

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  07/02/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide barber services for Resident #38. This affected one resident (#38) of four residents reviewed for activities of daily living. Facility census was 90.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #38 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis, depression, and adjustment disorder with anxiety.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #38 was cognitively intact.</p> <p>An interview on 06/23/25 at 10:59 A.M. Resident #38 stated he had not had a haircut since he was admitted to the facility, and he wanted his hair cut. Observation of Resident #38 revealed his hair was below his shoulders.</p> <p>An interview on 06/26/25 at 9:11 A.M. Licensed Nursing Home Administrator (LNHA) verified the facility had not had a beauty shop license since 2021. LNHA verified residents could not receive haircuts or beauty salon services at the facility. The LNHA stated he was currently looking into possibly taking residents to a local barber school and/or cosmetology school to receive haircuts.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165933.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, interviews, work orders, and policy review, the facility failed to ensure temperatures in the facility were at a comfortable level. This had the potential to affect all 90 residents. Facility census was 90.</p> <p>Finding include:</p> <p>Review of quote dated 04/22/25 from heating, ventilation, and air conditioning (HVAC) company revealed cooling tower repairs due to coil froze and burst due to being shut off over the winter. The coil would need replaced for a total of \$79,990. A quote dated 04/24/25 was received from the same HVAC company for temporary cooling tower, temporary pump, piping, electric, and breakers as needed for a total of \$48,659.00. The work was completed and paid for sometime in May.</p> <p>Review of temperature logs from 04/28/25 to 06/12/25 revealed temperatures from 74 degrees to 82 degrees. The temperatures for resident rooms at 80 degrees or above had notation of air conditioner unit being off and/or windows open.</p> <p>A work order dated 06/06/25 revealed the air unit on the second floor (Blue) was not working. On 06/11/25 a work order was placed for a problem with air conditioning in Resident #57's room. On 06/13/25 a work order was placed for air conditioning not working for Resident #60.</p> <p>A timeline of events revealed on 06/22/25 maintenance reported to the facility to assist with elevated temperatures. HVAC company was contacted when complaints were received on increased temperatures. Residents were offered extra fans and portable air conditioning units.</p> <p>Observations and interviews on 06/23/25 from 10:25 A.M. to 1:22 P.M. Residents #26, #28, #38, #60, #73, and #75 stated it was hot in the facility. Resident rooms and common areas were warm and multiple fans and portable air conditioners were noted.</p> <p>An observation on 06/23/25 at 1:11 P.M. of the thermostat at the nurses station on the third floor near the elevator showed 84 degrees. An observation on 06/23/25 at 1:12 P.M. of the nurses station on the back unit on the third floor had an electronic thermometer that showed 85 degrees.</p> <p>On 06/23/25 at 1:47 P.M. weather.com revealed the temperature in Columbus, Ohio, was 94 degrees.</p> <p>On 06/23/25 room temperatures were conducted with [NAME] President of Plant Operations #600 revealed the following temperatures:</p> <p>At 1:50 P.M. Resident #78's room was 81.8 degrees</p> <p>At 1:51 P.M. Resident #76's room was 82.9 degrees</p> <p>At 1:52 P.M. Resident #59's room was 82.2 degrees</p> <p>At 1:52 P.M. Resident #40's room was 82 degrees</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 1:56 P.M. Resident #52's room was 81.1 degrees</p> <p>At 1:57 P.M. the common area on the locked unit was 81.8 degrees</p> <p>At 2:14 P.M. Resident #68's room was 83.3 degrees</p> <p>At 2:15 P.M. Resident #75's room was 84.2 degrees</p> <p>At 2:16 P.M. Resident #38's room was 84 degrees</p> <p>At 2:17 P.M. Resident #73's room was 81.1 degrees</p> <p>At 2:23 P.M. the nurses station on the third floor near the elevators was 85 degrees</p> <p>At 2:24 P.M. Resident #57's room was 85 degrees</p> <p>At 2:31 P.M. the therapy room was 84 degrees</p> <p>An interview on 06/23/25 at 3:50 P.M. [NAME] President of Plant Operations #600 revealed the cooling tower fan was running backwards and caused breakers to trip which resulted in the air conditioning not working properly.</p> <p>An interview on 06/24/24 at 10:19 A.M. Occupational Therapist #501 verified therapy was being completed in resident rooms because the therapy room was hot. An interview on 06/24/24 at 10:22 A.M. Therapy Director #505 verified therapy was only done in the therapy room if residents wanted therapy done there because the therapy room was hot. Therapy Director #505 stated a portable air conditioner and two fan were placed in the therapy room to help with the heat.</p> <p>An additional interview on 06/30/25 at 8:47 A.M. [NAME] President of Plant Operations #600 verified in April a temporary chiller was used until a part could be made. The end of May the part was available and the cooling tower was fixed. On 06/22/25 there were complaints of the air conditioning not working properly. The HVAC company was called and it was discovered the high voltage was wired wrong and caused the units to trip and an air bleeder was found.