STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366207	A. Building B. Wing	06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terrace Rehabilitation and Nursing Center	1520 Hawthorne Avenue Columbus, OH 43203

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42727 Based on medical record review, facility financial record review, staff interviews, and review of policy, the facility failed to ensure accurate accounting documentation was maintained to accurately reflect a residents' personal funds and ensure a resident received stimulus checks timely. This affected one (#8) of three residents reviewed for management of residents' personal funds. The facility managed 22 resident funds accounts. The census was 48. Findings include: Review of the closed medical record for Resident #8 revealed an admitted [DATE] and discharge date [DATE]. Diagnosis included chronic obstructive pulmonary disease (COPD), transient cerebral ischemic attack (TIA), unspecified open wound right thigh, and chronic venous hypertension with ulcer of right lower extremity. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of the form titled Resident's Personal Fund Management Service Quarterly Statement for period 01/01/21 through 03/31/21 revealed a balance of $1201.01 on 03/31/21. Review of document titled, Invoice Detail Form, invoice date 03/29/21, revealed date of service 03/29/21 for an invoice amount of $1600.00. Explanation revealed refund request for funds posted to private pay instead of resident funds. Check must be made out to the resident. Description revealed refund to resident from AR to deposit into resident funds account. Total amount was $1600.00. Review of document titled, Closed Transaction Report dated 04/27/21 revealed a posting date of 04/23/21. Document indicated petty cash account has been credited $1168.07. Review of check dated 04/27/21 in the amount of $1168.07 with a notation: Resident #8's closed account was paid to the order of Resident #8. Interview on 05/13/21 at 11:07 A.M., with the Administrator and Director of Nursing (DON), revealed Resident #8's funds on 01/01/21, beginning balance was $0.00. A $601.0 cash deposit on 01/21/21, social security check deposit of $600 on 02/05/21, and an ending balance of $1201.01 on 03/31/21. (continued on next page)

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
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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/13/21 at 11:15 A.M., via telephone, with Former Administrator #411, revealed funds pay out in thirty days of discharge. The facility had not set up a resident trust fund account correctly and it took corporate a couple of months to set up check signers. The facility submitted the request to the bank and had to wait on approval. Prior to January 2021, the Former Administrator #411 was not aware there were any issues. It was identified that the money was in the wrong petty cash operating account which required a petty cash card and a small cash box. In January 2021, the Former Administrator #411 moved the money to the right account. The stimulus checks were deposited there. The stimulus checks received went directly into the resident fund management service account interest bearing account and verified there were at least two since June. Former Administrator #411 was able to make deposits but was not able to write checks until March. Former Administrator #411 was not aware how far back it was in the wrong petty cash account when this Former Administrator moved it in 01/2021. Review of document titled, Resident Statement Landscape dated 05/27/21, revealed a detailed account of Resident #8's debits, credits and balances from 01/21/21 through 04/23/21, with a beginning balance of $601. 00 on 01/21/21 and an ending balance of $1168.07 on 04/23/21. There was a social security check deposit made of $600.00 on 02/05/21, a personal check deposit of $1600 on 04/19/21 and a care cost payment of $1633.00 on 04/23/21 in addition to interest paid accounting during this timeframe. No evidence of stimulus check deposit. Interview on 05/27/21 at 4:36 P.M., with the Administrator confirmed he was not able to locate a signature page for Resident #8's resident trust fund account (RTF) to authorize the facility to handle the residents RTF. Administrator confirmed he was not able to locate any accounting information for the petty cash accounting prior to rectification to the proper RTF account. Administrator reported they changed over to the new company in 03/2020 and could not speak to when it was identified that the concern with the accounts were identified. Acknowledged that the farthest the Resident Fund Management Service (RFMS) goes back was 01/2021 and has no information beyond that. Administrator reported the stimulus checks were deposited and are included in the RFMS statements. (continued on next page)

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled Management of Residents' Personal Funds, revised 04/2017, indicated management of the personal funds of residents who request the facility to do so. Policy interpretation and implementation listed 1. Resident funds may be managed by any of the following: a. The resident may manage his or her own personal funds, b. The resident may designate a representative to manage his or her personal funds, c. The resident may apply to the Social Security Administration to have a representative payee designated for purposes of federal and state benefits to which he or she may be entitled, or d. The resident may have the facility hold, safeguard, and manage his or her personal funds. 2. Should the resident elect to have the facility manage his or her personal funds, it must be authorized in writing by the resident or the resident's representative, and a copy of such authorization must be documented in the resident's medical record. 