

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Bellbrook Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, policy review and record review, the facility failed to notify the provider and resident representative of a resident's change in condition. This affected one (Resident #9) of one resident reviewed for notification of change. The facility census was 34. Findings include: Review of the medical record for Resident #9 revealed an admission date of 10/19/22. Diagnoses included epilepsy. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 had moderately impaired cognition. The care plan, last revised on 10/17/25, revealed Resident #9 had impaired neurological status related to seizure disorder. Interventions included to monitor and report any seizure activity, monitor environment if involuntary muscle movements place the resident at risk for injury, monitor for need of padding to side rails or wheelchairs, monitor vital signs as needed, and report abnormal to physician. Review of Resident #9's progress notes dated 01/07/25 to 01/14/25 revealed no documentation of Resident #9 having a seizure or notification to the resident representative or provider of Resident #9 having a seizure. Interview on 01/13/26 at 7:05 A.M. with Licensed Practical Nurse (LPN) #149 stated Resident #9 had a seizure last night (01/12/26) around the start of his shift. LPN #149 confirmed the oxygen was being administered to Resident #9 at two and a half liters. LPN #149 stated Resident #9 doesn't need the oxygen, he only put it on due to Resident #9 seizing last night. Interview on 01/14/26 at 7:29 A.M. with the Director of Nursing (DON) confirmed no documentation in Resident #9's record of seizure that happened on 01/12/26 and no documentation of notification to provider or resident representative. The DON also confirmed no order for oxygen in Resident #9's record. Interview on 01/14/26 at 8:11 A.M. with LPN #149 stated Resident #9's seizure from 01/12/26 lasted about five minutes. When Resident #9 was lying on his back, he was having difficulty breathing, then gave Resident #9's order for scheduled Keppra (anti-seizure medication). LPN #149 applied oxygen when Resident #9 started to have the seizure, LPN #149 said the other LPN (#141) got an order from the provider for oxygen while he was in the room. Interview on 01/14/26 at 1:15 P.M. with Nurse Practitioner (NP) #178 confirmed she was not notified of Resident #9 having a seizure on 01/12/26 until this morning (01/14/26). NP #178 stated if she was made aware of Resident #9's seizure on 01/12/26, they would have ordered for labs to be drawn. Interview on 01/14/26 at 10:05 AM with LPN #141 revealed Resident #9 had a seizure on 01/12/26 that lasted about five to ten minutes. LPN #141 confirmed he did not notify the provider, and did not speak to the provider about the oxygen. Review of the policy titled Acute Condition Changes Clinical Protocol, dated 03/2018, revealed the nursing staff will contact the physician based on the urgency of the situation. The staff and physician will discuss possible causes of the condition change based on factors including resident history, current symptoms, medication regimen, and diagnostic test results. If necessary, the physician will order diagnostic tests and evaluate the patient directly.</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Bellbrook Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, policy review, and staff and resident interviews, the facility failed to ensure a resident who was dependent on staff for personal hygiene and bathing received adequate assistance with nail care. This affected one (#11) of 12 residents reviewed for activities of daily living (ADL). The facility census was 34. Findings include: Review of the medical record for Resident #11 revealed admission date of 08/23/22. The resident was admitted with diagnoses including stroke, dementia without behaviors, type two diabetes mellitus, depression, anxiety and polyneuropathy. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was cognitively impaired. Resident #11 was dependent upon staff for personal hygiene and toileting. Review of the care plan revealed Resident #11 had a physical functioning deficit with interventions which included nail care as needed. Observation and interview on 01/12/26 at 11:01 A.M. revealed Resident #11's fingernails had extended approximately one eighth of an inch beyond his fingertips. His nails were observed to be encrusted with a dark brown substance. Resident #11 stated staff had not offered to clean and trim his nails and acknowledged he would like assistance with nailcare. Observation and interview on 01/13/26 at 11:36 A.M. with Certified Nurse Assistant (CNA) #118 verified Resident #11's fingernails were long and dirty. She stated another CNA had told her she would take care of his nails. She added she would clean them and inform the nurse Resident #11's nails needed cut, explaining Resident #11 was diabetic and CNAs were unable to cut the nails of residents who were diabetic. Interview on 01/13/26 at 12:25 P.M. with Licensed Practical Nurse (LPN) #152 stated it was the expectation the CNAs to clean and trim a resident's nails during showers and/or bed baths. LPN #152 explained the residents who were diabetic, it would be the responsibility of the nurse or podiatrist to ensure they were trimmed. Observation on 01/14/26 at 8:34 A.M. revealed Resident #11's fingernails were clean, however; they remained uncut. Interview on 01/14/26 at 8:34 A.M. with the Director of Nursing (DON) revealed the DON was informed Resident #11's request for nail care. Review of the progress note dated 01/14/26 at 9:58 A.M. revealed Resident #11's fingernails were cut per his request, hands were washed with soap and water, rinsed and dried. Review of the facility policy titled Activities of Daily Living (ADLs) dated 2001 documented residents who were unable to carry out ADLs independently would receive appropriate support and assistance with hygiene (bathing dressing, grooming and oral care). This deficiency represents non-compliance investigated under Complaint Numbers 2573072 and 2703714.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Bellbrook Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a resident received adequate care and treatment for intravenous line placements, skin assessments, and a wound vac. This affected one (Resident #46) of five residents reviewed for hospitalization. The facility census was 34. Findings include: Review of Resident #46's medical record revealed an admission date of 08/05/25 with diagnoses including acute respiratory failure with hypoxia, anxiety disorder, tracheostomy status, and depression. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #46 had moderately impaired cognition, and dependent on staff with toileting and bathing. Resident #46 discharged from the facility on 08/12/25. Review of Resident #46's assessments from 08/05/25 to 08/12/25 revealed there were no wound or skin assessments completed upon admission or after. Review of Resident #46's physician orders dated 08/05/25 revealed wound vac to abdomen at 100 millimeters of mercury (mmHg) suction to be changed every Monday, Wednesday and Friday dayshift. The care plan dated 08/06/25 revealed wound vac to abdomen as per orders with settings as per orders. Resident #46 had an intravenous dressing and interventions included observe dressing, change dressing and record observations of site per physician orders. The progress note dated 08/07/25 at 2:24 P.M. revealed the wound vac applied to Resident #46's abdomen. Review of the Treatment Administration Record (TAR) revealed wound vac was applied on 08/07/25, and there were no further wound vac changes done. Physician orders revealed the wound vac should have been changed on Friday 08/08/25 and Monday 08/11/25. Review of Resident #46's progress notes dated 08/06/25 revealed Resident #46's intravenous (IV) pump continued to alarm when attempting to infuse via the peripheral line to the resident's right shoulder. The writer attempted to use the peripheral to the residents' left hand, and when attempting to flush, the resident stated that it was painful. Also noted some erythema to the area beneath the transparent dressing, so this access was removed. The Nurse Practitioner (NP) was notified. Peripheral IV to resident's left shoulder was flushed with no issues and the IV medications were continued via this access with no further issues noted. The NP note dated 08/08/25 revealed Resident #46 had three peripheral intravenous lines: a 20-gauge in the left wrist, a 20-gauge in the left shoulder, and a 18-gauge in the right forearm. The progress notes and TAR from 08/06/25 to 08/12/25 revealed no intravenous site care and monitoring of the access sites. Interviews on 01/14/26 at 10:25 A.M. with the Director of Nursing (DON) confirmed Resident #46 did not get skin/wound assessment done on admission through discharge. On 01/15/26 at 10:12 A.M., the DON confirmed Resident #46 had no wound vac changes done from 08/07/25 until discharge on [DATE]. The DON confirmed Resident #46 had no intravenous site care done from admission on [DATE] until discharge on [DATE]. This deficiency represents non-compliance investigated under Complaint Numbers 2589893 and OH00164513 (1367213).