

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/25/2026
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on review of the medical record, review of the Self-Reported Incident, review of the facility's investigation, review of facility policy, review of staff education, review of facility plan of correction documentation, and interview, the facility failed to ensure licensed nursing staff appropriately wasted narcotic medications and failed to ensure legible and appropriate documentation related to narcotic administration and wasting. This affected five residents (#7, #10, #12, #18, and #20) of seven reviewed for abuse. Findings Include: Review of the Self-Reported Incident (SRI) created 06/05/26 at 1:35 P.M. revealed during an in-house audit of narcotic records on 06/01/26 it was noted LPN #200 had not followed protocol for narcotic documentation for Residents #7, #10, #12, #18, and #20. LPN #200 had admitted during an interview that she was not following protocol by not wasting medications appropriately and scribbling out on the narcotic count sheets. LPN #200 stated she was either busy or tired. Medical records were reviewed, narcotic sheets and medication administration records were audited, and residents involved were assessed for pain. There was no evidence of the residents not receiving their medication or unrelieved pain. The facility reported the documentation issue to the Ohio Board of Nursing and the police. The Ohio Board of Nursing indicated there was suspicion for diversion, so the facility filed an SRI. The SRI was unsubstantiated. LPN #200 was terminated for not following protocol. Further review of the investigation revealed when LPN #200 was asked why she was not following policy and procedure she repeatedly stated she was either busy, tired, or had been helping the aides on the floor. She admitted to all of the above policy violations, and when the Administrator stated there was a blatant disregard for policy her response was I know!. She admitted everything except the diversion. She stated her residents received their medications and the residents were not reporting they did not receive their medications. Considering her admission to multiple violations of the facility's narcotic policy and procedure, she was terminated on 06/03/26 at the end of the interview. Review of the Notice of Disciplinary Action dated 06/01/26 revealed LPN #200 was suspended pending investigation. Review of the Notice of Disciplinary Action dated 06/03/26 revealed LPN #200 was terminated for not following narcotic administration and destruction policy and procedures, no witnesses or documentation on the MARS, administering and signing out more medication than orders allowed without physician's notification, and multiple documentation revisions making the narcotic log difficult to understand. Review of the letter to the Sheriff's office from the Administrator dated 06/08/26 revealed as a result of a state survey, the team was looking into pain management records. On 06/01/26, it came to the facility's attention the narcotic administration, narcotic wasting, and documentation revealed Licensed Practical Nurse (LPN) #200 failed to follow facility policy in many ways. Upon review of the findings, LPN #200 was suspended on 06/01/26 pending further investigation. On 06/03/26, LPN #200 was interviewed in person by the Administrator and Director of Nursing (DON). During this interview LPN #200 was specifically questioned about the following concerns: -Not wasting narcotics with another witnessing nurse. -Administering or signing out more (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	than the ordered amount of pills in a 24-hour period. -Only documenting as needed (PRN) medications in the narcotic log and not documenting in the resident's electronic health record (EHR). -The significantly increased frequency of being the only nurse who administered PRN medications when other nurses were not. -The frequent documentation of the resident coughing, spitting, or dropped as reasons to pull another pill with no witness of wasting these medications. -Scribbling out and frequent documented corrections on the narcotic logs making them illegible or confusing to follow. On 06/22/26 at 10:50 A.M. an interview with the Administrator revealed the facility did not file an SRI with the State agency for the potential misappropriation of narcotics for Resident #7, #10, #12, #18, and #20 because at first, they were just treating it as a documentation procedure concern, however after speaking to the Ohio Board of Nursing on 06/04/26 she stated they recommended filing an SRI and notifying the police. The Administrator confirmed LPN #200 frequently documented coughing, spitting, or dropped as reasons to pull another pill with no witness of wasting these medications, only documenting PRN medications in the narcotic log and not documenting in the resident's EHR, and the scribbling out/illegible notations on the log were not appropriate procedures for a nurse who was handling narcotics. Review of the undated facility policy titled Controlled Substance (Narcotic) Administration and Documentation revealed the wasting procedure stated to waste an unused portion of the medication with a licensed witness immediately after removal/prep, the waste must be performed with a licensed witness, and it must be recorded in the controlled substance log indicating the amount wasted, date and time, your signature, and the witness signature. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/23 revealed resident had the right to be free from abuse, neglect exploitation, and misappropriation of property. This included but was not limited to, freedom from corporal punishment, involuntary seclusion and any physician or chemical restraint that was not required to treat the resident's medical symptoms. It was the facility's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source, in accordance with this policy and to ensure that all individuals who reported such incidents and allegations were free from retaliation or reprisal for reporting the incident. Facility staff should immediately report all such allegations to the Administrator and to the Ohio Department of Health (ODH) in accordance with the procedures in this policy. In cases where a crime was suspected, the Administrator would report the same to local law enforcement in accordance with Facility's Crime Reporting policy. If any form of abuse was alleged or Serious Bodily Injury was identified related to any other reportable incident, the Administrator or his/her designee would notify ODH immediately, but not later than two hours after the allegation is made or the serious bodily injury identified. All other allegations involving Neglect, Exploitation, Mistreatment, Misappropriation of resident property and Injuries of Unknown Source would be reported to ODH immediately, but in no event later than 24 hours from the time the incident/allegation was made known to the staff member. The following medical records were included in the SRI related to the improper documentation and wasting of narcotics: 1. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, chronic pain, insomnia, osteoporosis and hypertension. Review of the May 2026 physician's orders revealed Resident #10 had an order for hydrocodone/acetaminophen (Schedule 2 controlled substance) 5/326 milligrams (mg) one tablet twice daily for chronic pain dated 03/08/26. Review of the Individual Patient Controlled Substance Administration Record for hydrocodone/acetaminophen 5/325 mg revealed Resident #10 was administered hydrocodone/acetaminophen 5/325 mg on the following occasions:-On 05/01/26, one tablet was administered to Resident #10 at 9:00 P.M. then another tablet at 9:10 P.M. by LPN #200. There was a handwritten note in the margin indicating the resident was coughing. No witness to the wasted narcotic was noted on the record. -On 05/15/26, one tablet was administered to Resident #10 at 9:00 P.M. and then another tablet at 9:20 P.M. There was a handwritten note in the margin indicating the resident spit the tablet out. No witness to the wasted narcotic was noted on the record. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/18/26 one tablet was administered to Resident #10 at 9:00 P.M. and then another tablet at 9:10 P.M. by LPN #200. -On 05/19/26, one tablet was administered to Resident #10 at 9:00 P.M. and then another tablet at 9:15 P.M. by LPN #200. There was a handwritten note in the margin indicating the resident was coughing. No witness to the wasted narcotic was noted on the record. -On 05/22/26, one tablet was administered to Resident #10 at 9:10 P.M. and then another tablet at 9:30 P.M. by LPN #200. There was a handwritten note in the margin, however it was errored out and not legible. -On 05/23/26, one tablet was administered to Resident #10 at 9:00 P.M. and then another tablet at 9:00 P.M. by LPN #200. There was a handwritten note in the margin indicating the resident was coughing. No witness to the wasted narcotic was noted on the record. -On 05/25/26, one tablet was administered to Resident #10 at 9:00 P.M. and then another tablet at 9:00 P.M. by LPN #200. -On 05/30/26, one tablet was administered to Resident #10 at 9:00 P.M. and then another tablet at 9:05 P.M. by LPN #200. There was a handwritten note in the margin indicating the tablet was dropped. No witness to the wasted narcotic was noted on the record. 2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE]. Diagnoses included left side hemiplegia, pneumonia, major depressive disorder, convulsions, right knee contracture, chronic obstructive pulmonary disease, protein calorie malnutrition, cerebral infarction, hypertension, spinal stenosis, gastroparesis, skin transplant, angina, anxiety disorder, repeated falls, hearing loss, insomnia, and hypothyroidism. Review of the April 2026 physician's orders revealed Resident #12 had an order for clonazepam (Schedule 4 controlled substance) 0.5 mg twice daily for anxiety dated 02/02/26. Review of the Individual Patient Controlled Substance Administration Record for clonazepam 0.5 mg revealed one tablet of clonazepam 0.5 mg was administered to Resident #12 on 04/27/26 at 9:10 P.M. then another tablet at 9:15 P.M. by LPN #200. There was a handwritten note in the margin indicating the tablet was dropped. No witness to the wasted narcotic was noted on the record. 3. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Diagnoses included necrotizing fasciitis, chronic obstructive pulmonary disease, respiratory failure, migraines, depression and insomnia. Review of the May 2026 physician's orders revealed Resident #7 had an order for tramadol (Schedule 4 opioid) 50 mg one tablet 30 minutes prior to dressing change dated 01/11/26. Review of the Individual Patient Controlled Substance Administration Record for tramadol 50 mg revealed one tablet of tramadol 50 mg was administered to Resident #7 on 05/30/26 at 2:00 A.M. then another tablet at 2:10 A.M. by LPN #200. There was a handwritten note in the margin indicating the tablet was dropped. No witness to the wasted narcotic was noted on the record. 4. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included congestive heart failure, hypertension, hypothyroidism, chronic pain, restless leg syndrome, tremors, chronic kidney disease, skin cancer, anxiety disorder, and colitis. Review of the May 2026 physician's orders revealed Resident #20 had an order for tramadol 50 mg one tablet three times daily dated 03/19/26. Review of the Individual Patient Controlled Substance Administration Record for tramadol 50 mg revealed one tablet of tramadol 50 mg was administered to Resident #20 on the following occasions:-On 05/23/26 at 5:00 A.M. then another tablet at 5:00 A.M. by LPN #200. No witness to the wasted narcotic was noted on the record.-On 05/24/26 at 7:00 P.M. then another tablet at 7:00 P.M. by LPN #200. No witness to the wasted narcotic was noted on the record. 5. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE]. Diagnoses included sepsis, diabetes, pain, major depressive disorder, peripheral vascular disease, transient ischemic attack, cerebral infarction, spinal cord injury, generalized anxiety disorder, chronic ulcer of the right foot, hydronephrosis, brain cancer, and quadriplegia. Review of the April 2026 physician's orders revealed Resident #18 had an order for hydrocodone/acetaminophen 5/326 mg one tablet via peg tube every six hours as needed (PRN) for pain dated 04/22/26. Review of the Individual Patient Controlled Substance Administration Record for the PRN hydrocodone/acetaminophen 5/326 mg revealed Resident #18 was administered one tablet of hydrocodone/acetaminophen 5/326 mg on 04/25/26 at 6:00 P.M., on 04/26/26 at 12:00 A.M., 6:00 A.M., and 6:15 P.M., on 04/17/26 at 12:00 A.M., 6:00 A.M., (continued on next page)		

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