3. Should the facility manage the resident's funds, the facility will act as a fiduciary of the resident funds and hold, safeguard, manage and account for the personal funds of the resident. No service change will be levied against the resident for the management of personal funds. 4. Should our facility be appointed the resident's representative payee, and directly receive monthly benefits to which the resident is entitled, such funds will be managed in accordance with established policies outlined in this chapter that relate to financial management. 5. The resident will be informed in advance of any charges imposed to his or her personal funds. 6. A copy of all financial transactions will be filed in the resident's permanent records. 7. The resident may withdraw his or her request for the facility to manage his or her personal funds at any time by submitting a written notice to the Administrator. 8. Inquiries concerning the facility's management of resident funds should be referred to the Administrator or to the business office. This deficiency substantiates the allegation within Complaint Number OH00122118.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42727 Based on medical record review, facility financial record review, staff interviews, and review of policy, the facility failed to ensure timely transfer of funds when residents were discharged from the facility. This affected three (#8, #9 and #10) of four residents reviewed for timely transfer of funds when discharged from the facility. The facility managed 22 resident funds accounts. The census was 48. Findings include: 1. Review of the closed medical record for Resident #8 revealed an admitted [DATE] and discharge date [DATE]. Diagnosis included chronic obstructive pulmonary disease (COPD), transient cerebral ischemic attack (TIA), unspecified open wound right thigh, and chronic venous hypertension with ulcer of right lower extremity. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. Review of the form titled Resident's Personal Fund Management Service Quarterly Statement for period 01/01/21 through 03/31/21 revealed a balance of $1201.01 on 03/31/21. Review of check dated 04/27/21 in the amount of $1168.07 with a notation: Resident #8's closed account was paid to the order of Resident #8. Interview on 05/13/21 at 11:07 A.M., with the Administrator and Director of Nursing (DON), verified the resident was not issued a check until 04/27/21, three months after the resident had discharged from the facility. 2. Review of the closed medical record for Resident #9 revealed an admitted [DATE] and a discharge date [DATE]. Diagnosis included traumatic subdural hemorrhage with loss of consciousness, malignant neoplasm of prostate, chronic embolism and thrombosis of unspecified vein, seizures and history of transient ischemic attack. Review of quarterly MDS assessment dated [DATE] the resident was unable to complete the interview. Review of document titled, Resident Statement Landscape dated 05/27/21 revealed a closed account for Resident #9 on 04/02/21. Details included a look back from 01/21/21 through 04/02/21. Beginning balance was $149.91 on 01/21/21. The ending balance was $149.91. Review of document titled, Resident Fund Management Service Statement, revealed a quarterly statement from 01/21/21 through 03/31/21. A new account was opened on 01/21/21 with a cash deposit of $149.91. The ending balance was $149.91 on 03/31/21. Review of document titled, 'Withdrawal Record' dated 04/01/21 revealed a credit to the petty cash account for $149.91 signed by the Former Administrator #411 on 04/01/21. Review of document titled, 'Withdrawal Transaction Report' posting date 04/02/21 revealed $149.91 was credited to the petty cash account. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of check dated 04/14/21 for $149.91 was paid to the order of Resident #9 and indicated Resident #9 closing account. 3. Review of the closed medical record for Resident #10 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnosis included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, peripheral vascular disease, seizures and chronic kidney disease. Review of the quarterly MDS assessment dated [DATE] revealed the resident had impaired cognition. Review of document titled, Resident Fund Management Service Statement from 01/14/21 through 03/31/21 revealed a beginning balance of $0.46 on 01/14/21 and an ending balance of $0.46 on 03/31/21. Review of document titled, Withdrawal Transaction Report, posting date 04/02/21 revealed a petty cash account has been credited $0.46. Account total indicated $0.46. Review of document titled, Withdrawal Record, dated 04/01/21 was signed by Former Administrator #411 on 04/01/21 with a total amount of $0.46 credited to the petty cash account. Review of check dated 04/14/21 revealed $0.46 was paid to the order of Resident #10 for closing amount. Interview on 05/13/21 at 10:49 A.M., with Human Resources Director #403 revealed the facility did not have check signers at this facility and we cannot close out an account without a check signer. They would have to go through the Administrator to get their funds. Interview on 05/13/21 at 11:07 A.M, with the DON confirmed Former Administrator #411 was doing the quarterly statements and the residents who had discharged did not receive their money back in a timely manner. (continued on next page)