</p> <p>Excessive heat policy dated 11/30/14 revealed air conditioning will be utilized. If air conditioning was not appropriate or feasible, fans would be utilized to provide air circulation. Fluid hydration would be encouraged and cool fluids would be passed to residents on a regular basis. Window treatments would be closed to block out the sun where appropriate, residents would be encouraged to relocate and spend time in the cooler sections of the building, residents would be monitored closely for signs of dehydration, respiratory difficulties, and transferred to appropriate facilities if indicated. The facility must maintain temperature range of 71 to 81 degrees.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00166971 and Complaint Number OH00165933</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, record review, policy and interview, the facility failed to ensure nail care was provided to dependent residents. This affected two (Resident #61 and #78) of four residents reviewed for activities of daily living. The census was 90.</p> <p>Findings include:</p> <p>1. Review of Resident #78 revealed a 05/01/25 admission with diagnoses including fracture of T11-T12 vertebra, protein calorie malnutrition, fracture of first lumbar vertebra, valve endocarditis, lumbosacral radiculopathy, lumbar spondylosis, muscle wasting and atrophy, difficulty walking, cognitive communication deficit, low back pain, and mood disorder</p> <p>Review of the 05/06/25 admission Minimum Data Set (MDS) Assessment revealed the resident was independent for daily decision. The resident had no functional impairment and was in need of partial/moderate assistance with personal hygiene.</p> <p>Interview and observation on 06/24/25 at 12:20 P.M. with Resident #78 revealed he asked staff for fingernail clippers and did not get them. He said he had ripped off his fingernails and they were jagged. He showed that his thumb nails were long because they were too thick to tear off. Further observation of the resident's fingernails revealed the nails were jagged with sharp edges and dark debris under the nails. The resident also had long toenails.</p> <p>Interview 06/24/25 at 4:43 P.M. with Certified Nurse Aide #244 revealed she provided the resident a bed bath. She verified she has never cut or cleaned his nails.</p> <p>Observation of Resident #78 06/24/25 at 4:48 P.M. with Licensed Practical Nurse (LPN) #353 verified Resident #78's thumb nails and toe nails were long. He showed her where he has ripped them off and they were jagged and had debris under the nails. The resident said no one had cleaned his nails or cut them since he arrived. LPN #353 stated activities will do nails in the activity room but they do not go to individual rooms unless the residents are on the locked unit.</p> <p>Interview 06/24/25 at 4:55 P.M. with the Director of Nursing verified the facility has shower aides who are to do nail care with showers.</p> <p>Review of the facilities Care of Fingernails/Toenails policy revised October 2010 included the purpose of this procedure are to clean the nail bed to keep nails trimmed and to prevent infections. Nail care includes daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Notify the supervisor if the resident refuses the care. The following information should be recorded on the residents medical record. The date and time the nail care was given, the name and title of the individual who administered the nail care. The condition of the resident nails and nailbeds including redness or irritation of the skin of hands and feet, breaks or cracks in skin especially between toes, pale bluish or gray discoloration of feet, bluish or dark colored nail beds, corns or calluses, ingrown nails, bleeding and/or pain or any difficulties in cutting the residents' nails. If the resident refused the treatment the reason why should be documented an the intervention taken along with the signature and title of the person recording the data. Notify the supervisor if the resident refuses the care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #61 revealed a 02/09/23 admission with diagnoses including dementia, alcohol induced amnesic disorder, hypertension, type 2 diabetes, conversion disorder with seizures or convulsions, psychosis not due to a substance or known physiological condition, restlessness and agitation, anxiety disorder, post traumatic stress disorder and major depressive disorder.</p> <p>Review of the 02/10/23 Activity of Daily Living (ADL) plan of care included the resident had an ADL self-care performance deficit. Interventions included a 05/16/24 intervention with bathing and showering to check nail length and trim and clean on bath day and as necessary.</p> <p>Review of the 06/01/25 Quarterly Minimum Data Set Assessment (MDS) revealed the resident was moderately impaired for daily decision making with no behaviors. She sometimes felt socially isolated. She has minimal difficulty hearing with no hearing aide. Has the ability to understand. Clear speech, and is understood. She had adequate vision without corrective lenses. She had trouble concentrating and falling asleep, feeling down, depressed or hopeless, with little pleasure in doing things. She had no functional impairment. The resident was supervision/ touch assistance for personal hygiene. Medications included antipsychotic, antidepressant, anticonvulsant. Receives antipsychotic on routine basis and no gradual dose reduction (GDR) had been attempted. The physician indicated a GDR was clinically contraindicated.