

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2023
NAME OF PROVIDER OR SUPPLIER Bella Terrace Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266</p> <p>Based on medical record review, resident and staff interviews, review of hospital records, and review of facility policy, the facility failed to ensure Resident #68 was properly secured in her wheelchair in the facility's transport van to prevent a fall and failed to contact Emergency Medical Services (EMS) timely upon request from the resident's representative following the incident.</p> <p>Actual Harm occurred on 05/03/23 when Resident #68's wheelchair tipped backwards during transport and the resident hit her head on the transport van's floor. Resident #68's husband (Resident #67) called 911 to have Resident #68 transported to the hospital for an evaluation where the resident was diagnosed with a three millimeter (mm) subdural hemorrhage (brain bleed between the brain and skull), a small right parietal subgaleal hematoma (bleeding between the skull and scalp), and remote right rib fractures. Resident #68 was admitted to the hospital for three days for treatment and monitoring before being discharged back to the facility. This affected one resident (#68) of three residents reviewed for accidents during transportation.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #68 revealed an admitted [DATE]. Medical diagnoses included chronic obstructive pulmonary disease (COPD), Type II Diabetes Mellitus, cirrhosis of liver with ascites, congestive heart failure (CHF), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and peripheral vascular disease (PVD).</p> <p>Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #68 had intact cognition and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. Resident #68 required limited assistance from one staff member to complete Activities of Daily Living (ADLs). Further review revealed the resident utilized a wheelchair.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/03/23 at 10:52 A.M., an Interdisciplinary Team (IDT) note revealed Resident #68 was being transferred from an appointment back to the facility. While being transported, as the van picked up speed, Resident #68's wheelchair tipped backwards. Resident #68 stated she hit her head and left shoulder when she fell. The driver and the resident's husband assisted Resident #68 back up and the driver brought the resident back to the facility to be examined by the nurse. Neurochecks were started and Resident #68 complained of pain rated an eight on a scale of one to 10. The resident was offered medication for pain. X-rays were ordered but were not completed due to Resident #68 agreeing to be sent to the hospital. Interventions included Resident #68 was helped back into her wheelchair, the straps in the wheelchair were assessed, and the driver was educated.</p> <p>On 05/03/23 at 12:58 P.M., Resident #68 reported while being transported in the facility's van, her wheelchair tipped over and she hit her head and left shoulder. Vital signs were obtained and within normal limits. No injuries were noted. Pain was reported at an eight out of ten with ten being the worst pain level. Medications were administered to treat the resident's pain. The Certified Nurse Practitioner (CNP) was notified who stated to continue to monitor.</p> <p>On 05/03/23 at 1:57 P.M., a change of condition note revealed Resident #68's vitals documented were dated 04/24/23, except for the resident's weight and blood glucose levels. The resident's pain level was not indicated. The nursing observations, evaluation, and recommendations included: patient had a fall while being transported from an outside appointment. Resident #68 did not want to go to the hospital however, the resident's husband was adamant.</p> <p>There was no indication the facility called EMS to transport Resident #68 to the hospital when Resident #68 agreed to be transported to the hospital or when the resident's husband requested the resident be transported to the hospital.</p> <p>Review of Resident #68's physician orders for May 2023 revealed an order dated 05/03/23 at 2:15 P.M. to send the patient to the emergency room (ER) for treatment and evaluation one time only for fall.</p> <p>Review of the Pain assessment dated [DATE] revealed Resident #68 reported frequent pain at a level of eight out of ten on a scale where ten is the worst pain level. Resident #68 had vocal complaints of pain as well noted. The assessment did not clarify where the pain was located.</p> <p>Review of the hospital records dated 05/03/23 revealed Resident #68 was admitted to the hospital at 2:30 P. M. The resident presented to the emergency department after a fall backwards from wheelchair. Resident #68 complained of posterior head, neck, and mid back pain. A chest x-ray revealed remote right rib fractures, no acute displaced fracture was noted. A non-contrast Computed Tomography (CT) scan of the head revealed a small, three millimeter (mm) subdural hemorrhage (brain bleed between the brain and the skull) and a small right parietal subgaleal hematoma (bleeding between the skull and scalp). Resident #68 was transferred to another local hospital to be monitored and treated by neurosurgery. Resident #68 was admitted to the hospital from 05/03/23 to 05/06/23 (three days).