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Management of Residents' Personal Funds, revised 04/2017 revealed the facility had a policy in place related to management of personal funds. Policy indicated management of the personal funds of residents who request the facility to do so. Policy interpretation and implementation listed 1. Resident funds may be managed by any of the following: a. The resident may manage his or her own personal funds; b. The resident may designate a representative to manage his or her personal funds; c. The resident may apply to the Social Security Administration to have a representative payee designated for purposes of federal and state benefits to which he or she may be entitled; or d. The resident may have the facility hold, safeguard, and manage his or her personal funds. 2. Should the resident elect to have the facility manage his or her personal funds, it must be authorized in writing by the resident or the resident's representative, and a copy of such authorization must be documented in the resident's medical record. 3. Should the facility manage the resident's funds, the facility will act as a fiduciary of the resident funds and hold, safeguard, manage and account for the personal funds of the resident. No service change will be levied against the resident for the management of personal funds. 4. Should our facility be appointed the resident's representative payee, and directly receive monthly benefits to which the resident is entitled, such funds will be managed in accordance with established policies outlined in this chapter that relate to financial management. 5. The resident will be informed in advance of any charges imposed to his or her personal funds. 6. A copy of all financial transactions will be filed in the resident's permanent records. 7. The resident may withdraw his or her request for the facility to manage his or her personal funds at any time by submitting a written notice to the Administrator. 8. Inquiries concerning the facility's management of resident funds should be referred This deficiency substantiates the allegation within Complaint Number OH00122118.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 34742 Based on observations, medical record review, review of the policy for Wandering Unsafe Residents, review of the facility investigation and staff interviews, the facility failed to provide adequate supervision to prevent one cognitively impaired resident (Resident #14) from eloping from the facility. This resulted in Immediate Jeopardy and the potential for serious injury when Resident #14, who was assessed as a moderate risk for wandering behaviors and early dementia, left the facility unknown to staff, out an unalarmed unlocked back door and was found in a neighboring State (Indiana), 18 hours later the following day. This affected one (#14) of three (#14, #30, and #06) residents reviewed for potential elopement. The facility identified 19 residents who were at risk for elopement. The facility census was 48. On 05/26/21 at 1:41 P.M., the Administrator, Director of Nursing (DON), and [NAME] President (VP) of Clinical Services were notified Immediate Jeopardy began on 05/17/21 at 10:51 P.M., when Resident #14, who was assessed as a moderate risk for wandering behaviors and early dementia, left the facility unknown to staff and was found in another State. Review of the facility security cameras revealed the resident exited the building through the unalarmed unlocked back door on 05/17/21 at 10:51 P.M. The facility was unaware Resident #14 was missing until staff from the neighboring state local hospital called the facility on 05/18/21 at 4:56 P.M. and spoke to Social Worker (SW) #301. The hospital staff member inquired about a resident who used a name that was familiar to the SW #301. It was determined through a physical description the resident was Resident #14. The Resident had used her sister's name. The facility was unaware Resident #14 was missing for 18 hours, until the hospital notified the facility. The Immediate Jeopardy was removed on 05/19/21 at 2:15 P.M., when the facility implemented the following corrective actions: On 05/18/21 at 5:00 P.M., the Director of Nursing (DON) instructed all staff to complete a whole house head count and called all managers in the facility to assist with head count and began the investigation. On 05/18/21 at 5:45 P.M., the DON confirmed all residents were accounted for except Resident #14. On 05/18/21 at 6:00 P.M., the Administrator and disciplinary team reviewed the facility surveillance video. The video revealed the resident exited the back door on 05/17/21 at 10:51 P.M. At that time, an employee was placed at the unalarmed back door to watch for safety. On 05/18/21 at 6:08 P.M. the DON notified the Medical Director of Resident #14 missing. On 05/18/21 at 6:15 P.M., the resident's sister was contacted and informed of the resident's elopement. On 05/18/21 at 6:15 P.M., maintenance staff and or designee completed a check of all exterior doors. Maintenance staff also changed all keypad codes. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/18/21 at 6:15 P.M. and ending at 11:00 P.M., all facility staff including all disciplines were educated on the wandering policy, census policy, medication administrator and not leaving medication at bedside, tray passing and validation of residents every two hours, by the DON, Unit Manager and/or Human Resource Director. On 05/18/21 at 7:50 P.M., the back door was engaged and activated with a coded keypad handle lock. The activated code handle required a code to exit and enter the door. On 05/18/21 at 8:30 P.M., all residents were re-assessed for wandering/elopement risk and care plans updated as needed, this was completed by DON or designee. On 05/18/21 at 8:45 P.M., Quality Assurance Performance Improvement meeting was held with the Interdisciplinary Team to address the resident leaving the facility without staff knowledge. On 05/18/21 at 5:00 P.M. and on 05/19/21 at 2:15 P.M., Elopement Drills were completed. On 05/18/21, Regional Maintenance Director #289 conducted an elopement drill with all staff scheduled and management team on the premises. Review of the elopement drill documentation dated 05/18/21 at 5:00 P.M., revealed signatures of seven staff attending the drill and the drill was completed without problems. Review