entire time of administration, however, was not active on the EMAR.In an interview on 04/21/26 at 8:32 A.M. the DON stated the progress note dated 04/08/26 at 9:01 A.M. was related to Resident #11's clonazepam medication. The resident's medication was renewed in December of 2025 by the ViaQuest nurse practitioner (NP); however the nurse who received the verbal order did not enter the order for the clonazepam in the medical record or make an entry on the MAR to indicate the administration instructions for the medication. The DON verified this administration, without an active order in the medical record, occurred from 01/02/26 through 04/06/26. The DON verified the pharmacy had a prescription for the medication from ViaQuest. In an interview on 04/22/26 at 12:09 P.M. Registered Nurse (RN) #148 stated she did not recall giving the medication or the medication not being on the MAR. She normally worked upstairs (the facility had a first floor and second floor which both housed residents) however she did know the resident had clonazepam ordered for a long time but did not know if it was scheduled or as needed. The RN said if it was as needed she would look for an order before giving the medication and would assess for symptoms such as anxiety, yelling out, and behaviors that were normal for him such as raising and lowering the head of his bed and saying he was unable to locate the bed control. Review of the Narcotic Control Log provided revealed RN #148 did document doses of the medication for Resident #11.In an interview on 04/22/26 at 1:40 P.M. ViaQuest (psychiatric services) Certified Nurse Practitioner (CNP) #200 confirmed she remembered Resident #11's clonazepam 0.5 mg one tablet twice daily as needed prescription had ended and the facility called her to get it reordered because the resident was restless and anxious, yelling out and the former Director of Nursing (DON) was who called her to get the order. CNP #200 stated that she sent a new prescription to the pharmacy for clonazepam 0.5 mg one tablet twice daily as needed after she received the call. The CNP stated she would provide verbal orders via phone if she wasn't in the facility to write the order herself. In an interview on 05/13/26 at 10:00 A.M. the DON stated she was made aware of the clonazepam 0.5 mg being given without being on the MAR, on one of the first days that she was working as the DON, when RN # 174 asked her to destroy the medication because there was not an order for it. The DON noted that it had been given recently and investigated to find out why. Her expectation was that the nursing staff would question any medication that was not on the MAR before administering the medication.Attempts were made to reach LPN #117 via phone during the onsite survey regarding her administration of the clonazepam 0.5 mg as needed when it was not on the MAR. No return calls were provided.Review of the policy titled Administering Medications, revised 12/2012, revealed medication must be administered in accordance with the orders. Further review of the policy revealed the individual administering the medication was to record in the resident's medical record the date and time the medication was administered, the dosage, the route of administration, any complaints or symptoms for which the drug was administered, any results achieved and when those results were observed.This deficiency represents non-compliance investigated under Master Complaint Number 2992141.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of pharmacy receipts, Pyxis spread sheet review, policy review, and interview, the facility failed to ensure residents were free of significant medication errors when medications were not administered per physician orders. This affected one resident (#26) of three residents reviewed for anticoagulant medications. The facility census was 31.Findings include: Medical record review revealed Resident #26 admitted to the facility on [DATE] with diagnoses including weakness and hypertension.Review of a care plan dated 01/15/26 revealed Resident #26 was at increased risk of adverse reactions related to taking anticoagulant (blood thinning) medications. The goal was to experience no adverse reactions to the medication regimen throughout the review date. Interventions included but were not limited to administering medications as ordered, monitor skin for increased bruising and abnormalities, and obtain/monitor lab/diagnostic work as ordered and report any abnormalities to the medical provider.Review of orders revealed Resident #26 had an order in place dated 01/09/26 for Eliquis oral tablet 5 milligrams (mg) give two tablets (for total of 10 mg) by mouth two times a day for blood clots until 01/14/26. Beginning on 01/15/26, the order decreased to Eliquis 5 mg give one tablet twice a day. Further review of the physician orders revealed no discontinue date for the Eliquis.Review of a pharmacy receipt revealed the facility received a 80 count of Eliquis 5 mg tablets on 01/09/26 from their contracted pharmacy for Resident #26.Review of the medication administration record (MAR) for January 2026 revealed Resident #26 received Eliquis two tablets by mouth twice daily as ordered from 01/09/26 starting at 8:00 P.M. through 01/14/26, with one refusal on 01/12/26 at 8:00 A.M. Resident #26 would have taken 20 of the tablets during the timeframe leaving 60 tablets.Further review of the MAR for January 2026 revealed Resident #26 received the medication as ordered. Out of the 60 tablets left, Resident #26 would have taken 34 of the tablets during this timeframe leaving 26 tablets.Review of the MAR for February 2026 revealed Resident #26 received medication as ordered except on 02/18/26 (see nurses note with no corresponding note) and 02/20/26 with no information. However, when totaled out, the 26 remaining tablets would have been used by 02/13/26. Review of the nurse progress notes revealed no entry in the notes for 02/18/26 regarding the Eliquis administration.Further review of the progress notes revealed no mention of the Eliquis being out of stock, needing re-ordered or issues with the Eliquis medication administration.No additional Eliquis was ordered in the month of February 2026.