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	04/07/2022

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 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** 43060 Based on record review, facility policy and procedure review and interview the facility failed to ensure physician orders were obtained and/or implemented for wound/skin care for Resident #75 and Resident #60. This affected two residents (#75 and #60) of three sampled residents reviewed for dressing changes and wound care. Findings include: 1. Review of the closed medical record for Resident #75 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #75 had diagnoses including necrotizing fasciitis, diabetes mellitus type two, obesity, chronic obstructive pulmonary disease, obstructive sleep apnea and congestive heart failure. Review of the nursing admission assessment, dated 03/25/22 revealed Resident #75 had a surgical site; wound on the left lower quadrant of her abdomen, approximately 15 inches long by 12 inches wide by 12 inches deep, which had a wound vacuum (vac) in place (the wound vac is for vacuum assisted closure of a wound). The assessment revealed the resident also had a crescent shape opening on her back, two centimeters (cm) wide by three cm long. Review of the physician's orders for Resident #75 dated March 2022 revealed no orders for the wound vac or for any wound care/dressing changes for any wounds. Review of the Treatment Administration Record (TAR) for Resident #75 for March 2022 revealed no instruction for or evidence of wound care being completed for the resident. Review of the physician's progress note, dated 03/28/22 revealed Nurse Practitioner (NP) #302 saw Resident #75 and ordered a wound consult from the in facility specialist. Review of the Resident #75's plan of care, dated 03/29/22 revealed the only plan of care was for nutrition. Wounds and dressing changes were not identified/included in Resident #75's plan of care. Review of the wound care provider note, dated 03/30/22, revealed they attempted to see Resident #75 on this date but the resident had already discharged from the facility. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/31/22 at 11:19 A.M. interview with Licensed Practical Nurse #124 revealed Resident #75 was admitted from a hospital with a wound vac to the wound on her abdomen and left labia. LPN #124 revealed, per the hospital orders, the wound vac was to be applied to Resident #75's abdomen and the wound to her labia was to be packed. LPN #124 revealed she cared for the Resident #75's wounds from 03/25/22 through 03/28/22. On 04/05/22 at 12:30 P.M. interview with the Director of Nursing (DON) confirmed there were no facility orders in place for the care of Resident #75's wound or for a wound vac during the resident's stay in the facility. The DON further confirmed the TAR was silent for any wound care and treatment. The DON revealed the hospital Resident #75 was admitted from did not send orders but stated the facility continued to provide the treatments the hospital was providing until the wound specialist could see Resident #75 at the facility. 2. Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses including osteomyelitis of vertebra, spinal stenosis, encounter for surgical aftercare and chronic pain. Review of the physician's orders, dated 03/02/22, revealed an order for nursing staff to cleanse the back wound with normal saline, apply calcium alginate to the open area and cover with a dry dressing every night shift. Review of the TAR for March 2022 revealed no evidence this physician ordered treatment was completed on 03/02/22, 03/07/22, 03/08/22, 03/10/22, 03/11/22 or 03/29/22. Review of the plan of care, dated 03/16/22, revealed Resident #60 had an infection of the vertebra. Interventions included to administer intravenous (IV) antibiotics per physician orders. The plan of care was silent for the wound to Resident #60's back. On 03/31/22 at 11:19 A.M., interview with LPN #124 revealed there was not always time to get the physician ordered dressing changes completed and indicated this was likely why the treatment was not provided as ordered for Resident #60 on the dates noted above. Review of the facility policy titled, Dressing, Sterile, revised 09/2013, revealed staff should verify the physician's order for the dressing change and document the treatment in the medical record. This deficiency substantiates Complaint Number OH00131399 and Complaint Number OH00131189. This deficiency is also an example of continued non-compliance from the survey dated 03/16/22.

