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	01/28/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure foods were stored under sanitary conditions. This had the potential to affect all residents residing in the facility. The census was 36. Findings include:Observation on 01/20/26 at 8:38 A.M. during the initial tour of the facility kitchen revealed a walk-in white refrigerator. Upon entry to the refrigerator a foul odor was noted. Upon inspection under the shelf in the right corner a rotten apple, an old onion, open cheese slice, and an unidentifiable rotted item.Interview and observation on 01/20/26 at 8:48 A.M. with the Dietary Manager confirmed a foul odor was noted in the white walk in refrigerator and items including a rotten apple, an old onion, open cheese slice, and an unidentifiable rotted item were seen under the shelf in the right corner of the refrigerator.Review of undated facility policy titled Food Storage revealed food will be stored in an area that is clean, dry, and free from contaminants. All refrigerator units should be kept clean and in good working condition at all times.

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure residents, who had resided in the facility for over a year, were offered the opportunity to be vaccinated with the updated Covid-19 vaccine for the 2025- 2026 respiratory season. This affected four residents (Resident #4, #5, #33, and #36) of five residents reviewed for vaccinations. Findings include: 1. Review of Resident #4's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD), morbid obesity, adult-onset diabetes mellitus, nicotine dependence, and hypertension. Review of Resident #4's Vaccination Consent Form dated 11/12/25 revealed the resident was offered several different vaccines at that time to include Influenza, Pneumococcal, Shingles, Respiratory Syncytial Virus (RSV), and Hepatitis B. There was a place on the form to add other vaccines that were offered but that box was left blank and no additional vaccines had been added to the form as having been offered. There was no evidence of the resident being offered the updated Covid-19 vaccine for the 2025-2026 respiratory season. Findings were verified by the interim Director of Nursing (DON). 2. Review of Resident #5's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included unspecified dementia, hypertension, and hyperlipidemia (high cholesterol). Review of Resident #5's vaccination consent forms dated 02/15/25 revealed the resident was offered the Influenza vaccine and the Pneumococcal vaccine on 02/15/25. He consented to receive the Influenza vaccine and received it on 02/15/25. He received the updated Influenza vaccine for the 2025-2026 respiratory illness season on 11/07/25. He was also offered the Pneumococcal vaccine, but refused it when offered on 02/15/25. There was no documented evidence of the resident having been offered the updated Covid-19 vaccine for 2025- 2026. Findings were verified with the interim DON. 3. Review of Resident #33's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, hypertension, adult-onset diabetes mellitus, hypercholesterolemia (high cholesterol), and bronchitis. Review of Resident #33's vaccination consent forms dated 11/03/25 revealed the resident was offered the Influenza vaccine and the Pneumococcal vaccine on 11/03/25. She declined both the Influenza and the Pneumococcal vaccines when offered. There was no evidence of the resident having been offered the updated Covid-19 vaccine for 2025- 2026 respiratory illness season. Findings were verified with the interim DON. 4. Review of Resident #36's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, morbid obesity, congestive heart failure, hypertension, and unspecified dementia. Review of Resident #36's Vaccination Consent Form dated 11/12/25 revealed the resident was offered several different vaccines at that time to include Influenza, Pneumococcal, Shingles, Respiratory Syncytial Virus (RSV), and Hepatitis B. There was a place on the form to add other vaccines that were offered but that box was left blank and no additional vaccines had been added to the form as having been offered. There was no evidence of the resident being offered the updated Covid-19 vaccine for the 2025-2026 respiratory season. Findings were verified by the interim DON. On 01/27/26 at 1:05 P.M., an interview with the interim DON revealed they did not have any evidence of an updated Covid-19 vaccine being offered and/ or provided to the above residents for the 2025-2026 respiratory illness season. They were offering Covid-19 vaccines to residents upon their admission to the facility and had the documentation for that. The DON was having trouble locating the consent forms for Covid-19 vaccines being offered to residents that have been residing in the facility for over a year. She assured that they were offering and providing to those residents if requested, but could not find documented evidence to support such. Review of the facility's Covid-19 Vaccination policy (updated in August 2024) revealed the facility would offer the Covid-19 vaccine when available and in accordance with it's policy on Covid-19 vaccination for residents. The rest of the policy was directed towards vaccinating staff with the Covid-19 vaccines.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, policy review, and staff interview the facility failed to document advance directives for a resident. This affected one resident (#2) of eighteen residents reviewed for advanced directives. The facility census was 36.Findings include:Review of the medical record for Resident #2 revealed admission to the facility on [DATE] for diagnoses including a stroke with left side paralysis, atrial fibrillation (irregular heartbeat), bilateral above the knee amputations, high blood pressure, anxiety and depression, schizophrenia (mental disorder with delusion thoughts and/or hallucinations), diabetes, and congestive heart failure.Further review of the medical record for Resident #2 revealed no current order for code status. Review of discontinued orders revealed an order to discontinue full-code status on 10/27/25. Interview on 01/21/26 at 10:40 A.M. with licensed practical nurse (LPN) #38 revealed that Resident #2's code status should be listed under the orders screen in the electronic medical record (EMR). LPN #38 reviewed the current orders and verified there was no current code status order. LPN #38 then checked Resident #2's additional paper chart and showed a green paper on the front of chart with FULL CODE written largely. LPN #38 reported that the paper charts were being phased out and new admissions did not have paper charts. LPN #38 reviewed the EMR for Resident #36 and found a discontinued order for full code status written on 10/27/25 when the resident was transferred to the hospital. LPN #38 reported that Resident #2's code status order must not have been updated after his hospital stay and return to the facility in October 2025.Interview on 01/21/26 at 10:45 A.M. with certified nurse aide (CNA) #22 revealed that resident's code status could be found in the Kardex section in the EMR. CNA #22 reviewed the Kardex for Resident #2 and could not find a code status listed. CNA #22 was unaware of the code status being listed in the paper chart. Review of the facility Advanced Directives Policy dated 08/2021 and last reviewed 08/2025 revealed, Resident wishes will be communicated to the staff via the care plan and (identify facility protocol for communication of advance directives either in written or oral format) and to the resident physician.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on review of beneficiary liability notices and staff interview, the facility failed to ensure residents and/ or their representatives signed the liability notices provided acknowledging their skilled services were ending for coverage under Medicare (MCR) Part A services. This affected two residents (#2 and #36) of three residents reviewed for liability notices. Findings include:1.) Review of Resident #2's liability notices revealed the resident's last covered day for MCR Part A services was on 09/05/25. Notice of non-coverage was documented on a Centers for Medicare and Medicaid Services (CMS) form 10123, titled Notice of MCR Non-Coverage (NOMNC) and was dated for 08/25/25. The form included a place for the residents or their representatives to sign acknowledgement of receiving that notice, but was only signed by two facility employees (Admissions Director #49 and MDS Coordinator #47), and not the resident or their representative. There was no documented evidence on the NOMNC of the resident or their representative having been notified their skilled service was ending or that the resident would no longer be covered under MCR Part A services. Resident #2 remained in the facility following their skilled service ending and was also provided a CMS form 10055, titled Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN). That form was also dated 08/25/25 and further specified the skilled service ending included physical therapy and occupational therapy. The form included three options to choose from specifying whether the resident wanted to appeal the decision and continue to receive the skilled service, or if they were opting out of continuing to receive those skilled services with the understanding they would not responsible for paying and could not appeal to see if MCR would pay for the services. Option #3 was marked as having been selected opting out of wanting to continue to receive those skilled services. The form also had a place for the resident or their representative to sign acknowledgement of receiving that notice. Again, Admissions Director #49 and MDS Coordinator #47 were the only ones who signed the SNF ABN, and there was not a signature from the resident or their representative acknowledging receiving that notice. 