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	03/12/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the Self-Reported Incidents (SRI), staff interview, and policy review, the facility failed to timely report an allegation of verbal abuse. This affected one (#23) out of three residents reviewed for abuse. The facility census was 41.Findings include:Review of the medical record for Resident #23 revealed an admission date of 02/02/26. Diagnoses included bipolar disorder current episode manic without psychotic features moderate, anxiety disorder, hypothyroidism, mixed hyperlipidemia, major depressive disorder single episode severe without psychotic features, and hypertension.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 was cognitively intact. Resident #23 was assessed to require supervision for toileting, bathing, dressing, and transfer, set up assistance for oral and personal hygiene, and was independent for eating and bed mobility.Review of the provider visit note dated 02/16/26 revealed Resident #23 reported an incident with a staff member, where they became angry with the resident, which involved yelling and the use of profanity towards the resident. The note was signed by Former Nurse Practitioner (FNP) #175.Review of the electronic system for SRIs from 02/16/26 to 03/11/26 revealed there were no alleged incidents involving Resident #23 that had been reported by the facility.Interview on 03/11/26 at 5:29 P.M. with the Administrator revealed she was not informed of any allegations of abuse involving the staff member, identified as Licensed Practical Nurse (LPN) #94, and Resident #23. The Administrator stated she would have reported the allegation and initiated an investigation if she had been made aware of the concern.Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 04/2021, revealed the facility would investigate and report any allegations within timeframes required by federal requirements.This deficiency represents non-compliance investigated under Complaint Number 2791092.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the hospital record, review of the incident report, review of the incident/accident log, and policy review, the facility failed to ensure residents were free of significant medication errors. This affected two (Resident #15 and #36) out of six (#15, #36, #01, #39, #23, and #45) residents reviewed for medication administration. The facility census was 41.Findings include:1. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, paroxysmal atrial fibrillation, hypertensive urgency, adult failure to thrive, and essential hypertension. Further review of Resident #15's medical record revealed the resident was assessed as having moderately impaired cognition according to the most recent Minimum Data Set (MDS) assessment dated [DATE].Review of a progress and Situation, Background, Assessment, and Recommendation (SBAR) note dated 02/17/26 contained in Resident #15's medical record revealed Resident #15 experienced severe chest pain rated nine out of ten (9/10) on 02/17/26 at 9:40 A.M. and was sent out from the facility to the emergency department. Further review of the note revealed notification of the resident's condition was given to the resident's Primary Care Clinician (Nurse Practitioner #175) on 02/17/26 at 9:48 A.M. Additional review of this note revealed no mention of any medications administered in response to Resident #15's reported chest pain symptoms on the morning of 02/17/26.Review of an incident report prepared by the Director of Nursing (DON) #171 dated 02/17/26 at 10:00 A.M. revealed the following: Resident complaint of chest pain 9/10. Vital signs taken, The Nurse Practitioner (NP) was called, medication given to the resident without an order. Sent to emergency room (ER) for evaluation. Further review of the report revealed the resident identified on the report was Resident #15. Additional review of the incident report revealed immediate action steps were documented as calling the Nurse Practitioner and sending Resident #15 to the emergency room. Review of an outside hospital history and physical note dated 02/17/26 revealed Resident #15 was admitted for hospital treatment via the emergency department on 02/17/26 after presenting with complaints of chest pain. Further review of the history and physical note revealed the following: Patient states that he was given a dose of sublingual nitroglycerin prior to coming to the ED.Interview on 03/12/26 at 10:42 A.M. with Nurse Practitioner #175 revealed that to their best knowledge, Resident #15 was given sublingual nitroglycerin without an order on the morning of 02/17/26. Further interview revealed the Nurse Practitioner was called by facility staff after the incident occurred, asking the Nurse Practitioner to place the order for the medication after the medication had already been administered. Nurse Practitioner #175 stated they did not place an order for Resident #15 to receive sublingual nitroglycerin, and they were not going to place an order for sublingual nitroglycerin on 