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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 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43060 Based on record review, facility policy and procedure review and interview the facility failed to develop and implement a comprehensive and individualized behavioral health program, including the administration of the psychoactive medication, Clozapine for Resident #16, who had mental health diagnoses, to ensure the resident maintained his highest practicable physical, mental, emotional and psychosocial well-being. Actual Harm occurred on 02/11/22 when Resident #16, who had not received his scheduled Clozapine for multiple days was transferred and admitted to the hospital for increased agitation and self harm (banging head). The resident was hospitalized for five days. This affected one resident (#16) of two residents sampled for behavior health medications. The facility identified two residents who had a physician order for the medication, Clozapine. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE]. Resident #16 had diagnoses including diabetes mellitus, major depressive disorder, heart failure, anxiety and schizoaffective disorder. Review of the physician's orders, dated 01/08/22 revealed an order for Clozapine 325 milligrams (mg) once per day for schizoaffective disorder. (The order was written for one 100 mg tablet, one 200 mg tablet and one 25 mg tablet to total the 325 mg ordered dose). Review of the plan of care, dated 01/08/22 revealed Resident #16 used psychotropic medications related to schizoaffective disorder. The goal was for the resident to have improved mood state. Interventions include to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness. Review of the Medication Administration Record (MAR) for Resident #16 for January 2022 revealed Clozapine 200 mg was marked as unavailable on 01/13/22, 01/20/22 and 01/29/22. Clozapine 25 mg was marked unavailable on 01/3/22 through 01/18/22, 01/20/22 through 01/23/22 and 01/29/22. Clozapine 100 mg was marked unavailable on 01/13/22, 01/14/22, 01/17/22, 01/18,22, 01/20/22 through 01/22/22 and 01/29/22. Review of the MAR for February 2022 revealed Clozapine 200 mg was marked as unavailable on 02/04/21, 02/05/22, 02/06/22 and 02/07/22, administered on 02/08/22, marked unavailable on 02/09/22. Clozapine 100 mg was marked unavailable on 02/04/22 through 02/10/22, marked administered on 02/08/22. Review of the facility documentation revealed Resident #16 was hospitalized from 02/11/22 through 02/15/22. (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 0740 Level of Harm - Actual harm Residents Affected - Few	Review of the local hospital emergency notes revealed Resident #16 was admitted for agitation, banging head and threatening facility staff. The notes further revealed reported medication non-compliance. Review of the MAR for March 2022 revealed Clozapine 100 mg was marked unavailable from 03/01/22 through 03/07/22 and on 03/10/22. Clozapine 50 mg was marked unavailable from 03/01/22 through 03/03/22 and 03/05/22 through 03/06/22. On 03/31/22 at 11:19 A.M. interview with Licensed Practical Nurse (LPN) #124 revealed sometimes medications did not get delivered from the pharmacy timely and residents had to wait two to three days before the medication could be administered. On 04/04/22 at 12:06 P.M. interview with Resident #16 revealed some confusion and memory impairment by the resident during the interview. However, Resident #16 did confirm the facility did not always have his medications in the past. The resident could not remember how long he had been on the Clozapine medication and reported he had increased anxiety, without the medication. On 04/04/22 at 1:55 P.M. interview with the Director of Nursing (DON) confirmed the MAR for Resident #16 revealed the Clozapine medication was administered inconsistently and this could have contributed to increased psychiatric symptoms exhibited by the resident. The DON further confirmed the Clozapine was not administered as ordered for the seven days leading up to Resident #16's psychiatric hospitalization in February 2022. In addition, review of the nursing progress notes revealed no evidence of comprehensive behavior monitoring, no notes related to the resident being transferred to the hospital or behaviors being exhibited leading to the hospitalization and no documentation related to the medication not being available, why it was not available or what staff did to attempt to obtain the medication. Review of facility policy titled Medication Administration, revised 12/2012 revealed medications should be administered in accordance with physician's orders. This deficiency substantiates Complaint Number OH00131399.