2.) Review of Resident #36's liability notices revealed the resident's last covered day for MCR Part A services was on 08/27/25. Notice of non-coverage was documented on CMS form 10123 (NOMNC) and was dated for 08/15/25. The form included a place for the residents or their representatives to sign acknowledgement of receiving that notice, but was only signed by two facility employees (Admissions Director #49 and MDS Coordinator #47), and not the resident or their representative. There was no documented evidence on the NOMNC of the resident or their representative having been notified their skilled service was ending, or that the resident would no longer be covered under MCR Part A services. Resident #36 remained in the facility following their skilled service ending and was also provided a CMS form 10055 (SNF ABN). That form was also dated 08/15/25 and further specified the skilled service ending included physical therapy and occupational therapy. The form included three options to choose from specifying whether the resident wanted to appeal the decision and continue to receive the skilled service, or if they were opting out of continuing to receive those skilled services with the understanding they would not responsible for paying and could not appeal to see if MCR would pay for the services. Option #3 was marked as having been selected opting out of wanting to continue to receive those skilled services. The form also had a place for the resident or their representative to sign acknowledgement of receiving that notice. Again, Admissions Director #49 and MDS Coordinator #47 were the only ones who signed the SNF ABN, and there was not a signature from the resident or their representative acknowledging they received that notice. On 01/26/26 at 8:45 A.M., the facility's Administrator acknowledged the liability notices provided to Resident #2 and #36 were not signed by the residents or their representatives showing evidence they had been notified their skilled services were ending and would no longer be covered under MCR Part A services. The Administrator indicated that Resident #2 was not physically able to sign the forms and Resident #36's daughter was allegedly notified via phone. The Administrator confirmed Resident #2's cognition was moderately impaired and his (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative should have signed acknowledgement of receiving the notification that his skilled services were ending. She further acknowledged there was no documentation on the liability notices for Resident #36 or in her electronic medical record to support her representative was notified when her skilled services and coverage under MCR Part A services ended on 08/27/25.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review, the facility failed to ensure residents with the diagnosis of dementia did not receive an anti-psychotic medication without an adequate indication for use. This affected two residents (#5 and #33) of five residents reviewed for unnecessary medications. Findings include:1.) Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included unspecified dementia (moderate) with agitation and depression. Review of Resident #5's acknowledgement/ consent for psychoactive medications dated 02/15/25 revealed the resident's representative signed consent for the use of the Seroquel that had previously been indicated to be used for dementia with behavioral disturbances on a prior acknowledgement/ consent dated 03/30/24. The target behaviors it was previously used for included anxiety and agitation. The more recent acknowledgement/ consent form did not include a diagnosis or condition that warranted the use or any new specific target behaviors it was being used for. The form signed by the resident's representative indicated they understood that non-drug approaches would continue to be utilized to reduce target behaviors, routine dosage reduction attempts would be made unless the reduction was clinically contraindicated, and also understood that the physician and interdisciplinary team (IDT) would review the order routinely for the continued need of the medication intervention. Review of Resident #5's active physician's orders revealed the resident had an order to receive Seroquel (an atypical anti-psychotic medication used in the treatment of schizophrenia, bipolar disorder, and as an add-on treatment for major depressive disorder) 50 milligrams (mg) with directions to receive one tablet by mouth twice a day related to unspecified dementia with agitation. The current order had been in place since 03/11/25. Review of Resident #5's pharmacy recommendation for an irregularity that was identified as a result of the monthly medication regimen review completed on 08/17/25 revealed the facility's contracted pharmacist recommended the physician evaluate the need for continued use of the Seroquel per the guidelines for psychotropic drug therapy. The recommendation indicated that the Centers for Medicare and Medicaid Services (CMS) had an increased focus on the use of psychotropic medications in long-term care. State and Federal surveyors would be scrutinizing their use as a result. The pharmacist asked the prescriber to review the resident's medication regimen and to indicate their professional opinion on further use of the medication listed above. The prescriber (a psychiatric nurse practitioner) agreed with the recommendation indicating that a dose reduction would be attempted and to see the new order provided below. The prescriber's response was to decrease the Seroquel to 25 mg po every day and give Seroquel 50 mg po every night at bedtime, if the resident's daughter/ family would agree. The response indicated that the family had refused the last gradual dose reduction (GDR) recommendation. Review of a nurse's progress note dated 09/29/25 at 10:47 A.M. revealed the nurse had talked with Resident #5's sister/ Power of Attorney (POA) that day and she did not want the resident's Seroquel changed in any way. She did not want the dose to be reduced or discontinued. The note indicated that the POA was very adamant about that and he (the resident) was to stay on the current dose. Review of a psychiatric note from Certified Nurse Practitioner (CNP) #200 dated 11/05/25 revealed she had seen Resident #5 on that date for a follow up evaluation for a psychiatric medication management visit to address symptoms related to anxiety and dementia. She indicated his mood had been fine and he denied any depression and anxiety. He was noted to have some confusion, which was at his baseline. He denied any intent to harm himself or others and also denied having any delusions. She noted his psychiatric history of dementia and alcohol abuse. A mental status exam at the time of the visit revealed his general appearance was within normal limits (WNL) as he was appropriately dressed and groomed for the occasion. His mood and affect was WNL and he was euthymic (a normal, stable mood state that was neither manic nor depressive) and congruent. She (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated on her assessment that the resident did not display any signs of psychosis or a disturbance of his perception. Her medical decision making indicated his anxiety was a stable, chronic condition. His chart indicated a possible history of an anxiety diagnosis and he was found to be irritable and distracted during the assessment. He was being managed on Lexapro (an anti-depressant) to manage that problem. His dementia was also indicated to be a chronic illness where he had been diagnosed prior to the start of service with the CNP's psychiatric company. He demonstrated memory loss and poor cognition and was being managed on Donepezil (medication used in the treatment of dementia). She listed his medications, which included Seroquel 50 mg twice a day for dementia with behaviors. She did not recommend any medication adjustments that that time and wanted to continue the current regimen. She would follow up with the resident in four to eight weeks unless acute issues or concerns presented. Her note referenced, per the nurse, the resident had a failed GDR of Seroquel in the past and had increased behaviors yelling out, agitation, irritability, and difficulty to redirect. The note did not specify when that failed GDR attempt allegedly occurred or if it had been attempted while residing in the nursing home side of the building. He was a resident of the assisted living facility prior to 02/15/25 that was connected to the nursing home. There was nothing in the resident's order history for the use of the Seroquel to indicate any dosage reduction attempts had been tried since he was admitted to the nursing facility on 02/15/25. Review of Resident #5's medication administration record (MAR) for January 2026 revealed the resident was receiving Seroquel 50 mg twice a day as ordered for unspecified dementia with agitation. The Seroquel was scheduled to be given every morning at 9:00 A.M. and every night at 9:00 P.M. Review of Resident #5's active care plans revealed he had a care plan in placed for an impaired cognition as evidenced by deficits in memory, judgement, decision making that was related to dementia. The only behavior the resident was indicated to have in his active care plans was him being known to crawl on the floor. Observations of Resident #5 throughout the course of the investigation with on-site visits 01/20/26- 01/22/26 and again on 01/27/26 revealed the resident was not observed to display any behaviors. He was mostly observed lying in bed or up in his recliner with his eyes closed and no behaviors being displayed. On 01/22/26 at 2:55 P.M., an interview with Certified Nursing Assistant (CNA #34) revealed she was a part- time CNA, but was somewhat familiar with Resident #5. She had been assigned to work his hall and has had interactions with him. She denied that he had much in the way of behaviors other than being known to yell out hey, hey, hey. She would respond to his calling out and some of the times he needed something, while other times he didn't. She stated she would usually just talk to him and it would help distract him. It would be effective for a while and then he may start yelling out again. She denied she had known him to display any aggressive behaviors towards staff or other residents on the days she was there. His behaviors was more in the afternoon/ evening time, when they occurred. On 01/22/26 at 3:11 P.M., an interview with CNP #200 via phone revealed dementia with agitation was not an appropriate diagnosis for the use of Seroquel. She acknowledged Resident #5 had been on Seroquel 50 mg twice a day (BID) since his admission to the nursing facility on 02/15/25. She identified three diagnoses that were appropriate for the use of anti-psychotics in nursing facilities to include Huntington's Chorea, Tourette Syndrome, and schizophrenia. She reported they have been trying to work with the resident's sister/ POA, who did not want his Seroquel discontinued. She reported she attempted to reduce his Seroquel when he was residing on the assisted living side, but his POA declined those attempts as well. The POA had been reluctant to allow them to make any changes to the medication. She was asked how she handled families that were resistant to allow psychotropic medication changes to be able to adhere to the regulations on GDR's. She stated in the end, they took a combined approach. The family had a big play in what medications a resident received. She indicated the family typically knew the resident's history better than the facility did. She again stated she attempted to write an order twice to reduce the dosage of the Seroquel and the POA refused. She agreed families should be able to give input on medications a resident received, but it was ultimately up to the prescriber to order the medication at the proper dose to treat a resident's condition. She was (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not able to indicate if the facility had tried any behavior management, changes in his environment, or person-centered approaches to manage behaviors in place of using an anti-psychotic for management of his dementia with agitation. She stated that would be more the facility's Director of Nursing that would have