STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366194	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennington Glen Nursing & Reha	825 State Route 61 Marengo, OH 43334

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 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** 47990 Based on record review, staff interview, family interview, and policy review, the facility failed to accurately transcribe physician's orders for medications upon admission to the facility. This affected one (Resident #90) of three residents reviewed for admission procedures. The facility census was 76. Findings include: Review of the closed medical record for Resident #90 revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, hyperlipidemia (elevated cholesterol), and hypertension (elevated blood pressure). Resident #90 was discharged from the facility on 08/12/24 with a family caretaker upon completion of his planned respite stay at the facility. Review of Resident #90's Minimum Data Set (MDS) 3.0 discharge return not anticipated assessment, dated 08/12/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 08, indicating moderately impaired cognition. Resident #90 was not recorded to have had any behaviors or rejection of care. Review of Resident #90's baseline care plan, dated 08/04/24, revealed the resident was not a candidate for self-administration of medications. The baseline care plan identified that a current medication list was provided to the resident and/or representative, and that a medication reconciliation was completed with the resident and/or representative. The section regarding physician orders listed to see the current Medication Administration Record (MAR) and Treatment Administration Record (TAR). Review of Resident #90's history and physical, dated 07/08/24, from an outside medical provider revealed the form contained the resident's current medical conditions, relevant assessment findings, and his list current medications. The form listed various ordered medications, of which included a highlighted area which specified a diagnosis of hypertension, and a notation to hold Losartan (a medication used to lower blood pressure) until the blood pressure reading was over 130/80 mmHg (millimeters of mercury). Additional instructions within the order stated to cut down the dose to 50 milligrams (mg) when re-starting the medication. The orders contained no order for Atorvastatin (a medication used to lower cholesterol) 20 mg one tablet daily. (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: 366194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #90's physician's orders contained in the electronic health record revealed an order dated 08/02/24 for Losartan 100 mg once daily. Instructions included to monitor for low blood pressure. Resident #90's Losartan order was modified on 08/05/24, to continue at 100 mg once daily, but parameters were added to the order which specified to hold the medication until Resident #90's blood pressure was greater than 130/80 mmHg. Resident #90's electronic health record also contained an order dated 08/02/24 for Atorvastatin 20 mg one tablet daily in the morning. Review of Resident #90's interdisciplinary progress notes, recorded vital signs, and review of the physical medical record revealed no indication the resident's blood pressure was monitored until the order was modified on 08/05/24 to include supplementary documentation. The progress notes made no mention of any new order, conversation with any medical provider, or a pharmacy change which could identify the source of the order for Resident #90's Atorvastatin 20 mg once daily. Review of Resident #90's Medication Administration Record (MAR) for August 2024 revealed the resident was recorded as having received the dose of Atorvastatin on three dates, 08/07/24, 08/08/24, and 08/09/24. On 08/03/24, 08/04/24, 08/05/24, 08/06/24, 08/10/24, and 08/11/24, the dose of Atorvastatin was recorded as not administered with supplemental documentation reflecting the medication was not available. Resident #90's MAR revealed the resident was recorded to have received Losartan 100 mg one tablet daily in the morning from 08/03/24 until 08/12/24. A telephone interview on 09/04/24 at 3:03 P.M. with a family member of Resident #90 revealed when the resident was discharged , she received a medication list which included a medication the resident did not have an order for. The family member reported she was driving, unable to reference the specific medication but reported it as definitely not on the list. She had questioned the facility nurse on duty during the date of discharge, and no one could provide any information on where the order originated from. The family member indicated she declined to sign the resident's discharge paperwork, and was concerned the resident had been receiving the wrong medications throughout his ten-day long respite stay. An interview on 09/04/24 at 4:18 P.M. with the Director of Nursing confirmed Resident #90's Losartan order was a weird order with the written physician's orders stating to decrease the dose when re-starting the medication. The DON stated she would expect nurse's to reach out to the provider and question the order for the dose of the medication and verified there is no documentation in Resident #90's record to reflect the order was ever questioned. Additionally, the DON verified Resident #90's Atorvastatin order was not included in the written physician's orders provided upon admission, and the resident's record contained no evidence or source for the origin of the Atorvastatin order. The DON stated the nurse on duty at the time of admission is responsible for inputting the physician's orders, the next shift was responsible for double checking the physician's orders, and then a nurse manager was the final check to ensure orders were implemented appropriately. Review of the policy Medication Administration, dated 10/04/20, revealed medications are administered in accordance with the order of the prescriber(s). Medications shall be administered following the scope of medication administration using nursing standards of practice. Assuring that the correct medication is administered in the correct dose, in accordance with manufacturer's specifications and with standards of practice, to the correct person via the correct route in the correct dosage form and at the correct time. This deficiency represents non-compliance investigated under Complaint Number OH00156784.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Bennington Glen Nursing & Reha		STREET ADDRESS, CITY, STATE, ZIP CODE 825 State Route 61 Marengo, OH 43334	

