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	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bennington Glen Nursing & Rehabilitation Center	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, medical record review, review of the Resident Assessment Instrument (RAI) User's Manual, the facility failed to adequately assess the activity preferences of a resident and met the needs and preference of the resident. This affected one (#6) of two residents reviewed for activities. The facility census was 68.Findings include: Review of Resident #6's medical record revealed an admission date of 10/04/25. Diagnoses included dementia, periprosthetic fracture around internal prosthetic of left hip joint and fracture of unspecified part of neck of left femur, depression, age-related macular degeneration, osteoarthritis, and sensorineural hearing loss. Resident #6 had a niece and daughters listed as emergency contacts.Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had a Brief Interview for Mental Score (BIMS) of six indicating she had severely impaired cognition. Resident #6 was interviewed for activity preferences and it was somewhat important to the resident to have books, newspapers, and magazines to read, listen to music, and be around animals such as pets.Review of the activity participation review (assessment) dated 10/06/25 revealed Resident #6 was hard of hearing and hard to communicate with. The assessment was completed with Resident #6 and not her family. Resident #6 was unable to identify preferred activities.Review of the plan of care dated 11/06/25 revealed Resident #6 was a sociable person, liked to participate in various activities, and had no current activities of interest. Resident #6 was unable to pursue their interests due to their physical and or cognitive condition. Resident #6 was willing to interact with others and participate in activities that were related to their interests as their condition would allow. The activities that were important to the resident included arts and crafts, bingo, and music. Interventions included discussing the calendar of activity events with the resident, encouraging and allowing the resident to rest so they may attend preferred activities, inviting to music related activities, and inviting to scheduled activities.Review of Resident #6's activity participation review (assessment) dated 12/15/25 revealed the assessment was not completed.Review of the activity participation record from 04/01/26 to 04/19/26 revealed Resident #6 had daily participation in relaxation, television/radio/movies, and news events. On 04/02/26 and 04/13/26, Resident #6 participated in one-on-ones (Activity Assistant #78 stated it was not completed though in her interview below) and reading books. Observation on 04/20/26 at 1:14 P.M. and 3:37 P.M. revealed Resident #6 was awake in her room with the lights off and no form of entertainment. Her bedside table was empty. Observation on 04/21/26 at 9:05 A.M. 11:40 A.M., and 2:45 P.M. revealed Resident #6 was awake in her room with the lights off and no form of entertainment. Her bedside table was empty.Interview on 04/21/26 at 11:40 A.M. with Certified Nursing Assistant (CNA) #20 verified Resident #6 was sitting in the dark without television, music, or another form of entertainment. CNA #20 reported she was unsure what kind of music or television the resident liked. Interview on 04/22/26 at 10:34 A.M. with Activities Assistant #78 revealed if a resident was confused, the director called their family to assist with activity preferences. Activities Assistant #78 reported Resident #6 did not get out of bed for activities lately. Activities Assistant #78 verified Resident #6's participation in April activities which included daily participation in relaxation, television/radio/movies, new events and one-on-one and reading books. Activity Assistant #78 (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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	reported relaxation meant Resident #6 was resting in bed, and Resident #6 did not actually participate on one-on-one activities on 04/02/256 and 04/13/26 because she was asleep. Interview on 04/22/26 at 10:43 A.M. with Activities Director #79 revealed she thought she had spoken to Resident #6's family about her activities but verified it may not be documented. Activities Director #79 reported reading was the resident's one on one activity and she read the daily news chronicle to her. She reported she was trying to identify some of the residents preferred activities but could not refer to any documentation of this.Review of the Resident Assessment Instrument (RAI) User's Manual, versionˆ1.20.1, page F-1, stated the intent of the data items for the Minimum Data Set (MDS) section F: Preferences for Customary Routine and Activities, is to obtain information regarding the resident's preferences for their daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences and is not meant to be all-inclusive. Most residents capable of communicating can answer questions about what they like. Further review revealed individuals who live in nursing homes continue to have distinct lifestyle preferences. A lack of attention to lifestyle preferences can contribute to depressed mood and increased behavior symptoms. Resident responses that something is important but that they can't do it or have no choice can provide clues for understanding pain, perceived functional limitations, and perceived environmental barriers. Care planning should be individualized and based on the resident's preferences. Care planning and care practices that are based on resident preferences can lead to improved mood, enhanced dignity, and increased involvement in daily routines and activities.This deficiency represents non-compliance investigated under Complaint Number 2974213.