to answer that. On 01/22/26 at 3:55 P.M., an interview with Regional Nurse #90 confirmed the resident did not have an adequate indication for use of the Seroquel as dementia with agitation was not an appropriate diagnosis. She further confirmed there had not been any GDR attempts with the resident's Seroquel, since the resident had been admitted to the facility on [DATE]. She thought they had attempted in the past, but acknowledged the psych CNP indicated she gave the order twice to reduce his dose when still on the assisted living unit, which was not followed through with due to the POA's refusal for any medication changes to be made. She acknowledged the prescriber was the one that ultimately decided what medications should be used for a resident and at what dose to manage medical diagnoses. The family could give input, but should not be determining the need for a particular medication or at what dose it should be given. Review of the facility's policy for Psychotropic Medication Use updated August 2025 revealed psychotropic medications may be considered for residents with dementia, but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Psychotropic medications would be prescribed at the lowest possible dosage for the shortest period of time and were subject to gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue those drugs. Residents may receive psychotropic medications when necessary to treat specific conditions for which they were indicated and effective. Psychotropic medications should generally be used for the following conditions/ diagnoses as documented in the medical record, consistent with the definition in the Diagnostic and Statistical Manual of Mental Disorders: Schizophrenia, Schizo-affective disorder, Schizophreniform disorder, delusional disorder, mood disorders (e.g. bipolar disorder, depression with psychotic features, and treatment refractory major depression), psychosis in the absence of dementia, medical illnesses with psychotic symptoms and/ or treatment- related psychosis or mania, Tourette's Disorder, Huntington Disease, hiccups, nauseas and vomiting associated with cancer or chemotherapy, and any other diagnosis deemed necessary by the physician/ nurse practitioner. Diagnoses alone did not warrant the use of psychotropic medications. In addition to the above criteria, antipsychotic medications may be considered if the following conditions were also met: the behavioral symptoms present a danger to the residents or others, and the symptoms were identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations, delusions, paranoia, or grandiosity, or behavior interventions have been attempted and included in the plan of care, except in an emergency. Psychotropic medications would not be used if the only symptoms were one of the following to include restlessness, impaired memory, mild anxiety, fidgeting, nervousness, or uncooperativeness. 2. Review of Resident #33's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (moderate) with mood disturbance. Review of Resident #33's monthly physician's orders revealed the resident was receiving Seroquel (an antipsychotic) 25 mg po three times a day (TID) for depressive disorder. She was also receiving 50 mg po every night at bedtime for agitation. Both order had been in place since her admission to the facility on [DATE]. She also received Sertraline HCL (Zoloft) 100 mg po once daily for depression. Review of Resident #33's psychiatric notes revealed she had been seen by the psychiatric nurse practitioner twice since her admission. Visits were made on 11/19/25 and again on 01/13/26 for an initial and follow up psychiatric evaluation for medication management and mental health services respectively. Her diagnoses included unspecified dementia (moderate) with mood disturbance and depression. Her initial visit on 11/19/25 indicated she had no suicidal or homicidal ideations, delusions, or hallucinations. Her follow up visit on 01/13/26 indicated she was redirectable and had no reports of aggression. Both visits she was not indicated to have psychosis or a disturbance in perception. The first visit on 11/19/25, the CNP indicated the resident was receiving Seroquel TID for (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia and there was no plan for a medication adjustment at that time, as the CNP would talk with the resident's family to see if they were agreeable to a GDR with the Seroquel. The last visit on 01/13/26, the CNP indicated the resident was receiving Seroquel 25 mg four times a day and her plan was to recommend a GDR of the Seroquel to 25 mg three times a day. She attempted to contact the resident's daughter but received no answer. Staff were made aware of the need to follow up with the resident's daughter, and if she was in agreement, to please reduce the Seroquel to 25 mg TID. Review of Resident #33's MAR's for January 2026 revealed the resident continued to receive Seroquel 25 mg TID for depressive disorder. The latest order originated on 01/14/26. Review of Resident #33's care plans revealed she had an active care plan in place for impaired cognition as evidenced by deficits in memory, judgement, and decision making related to dementia. She also had care plans for an attention to delirium or confusional episodes and insomnia related to dementia. No other behavior related care plans were noted. Review of Resident #33's progress notes revealed she had a electronic medication administration (eMAR) note dated 01/14/26 at 6:48 P.M. that indicated the system identified a black box warning pertaining to the use of Seroquel 25 mg where the resident was receiving one tablet three times a day for depressive disorder. The black box warning indicated there was an increased risk of death in elderly patients with dementia- related psychosis. Studies show those patients, when treated with an atypical antipsychotic had a 1.6 to 1.7 times higher risk of death compared to others taking a placebo, often due to cardiovascular events or infections like pneumonia. Seroquel was not approved for treating dementia- related psychosis. There was also an increased risk of suffering a stroke. Observations of Resident #33 during the course of the investigation with on-site visits between 01/20/26 and 01/22/26 and again on 01/27/26 revealed no evidence of the resident displaying any behaviors. She was observed to be out of her room and sitting in common areas around other residents pleasant and smiling. On occasion she was observed to be sleeping while in a chair or on the sofa by the nurses' station. She did not have any negative or aggressive interactions with staff or other residents. On 01/21/26 at 1:43 P.M., an interview with Registered Nurse (RN) #47 revealed the facility could not find an adequate indication for use for the Resident #33's use of Seroquel. She stated the only diagnosis they had was dementia with behaviors. On 01/21/26 at 2:00 P.M., an interview with Regional Nurse #90 revealed they (facility staff) had identified Resident #33 did not have an appropriate diagnosis for the use of Seroquel and they were having the psychiatric CNP address that. They would be tapering the resident's Seroquel down with plans to discontinue it, since she did not have an appropriate diagnoses to support the use. She provided a copy of the CNP #200's psychiatric note for 01/13/26 for supportive documentation as evidence of such. That visit note only indicated they planned to do a GDR for the resident's Seroquel, if it was okay with the resident's daughter. It did not indicate it was their intent to taper the medication until it could be discontinued, since she did not have an adequate indication for use. On 01/21/26 at 3:40 P.M. an interview with the director of nursing (DON) revealed the facility's hope was to eventually get the resident off the Seroquel, but her daughter may not be in agreement. She reported when Resident #33 first came, the daughter had showed them videos she had of the resident's agitative behaviors. She reported the daughter was totally against any medication changes being made with the resident's Seroquel, when she first came in, but they were able to get her to agree to a dosage reduction attempt a little while after. The DON was informed they needed an adequate indication for use for the Seroquel and dementia with behaviors was not an adequate indication for use. She was also informed, although the family can give input on medications received, they could not insist that a medication be given, if there was not a medical indication for use. It was ultimately the responsibility of the prescriber to justify the use and to order it at the lowest dose necessary to manage the resident's condition. On 01/22/26 at 9:10 A.M., an interview with CNA #74 revealed every now and then Resident #33 would want some alone time. She would want to go to her room and sit by herself for some quiet time. The resident could get overstimulated at times, and that was usually later in the afternoon. They would notice her being up more and walking around like she was getting anxious/ restless and looking for (continued on next page)

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	366448	A. Building B. Wing	01/28/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	things. If she was taken to her room and sat on her sofa or at the table in her room and provided with a magazine or had the TV turned on, she would calm down. She denied the resident had any other behaviors. She denied the resident showed any agitation towards staff or other residents. On 01/22/26 at 3:11 P.M., an interview with CNP #200 via phone revealed Resident #33 did not have an adequate diagnosis for the use of Seroquel. She confirmed with a mood disturbance was not typically an adequate indication for use. She stated they were working on a GDR for the resident's Seroquel and it was her ultimate goal to get the resident off that medication. The resident's daughter had indicated that the resident had been aggressive in the past. She was not sure where they would end up with the GDR's, so she did not write the order to slowly taper it until it could be discontinued, nor did she document it was her intent to take the resident off of the medication due to not having an appropriate diagnosis for it's use. They generally did not know a resident's history if the resident was already on the medication when they came in. She stated they wanted to ensure the resident was safe and other residents were kept safe as well. She was not able to state if any behavior management, environmental changes, or other person-centered interventions had been attempted in place of the Seroquel that was being used. She stated the DON would have more information about what modifications had been made.