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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** 47990 Based on record review, staff interview, and policy review, the facility failed to ensure Resident #90 was free of significant medication errors. This affected one (Resident #90) of six residents reviewed for medication administration. The facility census was 76. Findings include: Review of the closed medical record for Resident #90 revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, hyperlipidemia (elevated cholesterol), and hypertension (elevated blood pressure). Resident #90 was discharged from the facility on 08/12/24 with a family caretaker upon completion of his planned respite stay at the facility. Review of Resident #90's Minimum Data Set (MDS) 3.0 discharge return not anticipated assessment, dated 08/12/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 08, indicating moderately impaired cognition. Resident #90 was not recorded to have had any behaviors or rejection of care. Review of Resident #90's baseline care plan, dated 08/04/24, revealed the resident was not a candidate for self-administration of medications. The baseline care plan identified that a current medication list was provided to the resident and/or representative, and that a medication reconciliation was completed with the resident and/or representative. The section regarding physician orders listed to see the current Medication Administration Record (MAR) and Treatment Administration Record (TAR). Review of Resident #90's history and physical, dated 07/08/24, from an outside medical provider revealed the form contained the resident's current medical conditions, relevant assessment findings, and his current medications. The form listed various ordered medications, of which included a highlighted area which specified a diagnosis of hypertension, encouraged to hold Losartan (a medication used to lower blood pressure) until the blood pressure reading is over 130/80 mmHg (millimeters of mercury). Additional instructions listed to cut down the dose to 50 mg upon re-starting the medication. Review of Resident #90's physician's orders contained in the electronic health record revealed an order dated 08/02/24 for Losartan (a medication used to lower blood pressure) 100 milligrams (mg) once daily. Instructions included to monitor for low blood pressure. Resident #90's Losartan order was modified on 08/05/24, to continue at 100 mg once daily, but parameters were added to the order which specified to hold the medication until Resident #90's blood pressure was greater than 130/80 mmHg (millimeters of mercury). Review of Resident #90's interdisciplinary progress notes, dated 08/02/24 through 08/12/24, revealed no notation of any contact with the resident's current attending physician or any outside provider regarding the ordered Losartan dosage. Review of Resident #90's MAR for August 2024 revealed no evidence the resident's blood pressure was checked prior to administration of his morning dose of Losartan on 08/03/24, 08/04/24, and 08/05/24. The resident was administered his morning dose of Losartan 100 mg one tablet outside of the physician-ordered parameters on the following dates: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bennington Glen Nursing & Reha		STREET ADDRESS, CITY, STATE, ZIP CODE 825 State Route 61 Marengo, OH 43334	

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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	08/06/24 when the resident's blood pressure was recorded as 120/72. 08/08/24 when the resident's blood pressure was recorded as 119/71. 08/09/24 when the resident's blood pressure was recorded as 107/68. 08/10/24 when the resident's blood pressure was recorded as 121/74. 08/11/24 when the resident's blood pressure was recorded as 96/62. 08/12/24 when the resident's blood pressure was recorded as 99/65. An interview on 09/04/24 at 4:18 P.M. with the Director of Nursing (DON) revealed only some residents have parameters for their blood pressure readings, and typically the provider orders parameters for residents whose blood pressure can be unstable. The DON confirmed the Losartan was administered on the above dates outside of the physician-ordered parameters and the nurses should have held the resident's Losartan. The DON shared she will be checking the nurses who administered the medications outside the parameters as they required re-education. Review of the policy Medication Administration, dated 10/04/20, revealed the facility will hire and retain only authorized personnel to administer medications in accordance with manufacturer's specifications and with standards of practice. Medications are administered in accordance with orders of the prescriber(s). This deficiency represents non-compliance investigated under Complaint Number OH00156784.