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/10/23 at 10:30 A.M. with Resident #68 and the resident's husband (Resident #67) confirmed Resident #68 was in the hospital for three days from 05/03/23 to 05/06/23 due to a brain bleed. Resident #68 stated she was on the facility's transport van returning from an outside appointment when her wheelchair tipped backwards, and she hit her head very hard on the van floor. Resident #68 reported she requested the driver call an ambulance to transport her to the hospital, but the driver did not comply. The driver moved Resident #68 back into her wheelchair (she reported she had slid up in the chair and her bottom was resting on the back rest after the chair tipped), proceeded to pick up another resident (Resident #31) from another appointment, and then returned to the facility. Resident #68 stated the facility staff did not examine the back of her head where she hit the floor for any injuries. Upon arriving to the facility, Resident #67 stated he requested x-rays be ordered and Resident #68 be transported to the hospital to be evaluated due to hitting her head. Resident #67 stated the facility staff would not call 911 to have Resident #68 transported so he called 911 himself from his cell phone while standing at the nurse's station. Resident #67 reported Licensed Practical Nurse (LPN) #205 and LPN #207 were both standing at the nurse's station when the call was made. Resident #67 pushed Resident #68 in her wheelchair to the elevator that took them to the first floor where they waited for the ambulance to arrive to take Resident #68 to the hospital.</p> <p>Interview on 05/10/23 at 1:35 P.M. with Licensed Practical Nurse (LPN) #205 revealed she was one of the nurses who cared for Resident #68 on 05/03/23. LPN #205 stated Resident #68 informed her upon arriving on the floor from the elevator that her wheelchair had tipped in the transport van, and she hit her head and left shoulder. LPN #205 stated she completed neurochecks with no negative findings. The resident's husband (Resident #67) requested Resident #68 be transferred to the hospital and an order was obtained from the CNP, but the LPN stated Resident #68 refused to go to the hospital at that time. LPN #205 stated she assessed Resident #68, including her head, and did not find any injuries. LPN #205 stated Resident #68 complained of pain to her head, neck, and left shoulder. LPN #205 stated EMS did not come to the facility to transport Resident #68 to the hospital, the resident's husband (Resident #67) pushed her in her wheelchair across the street to the local hospital. LPN #205 confirmed she did not call 911 to have Resident #68 transported to the hospital.</p> <p>Interview on 05/10/23 at 2:18 P.M. with LPN #207 revealed she was the other nurse who cared for Resident #68 on 05/03/23. LPN #207 stated LPN #205 notified her Resident #68 had a fall in the facility's transport van and hit her head and shoulder. LPN #207 stated LPN #205 notified the CNP and offered to send Resident #68 to the hospital, but stated the resident had refused at that time. However, the resident's husband (Resident #67) was adamant Resident #68 needed to go to the hospital. X-rays were ordered but when the x-ray tech arrived, about an hour or two later, Resident #67 had called 911 to have Resident #68 transported to the hospital. Residents #67 and #68 went to the first floor but LPN #207 was not sure if EMS arrived to transport Resident #68 because she (LPN #207) remained on the second floor. LPN #207 confirmed she did not call 911 to have Resident #68 transported to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/10/23 at 3:47 P.M. with Transport Staff #200 revealed he was the driver who transported Resident #68 and her husband (Resident #67) on 05/03/23. Transport Staff #200 confirmed after picking the residents up from their appointment and enroute to pick up Resident #31, Resident #68's wheelchair tipped backwards, and Resident #68 hit her head. Transport Staff #200 revealed he did not properly strap Resident #68's wheelchair with four straps and only used three because he was rushing to pick up Resident #31. Transport Staff #200 stated, Had I properly done four straps, it would not have happened. Transport Staff #200 revealed Resident #68 requested he call an ambulance at the time of the incident to take her to the hospital but stated the resident's husband (Resident #67) said not to and to take Resident #68 back to the facility to be assessed. Transport Staff #200 confirmed he did not call EMS to have Resident #68 transported to the hospital as the resident had initially requested.</p> <p>Interview on 05/10/23 at 4:45 P.M. with the Administrator, LPN #205, and LPN #207 revealed per the Administrator (who spoke on behalf of the two nurses) the facility staff were not aware Resident #68's husband (Resident #67) had called 911 until after Resident #68 had been admitted to the hospital and Resident #67 returned to the facility to pick up some belongings and return to the hospital to stay with Resident #68.</p> <p>Review of the care plan, revised on 05/11/23, revealed Resident #68 had pain related to complaints of left shoulder pain and recent subdural hematoma. Interventions included administering medications as ordered, monitor for signs and symptoms of pain, and notify the physician of any significant changes or if interventions were unsuccessful.</p> <p>A facility policy related to transportation was requested during the entrance conference on 05/10/23 at 9:40 A.M. but a policy was not provided.</p> <p>Review of the facility policy, Falls-Clinical Protocol, revised 09/2012, revealed the policy indicated staff, with the physician's guidance, would follow up on any fall with associated injury until the resident was stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved. Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall.</p> <p>The deficiency represents non-compliance investigated under Complaint Number OH00142668.</p>		