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident and/ or their representative was provided a transfer notice in writing and a bed hold notice at the time of a transfer to the hospital. This affected one resident (#1) of three residents reviewed for hospitalizations. Findings include:Review of Resident #1's medical record revealed he was admitted to the facility on [DATE]. His diagnoses included a stroke, acute respiratory failure, and pneumonitis due to the inhalation of food and vomit into his lungs. Review of Resident #1's progress notes revealed a nurse's note dated 09/11/25 at 9:40 A.M. that indicated the nurse went into the resident's room to administer his medications and was unable to arouse the resident. He did not respond to tactile stimuli and remained unresponsive. The facility's Director of Nursing (DON) was notified and it was decided to send the resident to the emergency room. He was transported to the emergency room via squad at 10:05 A.M. The facility was asked to provide a copy of the transfer notice and the bed hold notice that was provided to the resident and/ or their representative at or around the time of the transfer. They provided a copy of a bed hold notice that had been provided and electronically signed by Resident #1 on 09/10/25, when his admission paperwork was completed with him. There was no evidence of a transfer notice being provided to the resident and/ or to his representative upon his transfer to the hospital on [DATE]. There was also no documented evidence of a bed hold notice having been provided to the resident or his representative at the time of the transfer giving him the option to hold a bed, if he chose to do so. On 01/26/26 at 2:38 P.M., the facility's Administrator confirmed they did not have evidence of a transfer notice being provided to the resident and/ or the resident's representative at the time of the resident's transfer to the hospital on [DATE]. She reported the resident's representative was notified of the need to transfer him to the hospital, as was indicated in a progress note, but denied the transfer notice was provided in writing as required. She further confirmed there was no evidence of a bed hold notice having been provided to the resident or his representative at the time of his transfer giving him the right to hold a bed, while out of the facility. She reported the employee responsible for providing the bed hold notices was unaware that all residents should be provided a bed hold notice despite their payer status. She indicated they had only been providing bed hold notices to residents who had Medicaid as their payer status and the resident was under private insurance.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure accuracy of minimum data set (MDS) assessments for residents. This affected two residents (#3, #33) of 18 residents reviewed for accuracy of assessments. The census was 36. Findings include:1.Record review revealed Resident #3 admitted to the facility on [DATE] with diagnoses including congestive heart failure, atrial fibrillation, cardiac pacemaker, type two diabetes, hypertension, and gastro esophageal reflux disease. Review of Resident #3 orders revealed an order to admit the resident to hospice active 11/20/24. Review of Resident #3 care plan completed 09/10/25 revealed the resident is receiving hospice services. Initiated on 09/10/25. Goals, include the resident needs, will be met with comfort and dignity through end-of-life services. interventions include coordinating care with hospice. Review of Resident #3 annual minimum data set (MDS) completed on 01/01/26 revealed a brief interview for mental status (BIMS) score of 04 indicating cognitive impairment. Review of Resident #3 MDS revealed no documentation of Resident #3 receiving hospice care and services or of Resident #3 having a life expectancy of six months or less. Interview on 01/22/26 at 12:20 P.M. with Regional MDS #91 revealed Resident #3 MDS was inaccurately coded to reflect the resident's hospice status. Interview on 01/27/26 at 8:49 A.M. with facility admissions director revealed Resident #3 does receive hospice care and services. 2. Review of Resident #33's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (moderate) with mood disturbance and insomnia. Review of Resident #33's active physician's orders revealed she had the use of Melatonin (a supplement that replaces a hormone naturally produced by the pineal gland in the brain that regulates the sleep-wake cycle) 10 milligrams (mg) by mouth (po) every night at bedtime for insomnia. She had been on that medication since the order originated on 11/02/25. Review of Resident #33's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's medications received during the seven day assessment period included a hypnotic. The box was marked to indicate the resident was taking a hypnotic and had an indication for use. Review of Resident #33's medication administration record (MAR) for November 2025 revealed the resident was receiving Melatonin 10 mg po at bedtime for insomnia. The order originated on 11/02/25 and the resident received it nightly as ordered. There was no evidence of a hypnotic having been administered to the resident, as was indicated on the admission MDS assessment completed on 11/10/25. Review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 Manual from October 2024 revealed it included coding tips for section (N.) of the MDS assessment, which documented medications received during the seven day assessment period. The coding tips instructed the assessor to code medications in Item N0415 according to the medication's therapeutic category and/ or pharmacological classification, not how it was used. They gave an example of a (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication that may have been prescribed for use as a hypnotic, such as Oxazepam, but was classified as another pharmacological classification (anti-anxiety medication). On 01/21/26 at 1:25 P.M., an interview with MDS Nurse #47 confirmed Resident #33's admission MDS assessment dated [DATE] was not coded accurately. She acknowledged she coded in the MDS assessment that the resident had received a hypnotic medication, when she had only been given Melatonin for insomnia. She confirmed Melatonin was considered a supplement and not a hypnotic, based on it's pharmacological classification. She further confirmed medications should be classified based on their pharmacological classification and not for how it was used, as specified in the RAI manual.

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F 0684 Level of Harm - Minimal harm or potential for 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, interview, and policy review the facility failed to ensure residents received complete treatment for infections including antibiotic therapy and failed to ensure physician prescribed weight loss treatment was completed. This affected two residents (#3, #17) of 16 residents reviewed for quality of care. The census was 36. Findings include:1.Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, atrial fibrillation, cardiac pacemaker, type two diabetes, hypertension, and gastro esophageal reflux disease. Review of Resident #3's annual minimum data set (MDS) completed on 01/01/26 revealed a brief interview for mental status (BIMS) score of 04. Review of Resident #3's orders revealed an order to clean left index finger around the nail bed with IHWC, pat dry, apply triple antibiotic ointment (TAO) and cover with band aid daily until resolved. Review of Resident #3's orders revealed an order for Doxycycline hyclate (antibiotic) tablet 100 milligrams (mg) give one tablet by mouth twice daily for infection for seven days starting 01/05/26 and ending 01/12/26. Review of Resident #3's January 2026 medication administration record (MAR) revealed Doxycycline hyclate 100 mg was not administered for both doses (8:00 A.M. and 9:00 P.M.) on 01/08/26 and for the morning (8:00 A.M.) dose on 01/09/26, for a total of three missed doses of the antibiotic. Review of Resident #3's progress notes revealed a progress note dated 01/08/26 at 2:59 P.M. stating Doxycycline hyclate tablet 100 mg give 1 tablet by mouth two times a day for infection for seven days, awaiting arrival from pharmacy. Review of Resident #3 progress notes revealed a note dated 01/09/26 at 9:23 A.M. revealing the resident's Doxycycline was unavailable. Unable to pull from emergency kit, Doxycycline was out of stock. Spoke with pharmacy who stated it would be out for delivery this day. Eventus aware. Review of Resident #3 progress notes revealed a note dated 01/09/26 at 10:59 A.M. revealed Doxycycline hyclate tablet 100 MG give one tablet by mouth two times a day for infection for seven days, awaiting delivery from pharmacy. E-kit was out of stock at this time. Review of Resident #3 record revealed no documentation of Resident #3 Doxycycline for finger infection being adjusted after doses were unavailable to ensure the full course of the antibiotic was received by the resident. The resident received 11 out of 14 doses of the antibiotic. Interview on 01/26/26 at 11:28 AM with Licensed Practical Nurse (LPN) #61 revealed they have been having issues with pharmacy. You may order something from pharmacy, and it doesn't come in for days. If an antibiotic is missing doses they can drop ship it from a local pharmacy, or pull from the emergency kit (E-kit). You can pull from the E-kit or call pharmacy to ensure they get full doses. If someone goes two days without their antibiotic then they are not receiving the full dose, unless its rescheduled/ extended. Interview on 01/27/26 at 1:30 P.M. with facility Director of Nursing and Assistant Director of Nursing confirmed Resident #3's Doxycycline was not rescheduled to make up for the missing doses for their finger infection. 2. Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including necrotizing fasciitis, chronic obstructive pulmonary disease, hyperlipidemia, insomnia, morbid obesity, and depression. Review of Resident #17's record revealed an order for Zepbound Subcutaneous Solution Auto-injector 10 milligram (MG) /0.5 milliliter (ML), (Tirzepatide for Weight Management), Inject 10 mg subcutaneously one time a day every Saturday for weight loss. Ordered on 12/27/25 and discontinued on 01/05/26. Review of Resident #17 progress notes revealed a progress note dated 01/03/26 at 9:28 A.M. stating Zepbound Subcutaneous Solution Auto-injector 10 milligram (MG) /0.5 milliliter (ML), Inject 10 mg subcutaneously one time a day every Saturday for weight loss. None available to give. Reordered from pharmacy. Review of Resident #17 record including progress notes, medication administration record, and treatment administration record revealed no documentation Resident #17 received their ordered dose of Zepbound for January (2026). Review of Resident #17's medication administration record revealed no documentation of Resident #17 receiving their prescribed dose of Zepbound 10 mg/ 0.5 ml for weight loss.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the facility failed to ensure catheter care was completed for Resident #17, urinary outputs were monitored as ordered for Resident #27, and Resident #36 completed their full course of prescribed antibiotics for a urinary tract infection (UTI). This affected three residents (#17, #27, #36) of four residents reviewed for urinary catheters and UTIs. The census was 36. Findings Include:1.Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including necrotizing fasciitis, chronic obstructive pulmonary disease, hyperlipidemia, insomnia, morbid obesity, and depression. Review of Resident #17's minimum data set (MDS) completed on 12/26/25 revealed the resident had an indwelling urinary catheter. Review of Resident #17's orders revealed an order to maintain 16 French (F) with 10 milliliter (ML) balloon catheter in place, to be changed every 30 days as needed to maintain patency. Review of Resident #17 record revealed no documentation of catheter care being completed. Review of Resident #17's care plan completed 12/20/25 revealed the resident has an indwelling catheter and is at risk for complications such as but not limited to infection, sepsis, skin decline, self image declines, and wound intervention. Goals include the resident will show no signs and symptoms of complications related to catheter use through the review date. Interventions include monitor and document for pain and discomfort due to catheter. Monitor/ record/ and report signs and symptoms of UTI such as pain, burning, blood-tinged urine, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Position the catheter bag and tubing below the level of the bladder and away from entrance door. Review of Resident #17's record including orders, medication administration record, treatment administration record, orders, and tasks revealed no documentation of Resident #17 being provided indwelling urinary catheter care. Observation and interview on 01/20/26 at 12:59 P.M revealed Resident #17 had an indwelling urinary catheter in place. Sediment and dark color were observed in the indwelling urinary catheter tubing. Interview on 01/27/26 at 1:33 P.M. with facility Director of Nursing and Assistant Director of nursing confirmed there was no documentation in the resident's medical record of indwelling urinary catheter care being completed. 2. Record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, type two diabetes mellitus, obstructive and reflux uropathy, hyperlipidemia, hypertension, urinary retention, Alzheimer's diseases, dementia, chronic kidney disease. Review of Resident #27's minimum data set (MDS) revealed the resident had an indwelling urinary catheter. Review of the resident's care plan completed on 11/06/26 revealed the resident has an indwelling (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter related to at risk for complications such as infection, sepsis, skin decline, self-image, obstructive uropathy, BPH, and urine retention. The resident will show no signs or symptoms of complications related to catheter use. 18 French catheter 10 milliliter balloon change per order, document and monitor pain, monitor and report signs and symptoms of UTI: burning, blood, cloudy, no output, increase pulse/ temp/ no output, fever, chills, altered mental status, position catheter and tubing below bladder and away from entrance room door. Enhanced barrier precautions for catheter. Review of Resident #27's orders revealed an order placed on 11/06/25 to record indwelling urinary output every shift for monitoring. Notify provider if less than 400 milliliter (ML) per shift. Review of Resident #27's treatment administration record revealed no documentation of indwelling urinary catheter outputs on 12/01/25, 12/06/25, 12/11/25, 12/17/25, 12/21/25, and 12/24/25 and no documentation of physician notification for an output of less than 400 ml for the shift. Review of Resident #27's record revealed documentation on the treatment administration record on 12/14/25, 12/18/25, 01/01/26, and 01/13/26 had no documented output and was documented as see nurses notes. Review of Resident #27's progress notes revealed no documentation of a nurses notes on 12/14/25, 12/18/25, 01/01/26, and 01/13/26 related to Resident #27 indwelling urinary catheter output. Review of facility policy titled Catheter Care (reviewed 04/28/25) revealed for documentation, catheter care was given, should be documented in the resident's medical record. Notify the supervisor if the resident refuses the procedure, any problems or complaints made by the resident related to the procedure. Observation on 01/20/26 at 10:00 A.M. revealed Resident #27 had an indwelling urinary catheter with a privacy bag in place, above the floor and below the level of the bladder. Interview on 01/20/26 at 10:11 A.M. with Resident #27 revealed he does have an indwelling urinary catheter. Resident #27 stated it gets clogged a lot, he is unsure why, but they [the staff] do have to flush his indwelling urinary catheter due to it getting clogged a lot. Interview on 01/27/26 at 1:35 P.M. with facility Director of Nursing and Assistant Director of Nursing confirmed Resident #27 had an indwelling urinary catheter, upon review of the MAR/TAR there were missing dates of indwelling urinary catheter outputs and see nurses notes with no corresponding nurses note. 3. Review of the medical record for Resident #36 revealed admission to facility on 7/28/25 for diagnoses including Atrial Fibrillation (an irregular heartbeat), congestive heart failure, contractures (stiffing of the joints preventing them from bending) of the bilateral hands and knees, Rheumatoid Arthritis, dementia (impaired memory and cognition), and frequent urinary tract infections (UTI). Review of the Minimum Data Set (MDS) 3.0 quarterly assessment completed on 11/24/25 revealed Resident #36 required set up assistance and supervision with meals, was dependent in several areas including bathing, dressing, toileting, and utilized a specialized wheelchair to be pushed by staff. The MDS assessment also indicated Resident #36 was incontinent of urine and feces. Further review of the MDS assessment for Resident #36 revealed a brief interview for mental status (BIMS) score of 3/15 indicating significant cognitive impairment (poor memory and brain function affecting communication of needs). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #36 revealed an order written on 01/15/26 for Macrobid (antibiotic use to treat UTIs) 100 milligrams(mg) capsule by mouth twice a day x 5 days through 01/19/26 for a total of 10 doses. Review of the medication administration record (MAR) for January 2026 revealed Macrobid being administered by nursing staff once on 01/15/26 and twice each day on 1/16/26 through 1/19/26 for a total of nine doses. Observation and interview on 01/21/26 at 7:50 A.M. with licensed practical nurse (LPN) #38 during the medication pass for Resident #36 revealed a medication card of Macrobid containing two doses of medication. LPN #38 reviewed the order for the Macrobid and reported it was completed on 01/19/26 and did not administer the medication and placed the medication card in bottom drawer for disposal. LPN #38 reported that the two doses could be left over because depending on the time of day the medication is prescribed it may not be delivered timely and the medication would be taken from the facility emergency medication supply to ensure it was given. Interview on 01/22/26 at 1:04 P.M. with regional registered nurse (RNN) #90 revealed verification that the MAR for Resident #36 indicated the resident only received nine doses of the Macrobid and not the prescribed 10 doses. RNN #90 notified the provider for further orders.

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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. Based on medical record review, resident observations, and staff interviews, the facility failed to provide adequate hydration for Resident #36. This affected one resident (#36) of two residents reviewed for hydration status. The facility census was 36.Findings include:Review of the medical record for Resident #36 revealed admission to the facility on 7/28/25 for diagnoses including Atrial Fibrillation (an irregular heartbeat), congestive heart failure, contractures (stiffing of the joints preventing them from bending) of the bilateral hands and knees, Rheumatoid Arthritis, and dementia (impaired memory and cognition). Review of the Minimum Data Set (MDS) 3.0 quarterly assessment completed on 11/24/25 revealed Resident #36 required set up assistance and supervision with meals, was dependent in several areas including bathing, dressing, toileting, and utilized a specialized wheelchair to be pushed by staff. Further review of the MDS assessment for Resident #36 revealed a brief interview for mental status (BIMS) score of 3/15 indicating significant cognitive impairment.Review of the medical provider's orders for Resident #36 revealed an order written on 11/16/25 at 6:00 P.M. to increase fluids; drink at least one large glass of water once every two hours; offer cranberry juice. Avoid drinks that irritate the bladder. Further review of Resident #36 provider orders revealed an order written on 05/02/25 to provide two-handled cups for every meal.Observation on 01/20/26 at 12:26 P.M. of Resident #36 revealed resident sitting in her wheelchair in the main hallway near the lounge with eyes closed and covered with a blanket. There were no staff continuously present in the immediate area. There were no fluids or two-handled cups present within reach of Resident #36.Observation on 01/20/26 at 3:00 P.M. of Resident #36 revealed her sitting in her wheelchair in the main hallway near the lounge with eyes closed and covered with a blanket. There were no staff continuously present in the immediate area. There were no fluids or two-handled cups present within reach of Resident #36.Observation on 01/21/26 at 7:50 A.M. revealed Resident #36 in bed eating breakfast. There was no divided plate or 2 handled cups present. Further observation revealed a nurse providing small 4-ounce (oz) plastic cup to Resident #36 to take her medications. Resident #36 hands were contractured and she used her index finger and thumb in pincer grasp to hold cup and drink all the water.Observation on 01/21/26 at 10:15 A.M. of Resident #36 revealed her sitting in her wheelchair in the main hallway near the lounge with eyes closed and covered with a blanket. There were no staff continuously present in the immediate area. There were no fluids or two-handled cups present within reach of Resident #36.Observation on 01/21/26 at 11:37 AM. of Resident #36 in the dining room eating noon meal. Observed a divided plate with onion rings and a sandwich wrap, and a bowl of soup. Further observation revealed a two-handled cup with a sip lid of coffee and another two-handled cup with straw with orange Kool-Aid. Resident #36 was slouched in wheelchair with eyes closed and bilateral hands contractured and resting on upper chest. A nurse approached and encouraged Resident #36 to eat meal. Resident #36 reported she was not hungry, but when the nurse attempted to feed her bites, she did eat and then would ask for a drink. Resident #36 drank 4 oz of the orange Kool-Aid then asked for more water and drank another 4 oz of water. The certified nurse aide (CNA) in the dining room reported to the nurse that Resident #36 had already consumed 2 glasses of orange Kool-Aid prior to the nurse sitting down to assist Resident #36.Observation on 01/21/26 at 12:26 P.M. of Resident #36 after the noon meal revealed her sitting in her wheelchair in the main hallway near the lounge with eyes closed and covered with a blanket. There were no staff continuously present in the immediate area. There were no fluids or two-handled cups present within reach of Resident #36.Observation on 01/21/26 at 1:30 P.M. of Resident #36 revealed her sitting in her wheelchair in the main hallway near the lounge with eyes closed and covered with a blanket. There were no staff continuously present in the immediate area. There were no fluids or two-handled cups present within reach of Resident #36.Observation on 01/22/26 at 8:25 A.M. revealed Resident #36 alone in bed eating breakfast. There was a divided plate present and no two-handled cups present. There was a 4 oz cup of orange juice with no lid, a one handled cup of (continued on next page)