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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** 47990 Based on observation, record review, resident and staff interview, and policy review, the facility failed to label and store medications in a safe and secure manner. This affected one (Resident #55) and had the potential to affect 18 residents whom the facility identified as recipients of medications stored in Cart A on the 200-hallway. The facility census was 76. Findings include: 1. Review of the medical record for Resident #55 revealed an admitted [DATE]. Medical diagnoses included Review of Resident #55's Minimum Data Set (MDS) 3.0 admission assessment, dated 08/08/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of Resident #55's baseline care plan, dated 08/09/24, revealed the resident was not identified as a candidate to self-administer medications. Review of Resident #55's physician's orders revealed an order dated 08/08/24 for Sodium Chloride Nasal Solution 0.65%, administer 4 sprays in both nostrils three times daily for allergies. Resident #55 also had an order dated 08/08/24 for Fluticasone Propionate Nasal Suspension (a nasal spray which contained a corticosteriod used to manage symptoms of seasonal allergies) 50 micrograms (mcg) per actuation, administer 2 sprays in both nostrils one time daily for allergies. Resident #55's physician's orders did not include an order allowing for self-administration or for medications to be kept at the resident's bedside. An observation on 09/04/25 at 9:35 A.M. of Licensed Practical Nurse (LPN) #232 revealed she prepared Resident #55's ordered morning medications. LPN #232 attempted to retrieve Resident #55's ordered Sodium Chloride nasal spray, but was unable to locate the nasal spray in the medication cart. LPN #232 stated the nasal spray may be in the resident's room as she had seen it in there before. LPN #232 proceeded to Resident #55's room. On Resident #55's overbed table were two boxes of nasal sprays next to the resident's breakfast tray he had just finished eating. The first box contained Sodium Chloride Nasal Solution 0.65%, and the second box contained Fluticasone Propionate 50 mcg/actuation. LPN #232 verified both nasal sprays were at the resident's bedside, and stated she was unsure if the resident was allowed to keep the nasal sprays at bedside, or if he had an order to self-administer medications. An interview on 09/04/24 at 9:53 A.M. with Resident #55 in the presence of LPN #232 revealed he frequently administered his own nasal sprays, even after admitting to the facility. Resident #55 stated sometimes the nursing staff left his nasal sprays at his bedside for a few days at a time, and he uses the sprays when he felt like he needed it. LPN #232 removed the two nasal sprays from Resident #55's bedside. (continued on next page)

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	366194	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 09/04/24 at 9:54 A.M. with LPN #232 revealed she checked Resident #55's current physician's orders and verified the resident does not have an order to self-administer medications. LPN #232 additionally checked Resident #55's nasal spray orders and indicated there is no notation or order that the resident could keep the medications at bedside. LPN #232 returned the two nasal sprays to the medication cart and verified the medications should not have been left at the resident's bedside. 2. An observation on 09/04/24 at 10:09 A.M. revealed three plastic pill cups in the top drawer of Cart A on the 200-hallway. The first cup, marked with Resident #43's first name, contained one oblong yellow medication capsule. The second cup, marked Fe, contained six dark green colored round tablets, and the third cup was unlabeled and contained four pills of various sizes, shapes, and colors. An interview on 09/04/24 at 10:11 A.M. with LPN #232 verified the three cups of medications should not be stored in the medication cart in small cups. LPN #232 stated the six dark green round tablets were over the counter iron supplement tablets. LPN #232 was unsure of the strength of the medication and verified without the label, she was unable to check the strength of the medication. LPN #232 stated she had began to prepare medications for Resident #43 but had not yet completed her morning medication administration. LPN #232 was unsure who the four various pills in the unlabeled cup were for, and stated the medications were there before she began her shift. LPN #232 verified the medications should not be stored this way and disposed of the medications in the medication cart's sharps container. An interview on 09/04/24 at 10:41 A.M. with the Director of Nursing (DON) revealed medications should not be pre-poured and should be contained in appropriate packages with labels. A follow up interview with the DON at 4:18 P.M. confirmed medications, including nasal sprays, should not be left at any residents' bedside unless the resident was identified to be capable of self-administration of medications. Review of the policy Labeling and Storage of Medications, dated 10/04/20, revealed the facility shall provide for the accurate labeling of medications/biologicals to facilitate consideration of precautions and safe administration of medications and safe and secure storage of all medication. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration date when applicable. The facility shall store all drugs and biologicals in locked medication rooms, carts, and/or compartments. This deficiency represents an incidental finding while investigating Complaint Number OH00156784.