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility's investigation, staff interviews, and policy review, the facility failed to ensure Resident #6 received adequate supervision and assistance with toileting to prevent the resident from falling. Actual Harm occurred on 03/21/26 when Resident #6 was not adequately supervised in the bathroom, was left on the toilet while Certified Nurse Aide (CNA) #41 went to get new bedding and an adult brief, and Resident #6 got herself off the toilet and was coming out of the door when CNA #41 came in and saw Resident #6 fall backwards hitting her back and head on the sink, sustaining serious physical harm and injuries and was subsequently hospitalized related to rib fractures to her left seven through eleventh left ribs, a small left hemopneumothorax (accumulation of air and blood in the pleural cavity commonly caused by trauma), an acute left T9 transverse process fracture (a break in the small bony projection on the side of the ninth thoracic vertebra), and hematomas to the left chest wall, retroperitoneum (space behind the abdominal lining in the back of the abdomen), and right iliacus muscle (a muscle filling the inner pelvis) as a result of being left unattended while toileting. This affected one (#6) of four residents reviewed for falls. Findings include:Review of Resident #6's medical record revealed an admission date of 10/04/25. Diagnoses included dementia, periprosthetic fracture around internal prosthetic of left hip joint and fracture of unspecified part of neck of left femur, history of falling, age-related macular degeneration, and osteoarthritis. Review of the care plan revised 10/16/25 revealed Resident #6 was at risk for falls due to history of falls, dementia, decreased mobility, increased weakness, and unsteady gait. Interventions included antiroll back to the wheelchair, commonly used articles in reach, and the assistance of one to two persons with all transfers, proper footwear, and non-slip footwear. An intervention was added on 03/21/26 for staff to remain in the bathroom until the resident finished toileting. The care plan dated 10/16/25 revealed Resident #6 could require assistance with activities of daily living (ADLs) and may be at risk of developing complications associated with decreased ADL self-performance. Interventions included that the resident was confused and disoriented, and she required assistance with transfers, ambulation, and toileting.Review of Resident #6's progress notes revealed on 10/12/25 she had a fall when standing without assistance, on 10/29/25, she had a fall when transferring without assistance, on 11/07/25, she had a fall when ambulating without assistance, on 12/02/25, she had a fall when transferring without assistance, and on 12/25/25 she had a fall when ambulating without assistance.Review of the fall risk evaluation dated 12/25/25 revealed Resident #6 was at risk for falls due to one to two falls in the last 60 days, she was unable to or unwilling to follow directions and was cognitively impaired. Additionally, Resident #6 displayed behaviors that included any of the following: easily distracted, periods of altered perception or awareness of surroundings, episodes of disorganized speech, periods of restlessness, increased lethargy, mental function varies over the day, wanders, resists care, combative, and altered safety awareness. She eliminated with assistance and ambulated with problems with or without an assistive device. The resident was unsteady and only able to stabilize with assistance when moving from seated to standing position, walking, moving on and off toilet, and surface to surface transfer. The resident had conditions affecting her neuromuscular or functional ability, cardiovascular, orthopedic, and perceptual status. Review of the occupational therapy Discharge summary dated [DATE] revealed Resident #6 was able to transfer from various surfaces with maximum assistance of one staff following multimodal cues (the combination of auditory, visual, and tactile signals used to enhance communication, learning, or sensory perception) for increasing ADL performance with staff. required 24-hour supervision and assistance during ADLs and transfers.Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 had severely impaired cognition and required substantial or maximal assistance with toileting hygiene and toileting transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #6's progress note dated 03/21/26 at 5:44 P.M. revealed Licensed Practical Nurse (LPN) #555 was called to the bedroom by Certified Nursing Aide (CNA) #41, the CNA had left Resident #6 in the bathroom on the toilet while she went to get new bedding and an adult brief. Resident #6 got herself off the toilet and was coming out of the door when CNA #41 came in and saw Resident #6 fall backwards and hit her back and head on the sink. Resident #6 was assessed and immediately a bruise on the back and a goose egg on the back of her head were found. The physician and guardian were notified. There was no mention of CNA #41 assisting Resident #6 