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	366448	A. Building B. Wing	01/28/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coffee with no lid and a regular large 1 handled pitcher of water with a straw. Resident #36 requested assistance to take a drink. Observation on 01/22/26 at 10:15 A.M. of Resident #36 revealed her sitting in her wheelchair in the main hallway near the lounge covered with a blanket. There were no staff continuously present in the immediate area. As the surveyor walked by, Resident #36 asked for a drink of water. There were no fluids or two-handled cups present within reach of Resident #36. Surveyor notified certified nurses' aide (CNA) #77, who confirmed that there was no water available to Resident #36 and went to get the resident a drink of water.Observation on 01/22/26 at 1:18 P.M. revealed Resident #36 resting reclined in bed with bedside table over bed. Observed large one handled water pitcher with straw, one plastic cup with lemonade and straw and no handles, and a 1/2 eaten peanut butter and jelly sandwich. Resident #36 requested assistance with getting a drink. Two CNA's (CNA #77 and #71) verified she did not have any two-handled cups present. CNA # 77 verified that Resident #36 sometimes does not always get a two-handled cup with meals like this morning for breakfast she did not have one. CNA #77 further reported that Resident #36 can sometimes feed herself but sometimes needs assistance with feeding and drinking.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview, and policy review the facility failed to ensure residents received necessary respiratory care and services in accordance with professional standards of practice and the residents care plan. This affected two residents (#10, #17) of three residents reviewed for respiratory care. The census was 36.Findings include:1.Record review revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including dementia, metabolic encephalopathy, type 2 diabetes, heart failure, hypertension, and acute kidney failure. Review of Resident #10's orders revealed an order for oxygen (O2) at 2-4 liters (L) per nasal cannula (NC) to maintain oxygen saturation above 90% as needed for shortness of breath and low oxygen saturations (sats), active as of 11/28/25. Review of Resident #10's admission minimum data set (MDS) completed 12/01/25 revealed a brief interview for mental status score of 03 and the resident required oxygen therapy.Review of Resident #10's admission care plan completed 11/26/25 revealed the resident has altered cardiovascular status related to congestive heart failure (CHF), hypertension, and hyperlipidemia. interventions include to give oxygen as ordered.Review of Resident #10's paper and electronic medical record including care plan, medication administration record, treatment administration record, and orders revealed no evidence of Resident #10's nasal cannula tubing being changed.Review of Resident #10's paper and electronic medical record including care plan, medication administration record, treatment administration record, and orders revealed no evidence of Resident #10's oxygen being initiated or titrated as ordered when the resident was wearing their oxygen.Review of Resident #10's vital signs revealed the last date the oxygen saturation monitoring was documented was on 01/10/26 at 8:27 A.M. There was no evidence of oxygen saturation monitoring being completed since.Observation on 01/20/26 at 12:54 P.M. revealed Resident #10 laying in bed with oxygen at 3L via NC. There was no date on the oxygen tubing.Interview on 01/26/26 at 11:28 AM, with Licensed Practical Nurse #61, revealed residents who have as needed (PRN) oxygen orders should have periodic checks completed on them. In addition, staff should assess the resident's mental status, color, work of breathing, listen to their lungs. Staff should document when they apply the oxygen to the resident and how many liters they are on and what their oxygen saturation is. In addition, staff should identify if or when they are titrating the resident's oxygen, and staff need to monitor their oxygen saturation levels (SpO2), only nurses are able to adjust a resident's oxygen level.Observation and interview on 01/21/26 at 8:31 A.M. of Resident #10 revealed the resident lying in bed with oxygen via NC on their nose. At this time, Licensed Practical Nurse #38 confirmed Resident #10 was on oxygen via nasal cannula at 3 Liters.2. Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including necrotizing fasciitis, chronic obstructive pulmonary disease, hyperlipidemia, insomnia, and depression. Review of the admission MDS completed on 12/26/25 revealed the resident had a brief interview for mental status score (BIMS) of 15 and the resident received oxygen therapy. Review of Resident #17's orders revealed an active order placed 12/23/25 for oxygen at 2 L per minute via NC continuously to keep oxygen saturation above 90%. Review of Resident #17 orders revealed an active order placed 12/23/25 to change oxygen tubing / cannula / mask weekly every night shift every Sunday and as needed. Review of Resident #17's record revealed no evidence in the resident's care plan reflecting the resident's use of continuous oxygen therapy.Observation and interview on 01/20/26 at 12:59 P.M. of Resident #17 revealed the resident had oxygen on via nasal cannula at 2 Liters. Resident #17 confirmed she wears the oxygen at all times.Review of facility policy titled Oxygen Administration, revised April of 2023, revealed staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. The resident's care plan shall identify the interventions for oxygen therapy, based upon the residents' orders , such as, but not limited to, the type of oxygen delivery system, when to administer, such as continuous or intermittent, and/or when (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to discontinue, equipment setting for the prescribed flow rates. monitoring of oxygen saturation (SPo2) levels as ordered, and monitoring complication associated with use of oxygen.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, review of facility contracts and personnel files, the facility failed to provide administration of an intravenous (IV) medication by a competent licensed nurse to Resident #38. This affected one resident (#38) of two residents reviewed for IV medications. The facility census was 36.Findings include:Record review of Resident #38 revealed admission to the facility on 1/13/26 for diagnoses of post operative wound infection with central line placement for intravenous (IV) antibiotic therapy, diabetes, liver disease, high blood pressure, anemia (low blood count), depression, and history of stroke. Further review of the medical record for Resident #38 revealed an order written on 01/13/26 for cefepime hcl (antibiotic used for wound infection) 2 grams (GM) in 100 milliliters (ml) normal saline to be administered three times a day intravenously through 02/20/26.Review of the medical record for Resident #38 revealed a peripherally inserted central catheter (PICC) was placed in the residents right upper arm while in the hospital prior to admission to the facility for long term use with antibiotic therapy. Observation on 01/21/26 at 1:38 P.M. of Resident #38's PICC line revealed a Bard Solo Power PICC inserted to right upper arm with a flesh-colored bandage wrapped around the base of the line thereby preventing view of the insertion site. The exposed portion of the external catheter line had a purple open ended hub with the writing of 5 ml on it. There was no needleless connector devices/valves attached to the end of the external catheter. Further observation and interview on 01/21/26 at 1:38 P.M. with licensed practical nurse (LPN) #53 revealed administration of IV cefepime to Resident #38. LPN #53 cleaned the open end of external portion of PICC with an alcohol swab and then attached a 10 ml syringe of normal saline to flush the catheter then attached the tubing of the IV cefepime to the open end of the external portion of the resident's PICC line without a needleless connector device/valve present. When LPN #53 was asked about the absence of a valve at the end of the PICC line, LPN #53 replied that the PICC lines she works with never have valves on the end of them and that is how PICC lines are. LPN #53 further verified she had IV therapy training and certification.Review on 01/26/26 of the Ohio Board of Nursing licensure review website revealed LPN #53 was originally licensed as a licensed practical nurse on 01/26/25.Interview on 01/27/26 at 9:45 A.M. with the Human Resource Director (HRD) #30 revealed she does not keep a personnel file on agency staff and if any education or training completed would be done and kept by the Director of Nursing. HRD #30 further reported she does not check for agency staff licensure or certification status. HRD #30 verified she did not have a personnel file or competency list for LPN #53.Interview on 01/27/26 at 10:10 A.M. with a staff representative at the Ohio Board of Nursing verified that on 04/06/23 House [NAME] 509 was issued indicating that LPN's no longer will have IV certification on their license and the training and competency verification related to IV therapy will be the responsibility of the employer for any LPN issued a license after 04/06/23.Interview on 01/27/26 at 11:39 A.M. with the interim Director of Nursing (DON) revealed she did not have any education or training/competency files or documents other than the IV training provided on 1/21/26 by the regional nurse after it was noted that LPN #53 was not aware of the use of needleless connectors on PICC lines. The interim DON reported that the agency that LPN #53 was employed through would have any competency records.Interview on 01/27/26 at 12:00 P.M. with the facility Administrator revealed that LPN #53 was utilized for staffing by two staffing agencies, Clipboard and Shift Key. The Administrator revealed that she had spoken with Shift Key on 01/26/26 and they reported that they consider staff as independent contractors, so they only check licensure verification but do not check