</p> <p>Observation 06/24/25 at 10:35 A.M. revealed the resident had very long toe nails on her great toes bilaterally.</p> <p>Interview 06/24/25 at 10:35 A.M. with the resident revealed she had not been seen by a podiatrist to have her toenails cut since she was admitted .</p> <p>Review of the 04/23/25 podiatry list revealed the resident was not on the list to be seen.</p> <p>Interview 06/26/25 at 9:27 A.M. with Guardian #700 revealed Resident #61 is eligible for Veteran's benefits. She included she had asked in the past for the resident to take advantage of the veteran benefits for ancillary services.</p> <p>Interview 06/26/25 at 9:49 A.M. with the Director of Nursing verified the resident had not had ancillary services since admission.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166595 and OH00165933.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, policy and interview, the facility also failed to remove a resident's surgical staples and administer antibiotics to meet professional standards. This affected two residents (#134 and #234) out of 29 residents reviewed for appropriate care and services. Facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #234 was admitted on [DATE] with diagnoses that included staphylococcal arthritis right hip, osteomyelitis of vertebra, type 2 diabetes, protein-calorie malnutrition, asthma, hypertension, major depressive disorder, and anxiety disorder.</p> <p>The quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #234 was cognitively intact.</p> <p>Review of the after visit summary (AVS) from the hospital dated 06/16/25 revealed Resident #234's surgical staples would be removed at the skilled nursing facility two weeks post operative on 06/20/25.</p> <p>An interview on 06/23/25 at 11:58 A.M. Resident #234 stated he recently had surgery and needed staples removed. Resident #234 was unsure when the appointment for the staple removal was.</p> <p>An interview on 06/25/25 at 3:50 P.M. the director of nursing (DON) stated Resident #234 probably would not allow the skilled nursing facility staff to remove the staples. The DON was not aware the AVS revealed Resident #234's staples were to be removed by the facility staff on 06/20/25.</p> <p>An additional interview on 06/26/25 at 2:38 P.M. the DON verified there was an order on the AVS for the skilled nursing facility to remove Resident #234's staples. The DON stated Resident #234 permitted staff to remove the staples on 06/25/25.</p> <p>2. A review of the medical record for Resident #134 revealed an admission date 05/21/25 with diagnoses including osteomyelitis of right foot, congestive heart failure (CHF), and type two diabetes. Resident #134 was discharged from the facility on 05/25/25.</p> <p>A review of Resident #134's physician orders revealed an order dated 05/21/25 for antibiotic Daptomycin Intravenous Solution Reconstituted use 14.5 milliliter (ml) per hour (hr) intravenously at bedtime for wound until 06/22/25, order was discontinued on 05/23/25.</p> <p>An order dated 05/23/25 for antibiotic Daptomycin Intravenous Solution Reconstituted use 700 milligram (mg) intravenously at bedtime for staph infection of right foot until 06/22/25, order was discontinued on 05/25/25, and an order dated 05/25/25 for antibiotic Daptomycin Intravenous Solution Reconstituted use 700 milligram (mg) intravenously at bedtime for staph infection of right foot until 06/25/25, order was discontinued on 05/27/25.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #134's Medication Administration Record (MAR) dated 05/21/25 to 05/25/25 revealed the order for antibiotic Daptomycin Intravenous Solution Reconstituted use 14.5 milliliter (ml) per hour (hr) intravenously at bedtime for wound until 06/22/25 was marked on 05/21/25 as not administered with no reason documented and marked on 05/22/25 as not administered due to being in the care of the pharmacy. Further review revealed the order for antibiotic Daptomycin Intravenous Solution Reconstituted use 700 milligram (mg) intravenously at bedtime for staph infection of right foot until 06/22/25 was marked as being administered on 05/23/25 and 05/24/25. On 05/25/25 and 05/26/25 the order for Daptomycin Intravenous Solution Reconstituted use 700 milligram (mg) intravenously at bedtime for staph infection of right foot until 06/22/25 was marked as being not administered due to Resident #134 not being at the facility.</p> <p>A review of Resident #134's progress notes dated 05/21/25 to 05/25/25 revealed no notifications to the physician concerning the required clarification of the order dated 05/21/25 for antibiotic Daptomycin Intravenous Solution Reconstituted use 14.5 milliliter (ml) per hour (hr) intravenously at bedtime for wound until 06/22/25, and there were no entries in the progress notes to reflect the physician was notified of the two dose of antibiotic not being administered to Resident #134.</p> <p>An interview on 06/30/25 at 1:43 P.M. with the Director of Nursing (DON) confirmed Resident #134 was not administered the antibiotic Daptomycin on 05/21/25 and 05/22/25, and there were no notifications to the physician reflecting the need for the order clarification or the missed doses of the antibiotic.</p> <p>A review of the facility's policy titled Change in a Resident's Condition or Status dated 05/17 revealed the nurse will notify the resident's Attending Physician or Physician on call when there is a need to alter the resident's medical treatment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166200.