to the floor.The progress note dated 03/21/26 at 6:17 P.M. revealed Resident #6 was complaining of pain in the back where her bruising was. Her as needed pain medication was provided, and the physician ordered a stat x-ray. The progress note dated 03/21/26 at 9:09 P.M. revealed the x-ray was unable to come to the facility on that day. Resident #6 was to be transferred to the hospital for an x-ray. Review of the fall investigation dated 03/21/26 revealed Resident #6 sustained a fall at 5:35 P.M. LPN #555 was called into the room, and Resident #6 was on the floor in the bathroom. Resident #6 was oriented to person only, her predisposing factors included impaired memory, incontinence, and ambulating without assistance. It was not indicated that Resident #6 was using a walker. Resident #6 was left in the bathroom while CNA #41 went to get an adult brief and bedding. The intervention was for staff to stay with Resident #6 in the bathroom. There was no witness statement obtained from CNA #41 and LPN #555 during the time of the investigation.Review of the fall questionnaire dated 03/21/26 at 5:30 P.M. revealed CNA #41 indicated she put Resident #6 in the bathroom and went to get bedding, when she came back, she found her standing up, she got spooked and fell back into the sink, hitting her back. There was no mention of CNA #41 assisting with Resident #6's fall.Review of Resident #6's hospital discharge summary revealed she was admitted to the hospital on [DATE] and was discharged on 03/26/26. Resident #6 presented to the hospital after a mechanical fall with a complaint of chest wall pain. Resident #6 was noted to have bruising to the left side by the emergency room physician. Resident #6 had hit her head but did not lose consciousness. Resident #6 was found to have rib fractures to her left seven through eleventh left ribs, a small left hemopneumothorax, an acute left T9 transverse process fracture, and hematomas of the left chest wall, retroperitoneum, and right iliacus muscle. The hospital x-ray results did not show the five rib fractures, and acute left T9 process fracture were pathological in nature; it stated it was unknown if related to osteoporosis and/or osteopenia. The physician note dated 03/26/26 revealed Resident #6 was at high risk of falls and had been sent to the emergency room after a fall. Resident #6 sustained multiple injuries; however, they did not require surgical intervention. Resident #6 had left seven to 11 rib fractures, and it was unknown if osteopenia or osteoporosis contributed to fracture. Right subacute fifth to six rib fractures and it was unknown if osteoporosis or osteopenia. A small left hemopneumothorax. An acute fracture of T9 and it was unknown if osteopenia or osteoporosis contributed to fracture. The physician note made no mention of the fractures being pathological in nature. Interview on 04/22/26 at 8:05 A.M. with CNA #16 revealed residents who need assistance with toileting and were forgetful required frequent checks. CNA #16 reported they wanted to maintain some level of privacy so they may stand outside the bathroom door and peak at them occasionally; however, they would stay in the room just in case. Interview on 04/22/26 at 11:13 A.M. with LPN #555 revealed Resident #6 was a fall risk who frequently got up without assistance, because of this, she was not left alone on the toilet. On 03/21/26, CNA #41 who worked with Resident #6 was unfamiliar with Resident #6 and her risks. CNA #41 left the bathroom and the bedroom to get linens from the hallway closet. When she returned to the bathroom, Resident #6 had already gotten up and she witnessed her fall. LPN #555 reported Resident #6 was not in any pain at that time; however, she had a goose egg on the head and a bruise on her back. The bruise spread which was what prompted the orders for an x-ray. Interview on 04/22/26 at 4:05 P.M. with the Administrator revealed she recalled Resident #6's fall on 03/21/26. They were using a lot of staff from other buildings who were not familiar with the residents and their risks and were unlikely to review the care plans. The Administrator implemented a daily sheet with important (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	reminders about residents. Review of the typed witness statement dated 04/23/26 (over a month after the fall occurred) revealed on 03/21/26 at approximately 5:30 P.M., CNA #41 briefly left Resident #6 in the bathroom to grab fresh bedding from the linen room. When she returned, Resident #6 had pulled her pants up and was standing at the sink with her walker. When CNA #41 walked into the bathroom, Resident #6 became startled by her reflection and began to fall. CNA #41 was able to partially assist her to the floor. Additional interview on 04/27/26 at 10:56 A.M. with LPN #555 revealed when he went to the restroom, Resident #6 was positioned between the toilet and the sink. CNA #41 reported to him that Resident #6 hit her head on the sink. LPN #555 reported when describing the fall, CNA #41 told him she saw Resident #6 fall and was unable to get to her in time to assist her.An attempt to interview CNA #41 during the survey was unsuccessful.Review of the policy titled ?Fall Management' revised 10/24/25 revealed the care plan was to be reviewed throughout the course of treatment by the interdisciplinary team to ensure the most recent resident specific fall reduction interventions have been incorporated as necessary into the plan of care. A fall risk evaluation was completed on admission, after a significant change, quarterly, and as necessary. The evaluation was to be used by the interdisciplinary team to further identify individualized fall risk factors. This deficiency represents non-compliance investigated under Complaint Numbers 2974213, 2603937, 2595389, and 1388007 (OH00165757).