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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** 43060 Based on closed record review, facility policy and procedure review and interview the facility failed to provide routine medications to Resident #75 as ordered. The facility failed to provide pharmaceutical services (including procedures to assure the accurate and timely acquiring, receiving, dispensing and administering of all drugs/medications) to meet the needs of each resident and to ensure physician ordered medications were available timely for administration to Resident #75. This affected one resident (#75) of three residents reviewed for medication availability. Findings include: Review of the closed medical record for Resident #75 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #75 had diagnoses including necrotizing fasciitis, diabetes mellitus type two, chronic obstructive pulmonary disease, obstructive sleep apnea and congestive heart failure. Review of the comprehensive plan of care revealed the only plan of care for Resident #75 was for nutrition. Medications were not included or identified in the plan of care for Resident #75. Review of the physician's orders, dated 03/25/22 revealed orders for Hydromorphone 2 milligrams (mg) twice daily as needed for pain. Physician's orders, dated 03/26/22 at 6:00 A.M. included an order for Atorvastatin (for high cholesterol) 60 mg in the morning, Diltiazem (medication for high blood pressure/chest paint), extended release 240 mg in the morning, Ferrous sulfate (iron supplement) 325 mg in the morning, Oxybutynin chloride (for overactive bladder) 10 mg in the morning, Spironolactone (treatment for high blood pressure and/or fluid retention) 50 mg every night and Torsemide (used to treat fluid retention) 40 mg daily. Review of the medication administration record (MAR) for March 2022 revealed the Atorvastatin, Diltiazem, extended release, Ferrous sulfate, Oxybutynin Chloride, Spironolactone and Torsemide were all unavailable for administration to Resident #75 as ordered by the physician until 03/27/22, two days after admission. Review of Resident #75's nursing progress note on 03/26/22 at 6:08 A.M. revealed nursing staff were awaiting medications from pharmacy. Review of the March 2022 MAR revealed Resident #75 was administered two doses of pain medication, Hydromorphone, on 03/28/22. However, the nursing progress noted 03/29/22 revealed Resident #75 requested pain medication but the pain medication was documented as unavailable on this date. On 04/05/22 at 12:20 P.M. interview with the Director of Nursing (DON) confirmed the medications for Resident #75 ordered on 03/26/22 were marked as unavailable for administration by the nursing staff. The medications were not available and administered until 03/27/22. Review of the facility policy titled Administering Medications, revised 12/2012, revealed medications must be administered per the physician's orders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency substantiates Complaint Number OH00131399.

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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 - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43060 Based on record review, facility policy and procedure review and interview the facility failed to ensure Resident #16 was free from a significant medication error when the resident was not administered the psychoactive medication, Clozapine to treat his diagnosis of schizoaffective disorder as ordered by the physician. Actual Harm occurred on 02/11/22 when Resident #16, who had not received his scheduled Clozapine for multiple days was transferred and admitted to the hospital for increased agitation and self harm (banging head). The resident was hospitalized for five days. This affected one resident (#16) of two residents sampled for behavior health medications. The facility identified two residents who had a physician order for the medication, Clozapine. Findings include: Review of the medical record for Resident #16 revealed an admitted [DATE]. Resident #16 had diagnoses including diabetes mellitus, major depressive disorder, heart failure, anxiety and schizoaffective disorder. Review of the physician's orders, dated 01/08/22 revealed an order for Clozapine 325 milligrams (mg) once per day for schizoaffective disorder. (The order was written for one 100 mg tablet, one 200 mg tablet and one 25 mg tablet to total the 325 mg ordered dose). Review of the plan of care, dated 01/08/22 revealed Resident #16 used psychotropic medications related to schizoaffective disorder. The goal was for the resident to have improved mood state. Interventions include to administer psychotropic medications as ordered by the physician and monitor for side effects and effectiveness. Review of the Medication Administration Record (MAR) for Resident #16 for January 2022 revealed Clozapine 200 mg was marked as unavailable on 01/13/22, 01/20/22 and 01/29/22. Clozapine 25 mg was marked unavailable on 01/3/22 through 01/18/22, 01/20/22 through 01/23/22 and 01/29/22. Clozapine 100 mg was marked unavailable on 01/13/22, 01/14/22, 01/17/22, 01/18,22, 01/20/22 through 01/22/22 and 01/29/22. Review of the MAR for February 2022 revealed Clozapine 200 mg was marked as unavailable on 02/04/21, 02/05/22, 02/06/22 and 02/07/22, administered on 02/08/22, marked unavailable on 02/09/22. Clozapine 100 mg was marked unavailable on 02/04/22 through 02/10/22, marked administered on 02/08/22. Review of the facility documentation revealed Resident #16 was hospitalized from 02/11/22 through 02/15/22. Review of the local hospital emergency notes revealed Resident #16 was admitted for agitation, banging head and threatening facility staff. The notes further revealed reported medication non-compliance. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the MAR for March 2022 revealed Clozapine 100 mg was marked unavailable from 03/01/22 through 03/07/22 and on 03/10/22. Clozapine 50 mg was marked unavailable from 03/01/22 through 03/03/22 and 03/05/22 through 03/06/22. On 03/31/22 at 11:19 A.M. interview with Licensed Practical Nurse (LPN) #124 revealed sometimes medications did not get delivered from the pharmacy timely and residents had to wait two to three days before the medication could be administered. On 04/04/22 at 12:06 P.M. interview with Resident #16 revealed some confusion and memory impairment by the resident during the interview. However, Resident #16 did confirm the facility did not always have his medications in the past. The resident could not remember how long he had been on the Clozapine medication and reported he had increased anxiety, without the medication. On 04/04/22 at 1:55 P.M. interview with the Director of Nursing (DON) confirmed the MAR for Resident #16 revealed the Clozapine medication was administered inconsistently and this could have contributed to increased psychiatric symptoms exhibited by the resident. The DON further confirmed the Clozapine was not administered as ordered for the seven days leading up to Resident #16's psychiatric hospitalization in February 2022. In addition, review of the nursing progress notes revealed no evidence of comprehensive behavior monitoring, no notes related to the resident being transferred to the hospital or behaviors being exhibited leading to the hospitalization and no documentation related to the medication not being available, why it was not available or what staff did to attempt to obtain the medication. Review of facility policy titled Medication Administration, revised 12/2012 revealed medications should be administered in accordance with physician's orders. This deficiency substantiates Complaint Number OH00131399.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43060 Based on observation, record review and interview the facility failed to ensure menus and alternate menus were properly posted and available for residents on all four units of the facility. This affected four residents (#32, #37, #39 and #41) and had the potential to affect all 72 residents residing in the facility receiving meals/food from the kitchen. Findings include: On 04/05/22 at 11:50 A.M., observation of the lunch meal revealed Resident #39, #41, #32 and #37, who resided on the 2 Blue unit were receiving meal trays. The meal served was chicken, pasta, gravy, bread roll and green beans for all four residents. Resident #39 was observed to ask the State tested Nursing Assistant (STNA) for butter for her roll at 11:54 A.M. Resident #41's meal was observed and consisted of chicken, pasta, gravy, bread roll and green beans. However, review of Resident #41's meal ticket revealed the meal should have included a peanut butter and jelly sandwich. On 04/05/22 at 12:05 P.M., interviews with Resident #39, #41, #32 and #37 revealed none of the resident's knew what was being served for lunch on this date or on any date. Each resident reported there was no menu posted on the unit or delivered to their rooms. They all indicated they were not aware they had an option to request an alternate menu item. On 04/05/22 at 12:11 P.M. interview with Resident #39 revealed she had not received any butter for her bread roll and she had eaten 50 percent of the roll. On 04/05/22 at 12:11 P.M. observation and interview with the Administrator confirmed no menu or alternate menu options were posted on the 2 Blue or 3 Blue secured units. Observation with the Administrator at 12:15 P.M. revealed the menu posted on the 3 Yellow Unit was dated 03/02/22. The Administrator confirmed the menu posted on the 3 Yellow Unit was incorrect and the posted menu items did not match what was being served for lunch today. On 04/05/22 at 12:22 P.M. interview with Dietary Supervisor #129 confirmed the meal ticket for Resident #41 and verified he should have received a peanut butter and jelly sandwich in addition to his lunch, but it was not served. Dietary Supervisor #129 confirmed he had not posted any menus or alternate menus on the 2 Blue or 3 Blue secured units and he had not updated the posted menus on the 2 Red or 3 Yellow units. This deficiency substantiates Complaint Number OH00131399.