STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365626	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellbrook Health and Rehab	1957 North Lakeman Drive Bellbrook, OH 45305

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365626	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellbrook Health and Rehab	1957 North Lakeman Drive Bellbrook, OH 45305

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure residents were provided with a proper discharge. This affected one (#100) of the three residents reviewed for discharges. The facility also failed to ensure the discharges were reported to the local ombudsman office. This affected one (#100) of the three residents reviewed. The facility census was 33.Findings include: 1) Review of the medial record or Resident #100 revealed the resident was admitted to the facility on [DATE] and discharged to his home on [DATE]. Diagnoses included orthostatic hypotension, diabetes mellitus (DM), dehydration, dysphagia, and anxiety disorder.Review of the Care Plans dated 04/18/25 for Resident #100, revealed no care plan developed for discharge planning.Review of the April and May 2025 physician orders for Resident #100, revealed no orders for the resident to be discharge from the facility.Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #100 was cognitively intact. Resident #100 was dependent on staff for medication administration and required set-up assistance for other activities of daily living (ADLs). Review of a progress note for Resident #100 dated 05/05/25, revealed a referral was faxed to Queen City Home Health per the resident's request. Review of a progress note for Resident #100 dated 05/15/25 at 6:15 P.M., revealed the resident and sister were aware that the appeal was denied and the resident declined to complete another appeal. The resident wanted to discharge home tomorrow. Resident #100 would be discharged home on [DATE] with the home health care agency referral in place.Review of Nurse Practitioner (NP) progress note for Resident #100 dated 05/15/25, revealed the resident was seen related to a discharge visit. Notes indicated the resident resided in an Assisted Living Facility (ALF) and was receiving primary care services. The resident was planned on being discharged tomorrow but expressed discomfort with the discharge plan. The resident was stable but stated he felt as if he was not being adequately monitored and was unsure if he was ready to go home and did not feel comfortable administering his insulin. Review of a progress note dated 05/16/25 at 12:06 P.M., revealed the social worker contacted the resident's sister to schedule a discharge time. The resident's sister stated she would pick up the resident today at 5:15 P.M. Review of a progress note for Resident #100 dated 05/16/25 at 5:10 P.M., revealed the resident was discharged home with his personal belongings and medications including 19 tablets of Lomotil (anti-diarrhea) and 27 oxycodone (narcotic pain relief) five milligrams (mg). Diabetes teaching was completed, medications were discussed, and the nurse instructed the resident to follow-up with his primary care physician. All questioners were answered, and the resident left in private vehicle with no distress. There were no additional progress notes about a discharge summary being completed or being provided to the resident. Review of the Recapitulation of Stay dated 05/16/25 for Resident #100, revealed the only section completed was section two (Social Services). Social Services noted a referral was made to a home health agency and sent a referral to obtain a primary care physician. The admission information, discharge information, summary of stay, nursing services, dietary services, activities, and rehabilitation services were all blank, and the form was not signed. Interview on 10/29/25 at 9:20 A.M. with the Director of Nursing (DON) #52 from the ALF community where the resident was listed as being discharged to, revealed Resident #100 never resided in the ALF. DON #52 stated Resident #100 had always lived in an independent living apartment and was discharged back to his independent living apartment from the facility. Interview on 10/29/25 at 9:53 A.M. with Nurse Practitioner (NP) #501 revealed Resident #100 expressed concerns about not being ready to go home related to his insulin. NP #501 stated she thought Resident #100 was discharged to an ALF and was surprised to learn Resident #100 was discharged to an independent living apartment. NP #501 stated she was certain Resident #100 went home with home health referral because a home health care nurse called her to ask for a prescription for insulin because the resident was discharged without any insulin and without having a primary care physician in place.Interview on 10/29/25 at 10:25 A.M. with Home Health Care Registered Nurse (RN) #504 stated Resident #100 was discharged from the facility to an independent living apartment with no primary care physician to follow him. RN #504 stated she visited Resident #100 on 05/17/25 and the resident did not have any insulin in his apartment. RN #504 stated she reached out to NP #501 because Resident #100 did not have a primary care physician to contact. RN #504 requested an insulin order from NP #501 and to be sent to Resident #504's independent living apartment. RN #504 stated she had to assist Resident #504 with finding a primary care physician. Interview with the Administrator on 10/29/25 at 1:54 P.M. verified Resident #100 was discharged from the facility without a discharge summary