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, staff interview, and review of the facility's do not crust list, the facility failed to ensure their medication error rate was less than five percent (%). There were four medication errors out of 34 opportunities resulting in a 11.76% medication error rate. This affected one (Resident #68) of five residents observed during medication administration. The facility census was 68.Findings include:Review of Resident #68's medical record revealed an admission date of 09/25/18. Diagnoses included paroxysmal atrial fibrillation, polyosteoarthritis, and gastro-esophageal reflux disease (GERD) without esophagitis.Review of Resident #68's physician orders revealed on 04/01/26, Metoprolol Succinate extended release (ER) (treats high blood pressure) oral tablet 24-hour 25 milligrams (mg) give one tablet by mouth one time a day; and Metoprolol Succinate ER oral tablet 24-hour 50 mg give one tablet by mouth one time a day for a total of 75 mg daily. On 12/04/24, an order for Pantoprazole Sodium (treats GERD) tablet delayed release 20 mg one time daily. On 10/28/25, an order for Tylenol (acetaminophen) (treats mild pain) eight hour arthritis pain oral tablet ER 650 mg give one tablet by mouth two times a day.There was also an order dated 11/12/21 that nursing may crush medications/open capsules and mix in food or drink unless the medication was delayed release/ER, enteric coated or on the list of medications not to be crushed as needed.Observation and interview on 04/22/26 at 8:00 A.M. revealed Licensed Practical Nurse (LPN) #89 crushed Resident #68's Tylenol eight hour arthritis pain oral tablet ER 650 mg, Metoprolol Succinate ER oral tablet 24-hour 25 mg, Metoprolol Succinate ER oral tablet ER 24-hour 50 mg, and Pantoprazole Sodium tablet delayed release 20 mg and administered these medications in pudding to Resident #68. LPN #89 confirmed she crushed Resident #68's four medications and administered them in pudding to Resident #68.Review of the facility's do not crush list revealed Tylenol eight hour arthritis pain oral tablet ER 650 mg, Metoprolol Succinate ER 24-hour 25 mg and 50 mg oral tablets, and Pantoprazole Sodium tablet delayed release 20 mg were listed on medications that were not to be crushed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and medical record review, the facility failed to have accurate medical record documentation for Residents #17. The affected one (#17) of 26 residents reviewed for medical record accuracy. The facility census was 68.Findings include:Review of Resident #17's medical record revealed an admission date of 10/15/21. Diagnoses included hypothyroidism.Review of Resident #17's physician orders revealed an order for Synthroid oral tablet 175 micrograms (mcg) administer one tablet one time a day related to hypothyroidism.Review of Resident #17's Medication Administration Record (MAR) revealed no documentation for Resident #17's Synthroid oral tablet 175 mcg on 04/10/26, 04/11/26, 04/14/26, 04/15/26, and 04/16/26.The medical record did not reveal the reason why the Synthroid medication was not documented in the MAR.Interview on 04/22/2026 at 8:25 A.M. with Regional Registered Nurse #450 confirmed there was no documentation in the medical record regarding why Synthroid was not documented in Resident #17's MAR.This deficiency represents non-compliance investigated under Complaint Number 2603937.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and staff interview, the facility failed to ensure the resident's toothbrushes were stored in a manner to maintain infection control. This affected two (#11 and #37) of 26 residents observed for infection control. The facility census was 68.Findings include:Review of Resident #37's medical record revealed an admission date of 09/29/25. Diagnoses included dysarthria and anarthria, demyelinating disease of central nervous system, and muscle weakness.Review of the Activity of Daily Living care plan dated 08/17/25 revealed Resident #37 required assistance with oral hygiene.Review of Resident #11's medical record revealed an admission date of 05/04/21. Diagnoses included dementia, chronic respiratory failure and unilateral post-traumatic osteoarthritis of first carpometacarpal joint of the left hand.Review of the Activity of Daily Living care plan dated 08/17/25 revealed Resident #11 required assistance with oral hygiene.Review of the Minimum Data Set 3.0 (MDS) assessment dated [DATE] revealed Resident #11 was dependent on staff for oral hygiene.Observation on 04/21/26 at 1:40 P.M., of Resident #11 and #37's shared bathroom revealed a toothbrush resting on the bottom of the paper towel dispenser without a barrier. There were two of the same toothbrushes resting on the sink in between the faucet and wall with no barrier atop another different type of toothbrush and bottle of toothpaste.Interview on 04/21/2026 at 1:45 P.M, with Licensed Practical Nurse (LPN) #73 confirmed the toothbrushes were not stored to prevent potential contamination.This deficiency represents non-compliance investigated under Complaint Number 2974213.