competencies for staff. The Administrator also reported that Clipboard was able to produce a self-assessment skills check list dated 01/23/25 for LPN #53.Review of the self-listed skills competency sheet provided by the Clipboard Staffing Agency dated 01/23/25 revealed LPN #53 rated her IV therapy skills as a 1 on a 0-3 scale meaning limited competency, requires supervision.Review of the facility contract with Clipboard Staffing Agency revealed the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility is responsible for orientation to facility, education and training, and competency of the agency staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, the facility failed to ensure pharmacy recommendations that identified irregularities during monthly medication regimen reviews were appropriately addressed by the physician/ nurse practitioner and/ responded to timely. This affected two residents (#5, #33) of five residents reviewed for unnecessary medications. Findings include: 1. Review of Resident #5's medical record revealed he was admitted to the facility on [DATE] with the diagnoses of unspecified dementia (moderate) with agitation and depression. Review of Resident #5's monthly medication regimen reviews revealed the resident's medications were reviewed monthly by the consulting pharmacist to identify any irregularities in his medication regimen. Irregularities were noted during two of the 11 months reviewed. Review of Resident #5's pharmacy recommendations revealed the pharmacist noted an irregularity when reviewing the resident's medications on 04/17/25. The pharmacist indicated the resident was on an antipsychotic medication (Seroquel) and requested the physician provide an allowed diagnoses for the medication that complied with the new regulations. The diagnoses were split between two categories: long-term chronic conditions and short-term acute conditions. The long-term chronic conditions included schizophrenia, Tourette's disorder, Huntington's disease, delusional disorder, bipolar disorder, and severe depression refractory to other therapies and/ or with psychotic features. The short-term acute conditions included psychosis in the absence of dementia, medical illness with psychotic symptoms and/ or treatment related psychosis or mania, hiccups (not induced by other medications), and nausea/ vomiting with cancer or chemotherapy. The nurse practitioner did not respond to the recommendation until 05/19/25 (over a month from when the recommendation was made) and did not provide the requested diagnoses to support the use of the Seroquel. She responded to the recommendation that she would like a gradual dose reduction attempt of the Seroquel, if agreed to by the family. Review of a pharmacy recommendation for an irregularity identified during the monthly review of Resident #5's medications on 08/17/25 revealed the pharmacist recommended the prescriber evaluate the continued use of Seroquel, per the guidelines for psychotropic drug therapy. The nurse practitioner responded to the recommendation and agreed to a dose reduction attempt of the Seroquel, but only if agreed to by the resident's family. Again, the pharmacy recommendation was not addressed by the prescriber timely, as it was not responded to until 09/24/25 (over a month since the recommendation was made). On 01/22/26 at 3:55 P.M., an interview with Regional Nurse #90 confirmed Resident #5's pharmacy recommendations were not adequately addressed, as the nurse practitioner that responded to the pharmacy recommendation on 04/17/25, did not provide an appropriate diagnosis pertaining to the use of the Seroquel, as was requested in the recommendation. She further confirmed pharmacy recommendations were not being responded to timely, as there had been two recommendations made by the pharmacist that were not addressed until over a month, after it was given. Review of the facility's policy on Medication Regimen Reviews (revised December 2019) revealed recommendations by the pharmacist were to be acted upon and documented by the facility staff and/ or the prescriber. The prescriber was to accept and act upon suggestions or reject and provide an explanation for disagreeing. The policy did not specifically address the timeframe in which the recommendations should be addressed. 2. Review of Resident #33's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (moderate) with mood disturbance. Review of Resident #33's monthly physician's orders revealed she was receiving Seroquel 25 milligrams (mg) by mouth (po) three times a day for depressive disorder and 50 mg po every night at bedtime for agitation. The order had been in place since the resident's admission to the facility on [DATE]. Review of the monthly medication regimen reviews revealed the facility's consulting pharmacist had reviewed Resident #33's medications for irregularities on 11/21/25 and (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	again on 12/18/25. Neither time did the pharmacist identify any irregularities or make any recommendations pertaining to Resident #33's medications. The pharmacist did not identify the resident as not having an appropriate diagnosis for the use of Seroquel and no recommendations were made for the prescriber to provide a diagnosis that supported it's use. Findings were verified by Regional Nurse #90 on 01/21/26 at 2:00 P.M. that the facility's consulting pharmacist had reviewed the resident's medication regimen twice, since her admission, and did not identify that the resident did not have an appropriate diagnosis to support the use of the Seroquel.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on medical record review and staff interviews, the facility failed to obtain ordered laboratory tests and report results to provider for one resident. This affected one resident (#36) of one resident reviewed for laboratory services. The facility census was 36.Findings include: Review of the medical record for Resident #36 revealed admission to the facility on 7/28/25 for diagnoses including atrial fibrillation (an irregular heartbeat), congestive heart failure, contractures (stiffening of the joints preventing them from bending) of the bilateral hands and knees, rheumatoid arthritis, and dementia (impaired memory and cognition). Review of the Minimum Data Set (MDS) 3.0 quarterly assessment completed on 11/24/25 revealed Resident #36 was dependent in several areas including bathing, dressing, toileting, and utilized a specialized wheelchair to be pushed by staff. Further review of the MDS assessment for Resident #36 revealed a brief interview for mental status (BIMS) score of 3/15 indicating significant cognitive impairment.Review of Resident #36's provider orders revealed she was prescribed Methotrexate Sodium 2.5 milligrams(mg) oral tablet to be given by mouth once every seven days for management of rheumatoid arthritis.Review of the National Library of Medicine found on Medline Plus website: Methotrexate: MedlinePlus Drug Information methotrexate is a drug used for treatment of certain types of cancer, auto-immune disorders including Rheumatoid Arthritis and psoriasis (auto-immune skin disorder). Methotrexate can cause serious side effects including decreasing the number of blood cells made by bone marrow. Low blood cells may lead to increased risk of bleeding and the development of serious infections that can rapidly spread throughout the body. Methotrexate can also cause severe liver damage especially when taken for a long period of time. It is recommended that the prescriber monitor laboratory values of the blood count and liver function before during and after treatment with methotrexate.Further review of Resident #36's provider orders revealed on 08/26/25 an order was given to obtain a complete blood count with differential (CBC with diff) and liver function test (LFT) every four weeks on Tuesdays while on methotrexate regimen.Review of the treatment administration record (TAR) for Resident #36 revealed scheduled laboratory services for CBC with diff and LFT to be obtained on 08/26/25, 09/23/25, 10/21/25, 11/18/25, 12/16/25, and 01/13/26.Review of the laboratory results for Resident #36 obtained from the medical record revealed a CBC with diff and LFT were obtained by the facility on 08/26/25 and 09/23/25. There was no CBC with diff or LFT obtain during the month of October 2025. Further review revealed a CBC with diff obtained on 11/18/25 with no evidence of a LFT being completed. There was a CBC with diff obtained on 12/16/25 with no evidence of a LFT being completed. There was no CBC with diff or LFT obtained on 01/13/26.Interview on 01/22/26 at 1:04 P.M. with Regional Registered Nurse (RRN) #90 verified the facility did not obtain ordered labs for CBC with diff or LFT on 01/13/26 and that Resident #36 had been left off the laboratory list. RRN #90 notified the medical practitioner of the omission of labs and new orders were obtained.Review of email communication with the Administrator on 01/26/26 at 3:36 P.M. verified the facility did not have evidence that the CBC with diff or LFT were obtained on 10/21/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, review of medical records, and facility policies and procedures review, the facility failed to follow infection control practices to prevent the spread of infection. This affected one resident (#38) of five residents reviewed for medication administration and one resident (#10) of one resident reviewed for transmission-based precautions. The facility census was 36.Findings include:1.Record review of Resident #38 revealed admission to the facility on 1/13/26 for diagnoses of post operative wound infection with central line placement for intravenous (IV) antibiotic therapy, diabetes, liver disease, high blood pressure, anemia (low blood count), depression, and history of stroke. Further review of the medical record for Resident #38 revealed an order written on 01/13/26 for cefepime hcl (antibiotic used for wound infection) 2 grams (GM) in 100 milliliters (ml) normal saline to be administered three times a day intravenously through 02/20/26. Review of the medical record for Resident #38 revealed a peripherally inserted central catheter (PICC) was placed in the resident's right upper arm while in the hospital prior to admission to the facility for long term use with antibiotic therapy. Observation on 01/21/26 at 1:38 P.M. of Resident #38's PICC line revealed a Bard Solo Power PICC inserted to the right upper arm with a flesh-colored bandage wrapped around the base of the PICC line thereby preventing view of the insertion site. The exposed portion of the external catheter line had a purple open ended hub with the writing of 5 ml on it. There was no needleless connector devices/valves attached to the end of the external catheter. Further observation and interview on 01/21/26 at 1:38 P.M. with licensed practical nurse (LPN) #53 revealed administration of IV cefepime to Resident #38. LPN #53 cleaned the open end of external portion of PICC with an alcohol swab and then attached a 10 ml syringe of normal saline to flush the catheter then attached the tubing of the IV cefepime to the open end of external portion of PICC without a needleless connector device/valve present. When asked about the absence of a valve at the end of the PICC line, LPN #53 replied that the PICC lines she works with never have valves on the end of them and that is how PICC lines are. LPN #53 further verified she had IV therapy training and certification. Interview on 01/21/26 at 3:04 P.M. with the facility regional registered nurse (RNN) #90 verified that Resident #38 did not have a needleless connector/valve attached to the open end of external portion of Resident #38's PICC line. RNN #90 reported she would obtain a needleless connector device and attach it to PICC line as well as change the PICC dressing for Resident #38. Review of the policy and procedure manual from Specialty Rx (effective 01/17/2019) for IV therapy used by the facility revealed on page V-55 all lumens of catheters will have a needleless connection device on the hub to prevent intake of air embolus and/or prevention of outward blood flow. Needleless connector devices may be referred also as pressure valves or end caps. The needleless connector devices are also used to help prevent catheter associated infections. The procedure went on to state that anytime a needleless connection device/valve is removed it should be discard and replaced with a new sterile device. 2. On 01/27/26 at 9:35 A.M., an observation noted Activity Director #51 to enter the room of Resident #10. Resident #10 resided on the facility's memory care unit and was noted to be in transmission (continued on next page)