02/17/26 as they had not received an appropriate assessment that indicated the need for the medication to be administered, given the resident's reported status and health history.Interview on 03/12/26 at 12:34 P.M. with the DON #171 revealed they were aware of Resident #15 being administered sublingual nitroglycerin without an order in place on 02/17/26. Further interview revealed DON #171 did not directly witness facility staff administer the medication to Resident #15, though the DON #171 was in the facility that morning and went to the resident's room after the emergency medical squad had already arrived. DON #171 recalled receiving a telephone report from Nurse Practitioner #175 that Resident #15 had been administered sublingual nitroglycerin without an order prior to leaving the facility for the emergency department. DON #171 stated that when they were trying to investigate the incident, no facility nurse that was on duty the morning of 02/17/26 would admit to administering Resident #15 the nitroglycerin without an order.Interview on 03/12/26 at 12:40 P.M. with Certified Nursing Assistant (CNA) #30 revealed they were in the room with Resident #15 on the morning of 02/17/26 while the resident was experiencing chest pain. Further interview at this time revealed CNA #30 witnessed Resident #15 being administered a medication under their tongue by Licensed Practical Nurse (LPN) #188 in response to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the chest pain the resident was describing.Review of Resident #15's physician orders as reflected on the medication administration record (MAR) for February 2026 revealed no record of an order for sublingual nitroglycerin.2. Review of the medical record for Resident #36 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction, diffuse traumatic brain injury with loss of consciousness, essential hypertension, and anxiety amongst other diagnoses. Further review of Resident #36's medical record revealed a more recent diagnosis of sepsis due to methicillin resistant staphylococcus aureus (MRSA) dated 01/22/26. Additional review of Resident #36's medical record revealed the resident was assessed as having moderate cognitive impairment as of their comprehensive MDS assessment completed on 01/28/26.Review of the facility Incident and Accident Log for January 2026 revealed one medication error was recorded on 01/28/26, involving Resident #36. Further review of the incident log revealed documented findings that the wrong antibiotic had been administered to Resident #36 at approximately 10:30 A.M. on 01/28/26.Review of an incident report dated 01/28/26 revealed Resident #36 had been subjected to a medication error incident when they were given intravenous (IV) ceftriaxone instead of IV cefepime as ordered, and the infusion of the incorrect antibiotic ran for approximately five to ten minutes before the antibiotic was stopped. Further review of the incident report revealed a trainee nurse had obtained the wrong antibiotic from the medication refrigerator and started the medication, after having verified the resident's name, medication and dose with another nurse that was training them.Review of the Medication Administration Record (MAR) for the month of January 2026 revealed Resident #36 had an active order for the IV antibiotic cefepime, and there was no order for the IV antibiotic ceftriaxone.Interview on 03/12/26 at 3:51 P.M. with DON #167 verified a medication error involving Resident #36 occurred on 01/28/26 when the resident was administered the wrong antibiotic.Review of the facility policy titled Administering Medications, revised April 2019 revealed medications are administered in accordance with prescriber orders.This deficiency represents non-compliance investigated under Complaint Number 2791092.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, review of the Ohio Administrative Code (OAC), and policy review, the facility failed to ensure controlled substances were disposed of properly. This affected one (Resident #15) out of 33 residents with controlled substance medication orders. There were eight (#01, #02, #08, #10, #30, #31, #35, and #41) residents who were identified by the facility with no orders for controlled substances. The facility census was 41.Findings include:Review of the medical record for Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, paroxysmal atrial fibrillation, hypertensive urgency, adult failure to thrive, and essential hypertension. Further review of Resident #15's medical record revealed the resident was assessed as having moderately impaired cognition as of their most recent Minimum Data Set (MDS) assessment dated [DATE].Observation on 03/12/26 at approximately 9:55 A.M. revealed Licensed Practical Nurse (LPN) #155 pulled one medication from a locked drawer that was contained in the medication cart while preparing medications for Resident #15. Further observation at this time revealed the medication was one 150 milligram (MG) capsule of pregabalin (a medication to treat neuropathic pain). LPN #155 was