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had mildly impaired cognition and received anticoagulant medication.Review of the MAR for 03/09/26 indicated no disruption in Eliquis administration, however Eliquis was not ordered until 03/09/26 and the resident received a 60-count supply of Eliquis 5 mg tablets with that order.Review of the Pyxis (back-up medication storage) Orange Kit Product Location Key revealed six tablets of 2.5 mg Eliquis in stock. Review of a spreadsheet from 01/01/26 through 03/09/26 revealed Resident #26 did not receive any Eliquis from the Pyxis.Interview on 04/22/26 at 8:05 A.M. with the Administrator revealed a review of the amount of Eliquis received from the pharmacy on 01/09/26 (90 tablets) and a comparison of the orders with the MAR and the next re-order date for the Eliquis on 03/09/26. In review, the Eliquis should have been re-ordered before 02/13/26 as this would have been the date the resident had no additional tablets for administration. The Administrator declined to answer if the resident received the Eliquis per order. The Administrator did confirm Resident #26 did not receive Eliquis doses from the Pyxis system.A follow-up interview on 04/22/26 at 1:33 P.M. with the Administrator revealed she had no additional information regarding the resident's Eliquis including additional re-orders or how the resident would have had enough doses to be administered if the pharmacy did not deliver more Eliquis between 02/18/26 and 03/08/26. The Administrator, who was also a Registered Nurse (RN), indicated she believed missing that many doses of Eliquis (02/18/26 until delivered on 03/09/26) would be considered a significant medication error.Interview on 04/21/26 at 2:25 P.M. with (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pharmacist #550 revealed potentially missing doses of Eliquis could lead to a blood clot which is what they were trying to prevent with the medication. The pharmacist verified there was no Eliquis sent to the facility after 02/18/26 and was not re-ordered until 03/09/26.Review of a policy titled Administering Medications dated 12/2012 revealed medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required timeframe. This deficiency represents non-compliance investigated under Master Complaint Number 2992141.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on record review and interview, the facility failed to ensure the food license was renewed timely. This had the potential to affect 31 of 31 residents residing in the facility. The facility census was 31.Findings include: Review of an email from the Administrator to Corporate Accounts Payable dated 02/12/26 revealed the Administrator sent the appropriate food license application to the corporate office and requested payment be sent to the local health department to renew the building's food service license.Review of a Food Service Operation License revealed it was issued on 03/06/26 and would expire 03/01/27.Review of an additional food license application revealed it was completed on 03/11/26 and had a late fee of $110.00 applied to the renewal fee. (The initial renewal application fee was not paid).Interview on 04/20/26 at 9:29 A.M. with the local health department revealed the facility went without a license for three days. The original license expired on 03/02/26 and the new license was issued on 03/06/26. The facility did have to pay a late fee.Interview on 04/21/26 at 1:57 P.M. with Dietary Manager #104 revealed he had not been aware the food license was something he had to take care of because he thought the company completed it. He confirmed the license had expired for a few days.This deficiency represents non-compliance investigated under Complaint Number 2963559 and 2806419.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, pharmacy receipt review, interview and policy review the facility failed to ensure medication administration was accurately documented in the medical record for Resident #26. This affected one resident (Resident #26) of three residents reviewed for anticoagulant medication. The facility census was 31. Findings include:Medical record review revealed Resident #26 admitted to the facility on [DATE] with diagnoses including weakness and hypertension.Review of orders revealed Resident #26 had an order in place dated 01/09/26 for Eliquis oral tablet 5 milligrams (mg) give two tablets (for total of 10 mg) by mouth two times a day for blood clots until 01/14/26. Beginning on 01/15/26, the order decreased to Eliquis 5 mg give one tablet twice a day. Further review of the physician orders revealed no discontinue date for the Eliquis.Review of a pharmacy receipt revealed the facility received an 80 count of Eliquis 5 mg tablets on 01/09/26 from their contracted pharmacy for Resident #26.Review of the medication administration record (MAR) for January 2026 revealed Resident #26 received Eliquis two tablets by mouth twice daily as ordered from 01/09/26 starting at 8:00 P.M. through 01/14/26, with one refusal on 01/12/26 at 8:00 A.M. Resident #26 would have taken 20 of the tablets during the timeframe leaving 60 tablets.Further review of the MAR for January 2026 revealed Resident #26 received the medication as ordered. Out of the 60 tablets left, Resident #26 would have taken 34 of the tablets during this timeframe leaving 26 tablets.Review of the MAR for February 2026 revealed Resident #26 received medication as ordered except on 02/18/26 (see nurses note with no corresponding note) and 02/20/26 with no information. However, when totaled out, the 26 remaining tablets would have been used by 02/13/26. Review of the nurse progress notes revealed no entry in the notes for 02/18/26 regarding the Eliquis administration.Further review of the progress notes revealed no mention of the Eliquis being out of stock, needing re-ordered or issues with the Eliquis medication administration.No additional Eliquis was ordered in the month of February 2026.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had mildly impaired cognition and received anticoagulant medication.Review of the MAR from 02/13/26 through 03/09/26 indicated no disruption in Eliquis administration, however Eliquis was not ordered until 03/09/26 and the resident received a 60-count supply of Eliquis 5 mg tablets with that order.Interview on 04/22/26 at 1:33 P.M. with Administrator revealed she had no additional information on Eliquis and if given correctly, Resident #26 would've run out on 02/13/26 and more was not ordered until 03/09/26. Administrator confirmed if Resident #26 ran out of medication on 02/13/26, the medication administration record for 02/2026 and 03/2026 was filled out inaccurately because resident could not have received her medication and the MARs indicated she did receive the medication.Review of a policy titled Charting and Documentation dated 08/2024 revealed services provided to the resident, progress toward goals, or any changes in the resident's medical, physical, or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective, complete, and accurate.This deficiency represents non-compliance investigated under Master Complaint Number 2992141.