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Bellbrook Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and policy review, the facility failed to ensure fall interventions were in place for a resident who had a history of falling. This affected one (Resident #9) of two residents reviewed for accidents. The facility census was 34. Findings include: Review of the medical record for Resident #9 revealed an admission date of 10/19/22. Diagnoses included epilepsy, cerebral infarction, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. The Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 had moderately impaired cognition and was dependent on staff for toileting, bathing, and personal hygiene. The care plan dated 11/07/23 revealed Resident #9 was at risk for falls related to impaired mobility. Interventions included bilateral fall mats to floor on each side of bed, call light in reach at all times when in bed, educate/remind to use call light prior to transfer, encourage resident to use call light for assistance for toileting needs, ensure personal items are within reach at all times, and sign hung at eye level to remind to use call light for assistance with toileting. The progress note dated 10/03/25 revealed Resident #9 had a fall. Review of Resident #9's fall investigation revealed an intervention of bilateral fall mats to each side of bed. Observation of Resident #9's room on 01/12/26 at 9:43 A.M. revealed Resident #9 was lying in bed and there were no fall mats on the floor. The fall mat was leaning against the wall near his bed. Observation on 01/12/26 at 12:01 P.M. revealed Resident #9 was lying in his bed with his eyes closed. There were no fall mats on the floor. Observation on 01/12/26 at 1:02 P.M. revealed Resident #9 was lying in bed and there was one fall mat on the floor on the right side only. Observation and interview on 01/12/26 at 1:17 P.M. with Resident #9 revealed he needed help with his adult briefs and the call light was not within his reach. The call light was lying on the floor of Resident #9's room next to the bed. On 01/12/26 at 1:22 P.M., Certified Nursing Assistant (CNA) #104 confirmed Resident #9's call light was not within reach. Observation and interview on 01/12/26 at 2:24 P.M. revealed Resident #9 was lying in bed and the fall mat was leaning on the wall and not on the floor next to his bed. CNA #104 confirmed Resident #9 was lying in bed and his fall mat was next to the wall and not on the floor beside Resident #9's bed. Observations on 01/13/26 at 7:50 A.M. and 10:24 A.M. revealed Resident #9 was lying in bed and there was one fall mat on the floor on the right side only. Review of the policy titled Call System, Residents dated 09/2022 revealed each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting, bathing facilities and from the floor. Review of the policy titled Falls and Fall Risk Managing dated 2001 revealed the staff will implement a resident centered fall prevention plan to reduce the specific risk factor of falls for each resident at risk or with a history of falls. This deficiency represents non-compliance investigated under Complaint Number 2703714.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Bellbrook Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, staff interview, and review of facility policy, the facility failed to ensure areas of the facility were in good repair. This had the potential to affect all 34 residents residing in the facility. Findings include: Observation of the facility's outdoor courtyard on 01/13/26 at 11:59 A.M. revealed a square raised planter box that was filled with soil had a corner that was broken and coming apart. The broken corner had exposed rusty nails. A small inoperable portable heater was on the concrete next to the planter box. A wooden fence enclosing the courtyard was loose and was falling toward the courtyard. A bag of sand was holding a section of the fence up. A wooden picnic table was covered in peeling paint, and the wood appeared to be deteriorating. Interview and observation with the Administrator on 01/14/26 at 9:03 A.M. confirmed the courtyard had a planter box that was broken, coming apart and had exposed rusty nails, there was portable heater sitting in the courtyard, and the wooden fence was loose and falling toward the courtyard. The Administrator confirmed residents have access to the courtyard. Review of the facility's policy titled Homelike Environment dated February 2021 revealed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. This deficiency represents non-compliance investigated under Complaint Numbers 2566940 and 2581568.</p>		