observed signing this medication out in a binder labeled for tracking the dispensing of narcotics prior to opening the capsule and pouring the drug into a medication cup for Resident #15.Observations on 03/12/26 at 10:00 A.M. and 10:15 A.M. revealed Resident #15 refused their pregabalin along with all other medications offered at that time for their morning medication pass.Observation on 03/12/26 at 10:20 A.M. revealed the facility had no waste/disposal solution to safely and properly discard the pregabalin powder, or any other controlled substances in the facility. At this time, no facility staff could locate any solution designated for safely discarding the controlled substances.Interview on 03/12/26 at 10:24 A.M. with the Director of Nursing (DON) #167 revealed the Regional Director of Operations would have to drive to another facility to obtain a container of liquid solution for the disposal of medications and bring it back to the facility so that the medication could be properly discarded. Further interview at this time revealed DON #167 recommended LPN #155 dispose of the pregabalin along with all of Resident #15's other refused medications by flushing the drugs down the toilet.Observation on 03/12/26 at 10:28 A.M. revealed LPN #155 went into an empty, unassigned resident room and flushed the controlled substance down the toilet while they were not accompanied by any other facility staff to verify the medication was properly disposed of.During a follow-up interview on 03/12/26 at 3:28 P.M. the DON #167 revealed a nurse that is discarding medications that are considered controlled substances should be accompanied by another nurse to witness the safe disposal of controlled substances. Further interview with DON #167 at this time verified there should be two nurses present at the time of discarding the medication, to ensure controlled substances are safely disposed of.Review of the facility policy titled Discarding and Destroying Medications, revised November of 2022 revealed medications that cannot be returned to the dispensing pharmacy, such as medications refused by the resident, are disposed of in accordance with federal, state, and local regulations governing management of controlled substances.Review of the Ohio Administrative Code (OAC 4729:5-3-01, effective 07/01/24) regarding the disposal of controlled substances revealed that if a long term care facility uses a method of destruction pursuant to the Code of Federal Regulations (CFR 1317, 09/25/23), the controlled substances transferred to their waste method must be completed by the director of nursing and witnessed by a nurse licensed in accordance with Chapter 4723 of the Ohio Revised Code.This deficiency represents an incidental finding of noncompliance identified while investigating Complaint Number 2791092.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of an incident report, review of the hospital records, and staff interview, the facility failed to maintain an accurate and adequately comprehensive medical record. This affected one (Resident #15) out of six (#15, #36, #39, #01, #23, and #45) residents reviewed for accurate and complete medical records. The facility census was 41.Findings include:Review of the medical record for Resident #15 revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, paroxysmal atrial fibrillation, hypertensive urgency, adult failure to thrive, and essential hypertension. Further review of Resident #15's medical record revealed the resident was assessed as having moderately impaired cognition as of their most recent Minimum Data Set (MDS) assessment dated [DATE].Review of a facility incident report dated 02/17/26, an outside hospital history and physical note dated 02/17/26, and a Situation, Background, Assessment and Recommendation (SBAR) nursing communication note dated 02/17/26 revealed Resident #15 was administered a sublingual nitroglycerin tablet on 02/17/26 while experiencing chest pain at the facility.Interview on 03/12/26 at 12:40 P.M. with Certified Nursing Assistant (CNA) #30 revealed they witnessed Resident #15 being administered a medication under their tongue in response to complaints of chest pain prior to leaving the facility via ambulance. Review of progress notes contained in Resident #15's medical record revealed no mention of a sublingual medication being administered, or any reference of nitroglycerin being administered to the resident by facility staff on 02/17/26.Review of Resident #15's Medication Administration Record (MAR) for February 2026 revealed no mention of Resident #15 having received sublingual nitroglycerin on 02/17/26.Interview on 03/12/26 at 3:51 P.M. with Director of Nursing (DON) #167 verified that besides mention of medication given to resident without order as written on the incident report dated 02/17/26, there was no available facility produced documentation to identify that Resident #15 received sublingual nitroglycerin.This deficiency represents an incidental finding of noncompliance identified while investigating Complaint Number 2791092.