of the Elopement Drill dated 05/19/21 at 2:15 P.M., completed by the DON, revealed all staff, therapy, dietary and housekeeping staff that were present in the facility for the drill, participated without any problems. On 05/19/21 at 12:03 A.M., Resident #14 returned to the facility via a facility vehicle accompanied by staff members. A head to toe assessment was refused by the resident. On 05/19/21, an admission Wandering Risk Assessment was completed and revealed the resident was at a moderate risk for wandering. On 05/19/21 at 11:35 A.M., Resident #14 was transported to Riverside Methodist Hospital for psychiatric evaluation per physician order. Observation on 05/24/21 from 1:37 P.M. through 6:16 P.M., revealed a keypad code was required to exit the back doors without setting off the alarm. Residents were actively evacuated through the alarmed back door due to a heat emergency. Staff were present to code the alarm. Phone interviews on 05/26/21 from 5:33 P.M. through 5:37 P.M., revealed Licensed Practical Nurse (LPN) #220 and Registered Nurse (RN) #280 verified they received the in-Service education related to elopement policy, midnight census, charting and documentation, smoking, and nutritional services. Observation on 05/26/21 and 05/27/21, revealed no residents present in the facility. The facility evacuation with resident transfer was in effect related to heat. Interview on 05/27/21 at 8:34 A.M., with the DON revealed all employees had received the mandatory education except two, one dietary aide and one LPN. She stated voice messages were left that the mandatory in-service must be completed before return to work. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/27/21 at 8:41 A.M. With State tested Nurse Aide (STNA) #401 verified she received education related to Code doors, elopement, where to locate binder to identify residents at risk for elopement, smoking policy and monitoring, monitoring residents are present in the facility, and meal tray pick up protocols. Review of two additional medical records (#30 and #06) for elopement risk revealed no concerns. Review of the facility action plan revealed when residents return to the facility, all residents will be considered re-admission for new elopement assessments to be completed by DON or designee. Review of the facility action plan revealed when residents return to the facility, the DON and two Unit Managers will audit quarterly elopement assessments. Start every three-month quarterly assessment with re-admitted . DON and Unit Managers and Minimum Data Set (MDS) Nurse will complete assessments. Review of the facility action plan revealed when residents return to the facility, the DON will monitor exterior doors to make sure they are secure three times a week for four weeks. Review of the facility action plan revealed when residents return to the facility, Unit Managers and DON will complete tray audits three times a week for four weeks. Trays passed and picked up documentation. The purpose is to verify resident was present for meals. If resident did not consume food from tray pass, staff were to notify nursing. Review of the facility action plan revealed when residents return to the facility, the DON will complete audits three times a week for four weeks, cigarettes available for residents and supervised smoking. Review of the facility action plan revealed when residents return to the facility, the DON will audit daily headcount at 12:00 P.M. and 12:00 A.M. three times a week for four weeks. Although the Immediate Jeopardy was removed on 05/19/21, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy), as the facility was still in the process of implementing their corrective action plan and is unable to complete monitoring for ongoing compliance, due to there are no current resident in the facility. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), chronic kidney disease, hypertension, traumatic subdural hemorrhage without loss of consciousness sequela, paranoid schizophrenia, anxiety disorder, bipolar II disorder, pseudobulbar affect, unspecified dementia with behavioral disturbance, and encephalopathy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #14's wandering risk assessment dated [DATE] and 03/15/21, revealed the resident was at moderate risk for wandering. The resident was assessed as being independent with mobility, had early dementia and had forgetful/short attention span. Medications included antipsychotics, antidepressants, and narcotics. The resident was not identified as a known wanderer or history of wandering. Review of the plan of care dated 04/18/21 for wandering risk related to attempts to leave facility unattended revealed the resident was at elopement risk/wandering related to history of attempts to leave facility unattended. The resident's safety will be maintained through the review date. Interventions included: distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Identify pattern of wandering. Intervene as appropriate. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of the quarterly Minimum Data Set 3.0 (MDS) assessment dated [DATE], revealed the resident had impaired cognition and no wandering behaviors exhibited during the assessment. The resident required supervision with set up help only for bed mobility, transfer, walking in room and corridor, locomotion on and off unit, personal hygiene, eating, dressing and toilet use. Review of the nursing note dated 05/18/21 at 12:07 A.M., documented by Licensed Practical Nurse (LPN) #402, revealed the resident was resting quietly in bed at this time. No complaints of shortness of breath this tour. Breathing even and unlabored. Review of the facility investigation revealed the hospital in Indiana called the facility on 05/18/21 at 4:56 P.M. and spoke to Social Worker (SW) #301. The hospital stated they had a resident by the name of (Resident #14's sister's name). The facility stated that they did not have a resident by that name. However, SW #301 was familiar with the name, as a family member of Resident #14. SW #301 asked the hospital if the resident had a mole on her face and the hospital confirmed that she did. SW #301 then sent a face sheet to the hospital to identify the resident. The hospital confirmed that the resident they had was Resident #14 and was giving the hospital the name of her sister. The surveillance video was reviewed by management team and revealed Resident #14 exited the facility through the back door on 05/17/21 at 10:51 P.M. Review of the nursing note dated 05/18/21 at 6:06 P.M., revealed the physician was notified the resident was not in the facility. Resident #14 was at the hospital Emergency Department for psychiatric evaluation and the resident will be returning to facility tonight. Review of the nursing notes dated 05/19/21 at 3:32 A.M., revealed Resident #14 returned to facility from the hospital in Indiana per facility vehicle and two staff members around 12:10 A.M. Registered Nurse (RN) Supervisor #280 took the resident upstairs to second floor and took the resident out for a smoke. Resident #14 attempted to leave the facility while in the smoking area and was redirected by staff members. The nurse updated the DON of the resident's return from the Indiana hospital at approximately 12:34 A.M. The nurse left a call back message with the resident's sister at 1:39 A.M. RN Supervisor #280 left a call back message with the physician at approximately 1:30 A.M. Resident #14 was very hostile with staff and very uncooperative with staff and was on one-on-one supervision with STNA #403. Resident #14 refused to allow the nurse to complete a head to toe assessment for injuries and accused this nurse of sexual impropriety in front of RN Supervisor #280 and STNA #403. Resident #14 denied any pain at this time and was in her room with an STNA nearby. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a communication note dated 05/19/21 at 1:30 P.M., revealed SW #301 spoke with the resident about why she left and where she went. Resident #14 stated she was upset do to not having any smokes. Resident #14 stated she walked out the back door and just kept going. She went to the bus station where she bought some smokes and a bus ticket. Resident #14 stated she wanted to go to Indiana because she was born there. She went to Indiana and walked until she couldn't walk any more. She then hitch-hiked with a lady to the police station. The police took her to the hospital. Resident #14 stated no one hurt her and she doesn't understand why she had to come back. She wanted to get her birth records from the hospital and was never given them. Interview on 05/26/21 at 11:10 A.M., with the DON revealed Resident #14 was ambulatory and told SW #301, that another resident had stated, if you don't like it here, just leave. The DON revealed the resident did not like scheduled, supervised smoking. The DON further stated the day shift nurse on 05/18/21, had stated she passed the resident's 8:00 A.M. scheduled medications but had left them sitting at the bedside. The DON stated the Medication Administration Record (MAR) had documentation that the medications were administered, but then was changed to document not given as Resident #14 was not available. The DON stated when she had gone to Resident #14's room on 05/18/21 between 5:30 P.M. and 6:00 P.M., she noted the resident's 8:00 A.M. medications were sitting at the bedside. Interview on 05/26/21 at 4:06 P.M., with the DON revealed she immediately assigned staff for one-on-one at the back door, beginning on 05/18/21 at 6:00 P.M., when the facility learned Resident #14 was off the premises, through 05/19/21 at 11:05 A.M. Interview on 05/27/21 at 2:15 P.M. with the DON and Human Resources Director (HR) #403 verified the back door opened to the parking lot. They stated the back door had never been used as a main entrance for staff, visitors, or residents. They stated it was a service door for trash take out and deliveries. They further stated the door had never had an inside lock or alarm to restrict exits from the building. Observation on 05/27/21 from 8:30 A.M. through 4:00 P.M., revealed the facility had two elevators. One elevator was near the front of the building (not in use) and currently under contract for repair. The second elevator was toward the back of the facility and opened in a hallway adjacent to the back door. Residents, without a wander guard, had free access to the elevator from the second and third floor. The back door was 17 steps from the back-elevator first floor landing. Interview on 06/01/21 at 9:06 A.M., with LPN #283 verified the residents only use the back elevator and the unlocked, unalarmed back door was 17 steps from the elevator. Interviews on 06/01/21 from 9:06 A.M. through 9:27 A.M., revealed LPNs #281 and #283 stated they had not seen Resident #14 exit seek, nor speak of leaving the facility. LPN #281 stated she was not aware Resident #14 was an elopement risk, the resident moved about the facility freely, and was independent with ambulation and care needs. Interview on 06/01/21 at 1:55 P.M., verified the nursing note dated 05/18/21 at 12:07 A.M., documented by LPN #402, was documented while the resident was not even in the facility and was false documentation. (continued on next page)

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	366207	A. Building B. Wing	06/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terrace Rehabilitation and Nursing Center	1520 Hawthorne Avenue Columbus, OH 43203