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	366448	A. Building B. Wing	01/28/2026

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based precautions (TBP's) for being positive for Covid-19. She had signs posted on the door to see the nurse before entering the room and donning/ doffing procedures of personal protective equipment (PPE's) to be followed when entering and exiting the room. PPE was located in a cart that was outside the room in the hallway. Activity Director #51 already had a surgical mask on, as did all staff throughout the facility for the latest Covid-19 outbreak, and donned additional PPE to include a gown, gloves, and shoe covers. She was not observed to remove her surgical mask and replace it with an N-95 particulate mask before entering the resident's room. She was also not noted to don eye glasses over top of her smaller prescription eye glasses that did not fully cover her eyes. The activity director was noted to stand directly in front of the resident, while the resident was sitting in her recliner. She was then observed to doff her PPE leaving her surgical mask on as she entered the hallway. On 01/27/26 at 9:38 A.M., an interview with Activity Director #51 confirmed Resident #10 was in TBP's for Covid-19. She was asked what PPE should be worn when entering the room of a resident in TBP's for Covid-19. She named off all the PPE that should be worn including the N-95 mask. She was asked why she did not switch out her surgical mask for an N-95 mask before entering the resident's room. She stated the N-95 masks were too bulky and she had trouble breathing through them when worn. She acknowledged surgical masks did not provide the same amount of protection from respiratory droplets as a N-95 mask would. She further acknowledged by not wearing a proper N-95 mask she risked being infected with Covid-19 herself and could potentially spread it it to others including residents. She also confirmed eye glasses were available in the PPE cart for use and would provide better protection from getting respiratory droplets in her eyes should the resident cough while in her room. The prescription eye glasses she was wearing did not adequately cover her eyes to protect them from any droplets she may encounter when in the room. Review of the facility's policy for Transmission Based Precautions (reviewed August 2025) revealed TBP's must be used when a resident developed signs and symptoms of a transmissible infection or has a laboratory confirmed infection and was at risk of transmitting the infection to other residents. Implementation of TBP's included donning appropriate PPE upon entering into the room of a resident on TBP's. Droplet precautions applied when respiratory droplets contained viruses or bacterial particles, which may be spread to another susceptible individual. Respiratory droplets were generated when an infected person coughed, sneezed, or talked. Facemasks were to be used upon entry into a resident's room. Airborne transmission occurred when pathogens were so small that they could be easily dispersed in the air, and because of that, there was a risk of transmitting the disease through inhalation. Those small particles containing infectious agents may be dispersed over long distances by air currents and may be inhaled by individuals who have not had face to face contact with (or been in the same room with) the infectious individual. Staff caring for those residents should wear a fit-tested N95 or higher level respirator that was donned prior to room entry. Review of Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Covid-19 Pandemic (reviewed September 2024) revealed respirators provided a higher level of protection than facemasks. It was recommended that respirators (such as an N95 mask) be worn when caring for a resident with an active Covid-19 infection,

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility's infection control logs, staff interview, and policy review, the facility failed to ensure a resident, who was admitted to the facility on an antibiotic medication, was reviewed to ensure there were laboratory tests that supported the use of an antibiotic to treat a urinary tract infection (UTI), and the resident met criteria under the facility's antibiotic stewardship program for such treatment. This affected one resident (#48) of five residents reviewed for UTI's. Findings include: Review of Resident #48's medical record revealed the resident was admitted to the facility on [DATE]. Her diagnoses included hemiplegia and hemiparesis following a stroke affecting her right dominant side, adult onset diabetes mellitus, and a urinary tract infection. Review of Resident #48's hospital records for her hospital stay prior to her admission into the facility on [DATE] revealed an After Visit Summary (AVS) dated 11/05/25 that revealed the resident was diagnosed with acute cystitis (inflammation of the bladder) without hematuria (blood in the urine). Her medication list indicated she should begin taking Levofloxacin (Levaquin) 500 milligrams (mg) by mouth (po) daily x 7 days. Further review of Resident #48's hospital records that had been scanned in under the miscellaneous tab of the electronic medical record (EMR) revealed the resident had a urinalysis (U/A) collected on 11/05/25. The preliminary report indicated the urine was slightly cloudy, had a large amount of Leukocytes (white blood cells typically a sign of infection or inflammation in the urinary tract), and her urine had negative nitrites (nitrite- reducing bacteria that were common UTI culprits like E. coli were not detected in the urine, but did not rule the presence of a UTI). The final urine culture (that would identify the presence of an organism at a concentration great enough to cause a UTI) was not available at the time of his admission and was still in process. Review of Resident #48's medication administration record (MAR) for November 2025 revealed the resident received the complete course of the antibiotic (Levaquin), as was ordered upon the resident's admission, receiving the antibiotic daily between 11/06/25 and 11/13/25 (eight days). The dose that had been scheduled on 11/14/25 was not administered as scheduled due to the resident being in the hospital on that day. Review of the facility's Infection Log/ Antibiotic Surveillance report for November 2025 revealed Resident #48 was included on the log as having been admitted to the facility with a UTI on 11/05/25. The infection log indicated that a U/A had been collected in the hospital and there was no organism identified that had been recorded on the log. The log indicated that Levaquin 500 mg was the antibiotic ordered daily and the resident received it beginning on 11/06/25 and had a stop date of 11/15/25. The infection control log included a column to indicate if the resident met criteria for treatment using McGeer's criteria. The log indicated that the resident did not meet criteria for the treatment of a UTI, but the treatment continued. Review of a McGeer's Criteria for Infection Surveillance Checklist for Resident #48 dated 11/05/25 revealed the facility's infection preventionist (IP) evaluated the resident for a UTI. The resident was indicated on that checklist to not have met criteria for the treatment of a UTI. On 01/27/26 at 1:05 P.M., an interview with the facility's interim Director of Nursing (DON) revealed the Assistant Director of Nursing (ADON) was supposed to be the facility's IP for the entire building, but had just been handling the infections for the assisted living side of the building. The DON reported she had been the one keeping track of the infections for the nursing home residents, as best she could. It was her intent to get the ADON onboarded to oversee all infections in the building and planned to work with her until she was comfortable in doing so. She acknowledged Resident #48 was indicated on the November 2025 infection surveillance log to have admitted from the hospital on an antibiotic for a UTI that she did not meet criteria to treat. She further acknowledged there was no evidence of the facility's IP reviewing the resident's use of the antibiotic for the treatment of a UTI that she had been admitted from the hospital on. She denied anyone had followed up with the U/A that had been collected in the hospital on [DATE] to obtain the final U/A culture results. She provided a copy of the final culture results for the U/A that had been collected in (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hospital on [DATE], after being interviewed, that confirmed the resident did not have a UTI that needed treatment. The final U/A culture results showed less than 100,000 CFU/ml with a low number of organisms present of unclear significance. They recommended a repeat collection, preferably by straight catheterization, if clinically indicated. The final results was resulted on 11/06/25 at 4:23 P.M. Review of the facility's policy on Antibiotic Stewardship (updated August 2024) revealed antibiotics would be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program including utilization of McGeer's criteria or equivalent infection screening. The purpose of the antibiotic stewardship program was to monitor the use of antibiotics in residents. When a culture and sensitivity (C&S) was ordered, lab results would be communicated to the prescriber as soon as available to determine if antibiotic therapy should be continued, modified, or discontinued.