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy titled, Wandering, Unsafe Resident, revised date 10/13/20, indicated the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement or other risk due to judgement or cognition. This deficiency substantiates allegations in Complaint Numbers OH00122572, OH00122662, OH00122721 and OH00122885.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34742 Based on medical record review, facility investigation review, policy review for medication administration, and staff interview, the facility failed to administer resident medications per physician orders and facility policy. This affected one (#14) of four residents reviewed for medication administration. The facility census was 48. Findings include: Review of Resident #14's medical record revealed admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease, hypertension, traumatic subdural hemorrhage without loss of consciousness sequela, paranoid schizophrenia, anxiety disorder, bipolar II disorder, pseudobulbar affect, unspecified dementia with behavioral disturbance, and encephalopathy. Review of Resident #14's MAR for May 2021 revealed on 05/18/21 orders for 8:00 A.M., for the administration of amlodipine Besylate tablet 5 milligram (mg) one time daily by mouth, lisinopril 40 mg tablet one time daily by mouth, multivitamin adults tablet one time daily by mouth, Oystercal 500 mg tablet one time daily by mouth, potassium chloride extended release (ER) 10 milliequivalent (MEQ) tablet one time daily by mouth, carvedilol 3.125 mg tablet two times daily by mouth, guaifenesin ER 1200 mg two times daily by mouth, Namenda 10 mg tablet two times daily by mouth, and Vistaril capsule 25 mg two times daily by mouth. LPN # 282 documented listed medications as not given, absent from home without meds. Review of the DON's signed statement dated 05/18/21 revealed she checked Resident #14 room and observed medications on her bedside table. The medications were from 8:00 A.M., verified by the day shift nurse and the Medication Administration Record (MAR). The DON's statement further revealed medications were signed off in the MAR and verified by the dayshift nurse. Medications were then properly discarded. The nurse then went back and signed off that the medications were not given. Review of the facility investigation report dated 05/19/21 revealed Resident #14 left the facility through the back door on 05/17/21 at 10:51 P.M. The facility was unaware Resident #14 was missing until staff from [NAME] Health Hospital called the facility on 05/18/21 at 4:56 P.M. and spoke to the Social Worker (SW) #301. Interview on 05/26/21 at 11:10 A.M., with the Director of Nursing (DON) revealed the day shift nurse on 05/18/21, had stated she passed the resident's 8:00 A.M. scheduled medications and left them sitting bedside. The DON stated the Medication Administration Record (MAR) had documentation that the medications were administered, but then was changed to document not given as resident was not available. The DON stated she went to Resident #14 room on 05/18/21 between 5:30 P.M. and 6:00 P.M., and noted the resident's medications were sitting at bedside. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Administering Medications, revised date December 2112, stated medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one hour of their prescribed time, unless otherwise specified. The individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: checking identification band; checking photograph attached to medical record; and if necessary, verifying resident identification with other facility personnel. The facility did not follow it's policy. This deficiency substantiates the allegations in Complaint Number OH00122005.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42727 Based on observation, review of tray audits, staff interviews, and review of facility policies, the facility failed to serve food at appropriate temperatures and dispose of expired food items. This had the potential to affect 48 of 48 residents who received meals from the kitchen. The facility census was 48. Findings include: Observation on [DATE] at 11:43 A.M. of meal temperatures on the tray line for lunch service revealed pureed pork chop 154 degrees Fahrenheit, pureed lima beans 129 degrees Fahrenheit and mechanical soft pork chop 147.1 degrees Fahrenheit. Cook #285 performed and confirmed the temperatures for the tray line items. Interview with Cook #285, at the time of the observation reported the temperature for these items should be 165 degrees Fahrenheit on the tray line and 135 degrees Fahrenheit by the time it gets to the resident. The items were returned to the steamer. Cook #285 reported he did not take the temperature of the lima beans before pureeing them. Observations on [DATE] from 11:43 A.M. through 12:35 P.M., of tray line for the lunch meal revealed there were not enough dome lids to service all meal trays and pellet bottoms were utilized. A steam table, insulated dome lids, pellet bottoms, coffee carafes and metal steam carts were utilized for the meal service. There were not enough dome lids to service all meal trays and pellet bottoms were utilized as lids. Inspection of the kitchen revealed two outdated items in the walk-in refrigerator without use by dates with no original packaging. Items were corned beef with a prepared date of [DATE] and a couple ham slices with a prepared date [DATE], both covered in plastic wrap. A large sign was posted on the outside of the walk-in refrigerator, Refrigerated, ready to eat, time/temperature controlled for safety (TCS) foods that are held for longer than 24 hours must be clearly marked with a use by date that is within 7 days of the date opened or prepared. The day that you prepare the food is day 1. Interview on [DATE] at 12:33 P.M., with Dietary Manger #170 verified the outdated food items and discarded the items. The Dietary Manager #170 revealed currently using pellet bottoms of the dome/insulated lids due to not enough dome lids to cover the entrees. Plans to order more soup bowls, cereal bowls, plates, and dome lids. Dietary Manager #170 had given the previous Administrator a list on Monday to let her know the items needed and had not heard back anything yet. Observations on [DATE] between 12:35 P.M. and 1:02 P.M., of the lunch meal hall pass revealed the last cart exited the kitchen at 12:35 P.M., arrived on the hall at 12:37 P.M., staff started to pass the last cart at 12:38 P.M. on the 300 Hall. The last tray was delivered at 12:54 P.M. All trays were within the steam cart with the exception for the test tray which was on the top of the steam cart without an insulating dome lid and pellet base. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a sample dietary tray located on the 300 Hall food cart, on [DATE] at 12:55 P.M., revealed after all room trays were served, the sample tray was tested . The lunch meal was visually appealing; however, it was not served at the appropriate temperature. Dietary Manager #170 was asked during tray pass if the test tray should be placed inside of the steam cart and no changes were made. Temperatures were performed and verified by the Dietary Manager for the test tray on the unit. Test tray items were taken back down to the kitchen due to the temperature of the pureed pork was 117.7 degrees Fahrenheit and the pureed lima beans were 105.1 degrees Fahrenheit. Interview with the Dietary Manager #170, at the time of the test tray sample, revealed if this were a resident's tray, she would bring up a new tray. The Dietary Manager #170 verified the temperatures were not the proper serving temperatures. Observations on [DATE] at 1:02 P.M., revealed the steam table had been turned off and had a small amount of pureed pork, 98 degrees Fahrenheit, and lima beans, 84.7 degrees Fahrenheit, remaining on the steam table. The pureed pork and pureed lima beans were placed in the microwave to reheat with the pureed pork at 170.4 degrees Fahrenheit and the pureed lima beans at 174.5 degrees Fahrenheit. Taste test revealed the lunch meal to be palatable after reheating. Interview with the Dietary Manager #170, at the time of the observation, verified the temperatures were not the proper holding temperatures and the food needed to be reheated. Review of policy titled, Resident Nutrition Services, dated ,d+[DATE] revealed each resident shall receive meals, with preferences accommodated, prompt meal service and appropriate feeding assistance. The policy further dictated if an incorrect meal has been delivered, nursing staff will report it to the Food Service Manager so that a new food tray can be issued. To minimize the risk of foodborne illness, the time that potentially hazardous foods remain in the danger zone (41 degrees Fahrenheit to 135 degrees Fahrenheit) will be kept to a minimum. Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than two hours will be discarded. Review of policy titled, Food Receiving and Storage, dated ,d+[DATE] revealed foods shall be received and stored in a manner that complies with safe food handling practices. This deficiency substantiates the allegations contianed in Complaint Numbers OH00122005 and OH00122660.

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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 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** 34742 Based on medical record review, facility investigation review, policy review for charting and documentation, and staff interview, the facility failed to ensure accurate assessment of a resident was documented in the medical record. This affected one (#14) of four residents reviewed for accurate documentation. The facility census was 48. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE]. Diagnoses for Resident #14 included: chronic obstructive pulmonary disease (COPD), chronic kidney disease, hypertension, traumatic subdural hemorrhage without loss of consciousness sequela, paranoid schizophrenia, anxiety disorder, bipolar II disorder, pseudobulbar affect, unspecified dementia with behavioral disturbance, and encephalopathy. Review of the resident's wandering risk assessment dated [DATE] and 03/15/21, revealed the resident was at moderate risk for wandering. The resident was assessed as being independent with mobility, had early dementia and had forgetful/short attention span. Medications included antipsychotics, antidepressants, and narcotics. The resident was not identified as a known wanderer or history of wandering. Review of the plan of care dated 04/18/21, for smoking revealed the resident was not interested in smoking cessation. Interventions included: provide with education related to smoking cessation, the resident will smoke in designated area, and will smoke with supervision per facility policy. The care plan for wandering risk related to attempts to leave facility unattended, dated 04/18/21, revealed the resident was at elopement risk/wandering related to history of attempts to leave facility unattended. The resident's safety will be maintained through the review date. Interventions included: distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Identify pattern of wandering. Intervene as appropriate. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had impaired cognition and no wandering behaviors exhibited during the assessment. The resident required supervision with set up help only for bed mobility, transfer, walking in room and corridor, locomotion on and off unit, personal hygiene, eating, dressing and toilet use. Review of the nursing note dated 05/18/21 at 12:07 A.M., documented by Licensed Practical Nurse (LPN) #402, revealed the resident was resting quietly in bed at this time. No complaints of shortness of breath this tour. Breathing even and unlabored. Review of the facility investigation report dated 05/19/21 revealed Resident #14 left the facility through the back door on 05/17/21 at 10:51 P.M. The facility was unaware Resident #14 was missing until staff from [NAME] Health Hospital called the facility on 05/18/21 at 4:56 P.M. and spoke to the Social Worker (SW) #301. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing notes dated 05/19/21 at 3:32 A.M., revealed Resident #14 returned to facility from [NAME] Health Hospital in Indiana per facility vehicle and two staff members around 12:10 A.M. Interview on 06/01/21 at 1:55 P.M., verified the nursing note dated 05/18/21 at 12:07 A.M., documented by LPN #402, was documented while the resident was not even in the facility and was false documentation. Review of the policy titled, Charting and Documentation, revised date April 2008, stated documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a.) the date and time the procedure/treatment was provided; b.) the name and title of the individuals who provided the care; c.) the assessment data and/or any unusual findings obtained during the procedure/treatment. This deficiency substantiates the allegations contained in Complaint Number OH00122572.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34742 Based on maintenance records review, invoice and quote repairs review, review of the facility policy for maintenance service, observation, and staff interviews, the facility failed to maintain the air conditioning system in a safe working condition to provide a safe and comfortable environment for the residents. This affected 48 of 48 residents in the facility. The facility census was 48. Findings include: Review of the Work Order from [NAME] Heating Cooling Ref. Inc. dated 05/05/21, revealed job details, the cooling tower has a broken coil, need to confirm the diagnosis and gather information to quote repairs. Found the one of the tubes which had been repaired before has broken off where the repair was before. Inspected the other tubes and recommend that the coil be replaced due to condition. Took pictures, informed maintenance man and cleaned up the area. Review of the repair quote from JW Services, LLC dated 05/06/21, for cooling tower repair revealed close up obvious leak on the tower heat exchange coil. Pressurize the coil to be sure the repair is watertight. Fill the tower sump and check for leaks. This quote is for limited scope of work to get the tower operational for the summer. A replacement tower is months out and the tower alone is over $105,000.00 with a shipping weight of over two tons. If there were additional leaks, they would have to be assessed and priced individually. Should the tower repair be completed and the sump water tight, assisting in filling the building to restart the heat pumps would be billed time and materials. Review of invoice from JW Services LLC. dated 05/11/21 revealed, accessed unit and cut out broken section of tube. Repaired by inserting a copper tube and sealing with couplers. The valve was shut off from the boiler and let building loop water enter the tower. Multiple unknown leaks appeared in random areas of the heat exchanger tubes. All unreachable without cutting out a massive amount of tubes to access. Review of repair quote from All Hours Mechanical dated 05/25/21 revealed description of work on 05/20/21 cooling tower down. Would like repair versus replacement options. After looking at piping to cooling tower to figure out what valves to open. One of the pipes on the supply going into the tower had frozen. Had to go get materials to replace the section. Will return tomorrow to continue checking out tower after glue has dried. On 05/21/21, found additional cracks and was seeping. After leaving for additional supplies and returned to the building, loop had lost pressure. Shut system down and pulled suction strainer. Went out to tower and shut fan and spray pump down. It was leaking worse inside of tower out of coil pack. In conclusion building loop water could not keep up pressure because leaking inside of tower. Observation on 05/24/21 at 11:37 A.M., revealed the facility in the process of evacuating residents due to the air conditioning system had quit working. Interview on 05/24/21 at 11:37 A.M., the Director of Nursing (DON) stated the facility had placed portable air conditioners in resident rooms, closed the third floor today and moved residents to the second floor. She verified the facility was evacuating residents because the air conditioning was not working. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 05/24/21 at 12:40 P.M. the DON stated she arrived at the facility at 7:00 A.M. and immediately called corporate for an evacuation of residents because the air conditioning was not working and the temperatures were rising. Interview on 05/24/21 at 1:27 P.M. Regional Maintenance Director #289 stated the air was not out when repairs first began. He stated JW Services, LLC had been called for service on 05/06/21 when the previous Maintenance Director started to switch the heat system to the chiller system. The Regional Maintenance Director #289 stated he was unable to address the cause for the initial repair call. The cooling system was shut down on 05/21/21 when All Hours Mechanical was unable to maintain pressure for the coils. The Regional Maintenance Director #289 stated on 05/18/21, he rented 14 large portable air conditioning units from Sunbelt Rentals and installed in the hallways. He stated he purchased 31 portable units from three Lowe's on 05/22/21 and installed them in the rooms on the second floor. He stated the facility already had some portable units in storage. He stated on 05/23/21, he purchased ten box fans to place in front of the large hall units to circulate air. Review of the policy titled, Maintenance Service, revised date December 2009, indicated the Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The facility did not follow it's policy. This deficiency substantiates the allegations in Complaint Numbers OH00122010, OH00122660, OH00122661, and OH00122885.