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. Review of Resident #61 revealed a 02/09/23 admission with diagnoses including dementia, alcohol induced amnesic disorder, hypertension, type 2 diabetes, conversion disorder with seizures or convulsions, psychosis not due to a substance or known physiological condition, restlessness and agitation, anxiety disorder, post traumatic stress disorder and major depressive disorder.</p> <p>Review of the 06/01/25 Quarterly Minimum Data Set Assessment (MDS) revealed the resident was moderately impaired for daily decision making with no behaviors. She has minimal difficulty hearing with no hearing aide, had the ability to understand. Clear speech, and is understood. She had adequate vision without corrective lenses.</p> <p>Interview 06/24/25 at 10:34 A.M. with Resident #61 revealed she wore glasses for distance vision but had not seen an eye doctor since she was admitted to the facility. The resident indicated she wore glasses while driving and for distance vision before admission. The resident was unable to find her glasses in her room.</p> <p>Review of the record revealed no evidence of the resident having an optometry consult while a resident in the facility.</p> <p>Interview 06/26/25 at 9:27 A.M. with Guardian #700 revealed Resident #61 was eligible for Veteran's benefits. She included she had asked staff, in the past, for the resident to take advantage of the veteran benefits for ancillary services.</p> <p>Interview 06/26/25 at 9:49 A.M. with the Director of Nursing verified the resident had not had ancillary services including optometry care since admission.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166595 and OH00165933.</p> <p>Based on observation, record review, and interview, the facility failed to provide Resident #61 and #68 with adequate and timely vision care. This affected two (Resident #61 and #68) of three residents reviewed for vision care. Facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #68 was admitted on [DATE] with diagnoses that included encephalopathy, disseminated mycobacterium avium-intracellulare complex, human immunodeficiency viruses, severe protein-calorie malnutrition, dysphagia, congenital cytomegalovirus, pressure ulcer of sacral region, dementia, and sensorineural hearing loss.</p> <p>The admission/readmit form dated 03/12/25 revealed Resident #68 had impaired vision, wore glasses, and was deaf.</p> <p>The admission Minimum Data Set (MDS) date 03/15/25 revealed Resident #68 had cognitive impairment, had highly impaired hearing, impaired vision, and did not wear glasses. The quarterly MDS dated [DATE] revealed Resident #68 had impaired vision, and did not wear glasses.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A list of residents with vision appointments at the facility on 06/04/25 revealed Resident #68 was not on the list of residents seen.</p> <p>An observation on 06/23/25 at 1:15 P.M. revealed Resident #68 had glasses with one lens on the right side, no lens on the left side and tape on the right side of the glasses and the nose area.</p> <p>An interview on 06/24/25 at 9:07 A.M. with Resident #68's family member revealed Resident #68 was deaf and read lips or read what was written on paper to communicate.</p> <p>An interview on 06/25/25 at 8:51 A.M. Licensed Practical Nurse (LPN) #353 verified Resident #68 was deaf and read lips or used a communication board.</p> <p>An interview on 06/26/25 at 8:10 A.M. Regional Nurse #601 verified Resident #68 was admitted to the facility with broken glasses. A follow-up interview on 06/26/25 at 9:35 A.M. with Regional Nurse #601 verified Resident #68 had not seen the eye doctor and was unaware Resident #68 had glasses that only had one lens and the frame and lens were taped together.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, and policy review, the facility failed to provide a comprehensive, resident centered treatment plan for the prevention and/or management of pressure ulcers. This affected one (Resident #68) out of two residents reviewed for pressure ulcer care.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #68 was admitted on [DATE] with diagnoses that included encephalopathy, disseminated mycobacterium avium-intracellulare complex, human immunodeficiency viruses, severe protein-calorie malnutrition, dysphagia, congenital cytomegalovirus, a stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed) pressure ulcer of sacral region, dementia, and sensorineural hearing loss.</p> <p>The nursing admit/readmit care plan dated 03/12/25 revealed Resident #68 had a pressure ulcer to the right buttock and sacrum. There was no documentation of the size or any description of the wounds. The comments revealed Resident #68 needed to be seen by the wound nurse.</p> <p>A plan of care dated 03/12/25 revealed Resident #68 was at risk for skin breakdown related to decreased mobility and pressure ulcers. Interventions included an air mattress to the bed, encourage to turn and reposition every two hours and as needed, weekly treatment documentation to include measurement of each area of skin breakdown with width, length, depth, type of tissue, exudate, and any other notable changes or observations.</p> <p>Review of admission orders revealed no treatment orders for the wounds to Resident #68's right buttock or sacrum.</p> <p>A wound care note by the wound doctor dated 03/18/25 revealed the initial evaluation was completed and Resident #68 had a stage III pressure ulcer that was present upon admission. There was a large area to the sacral region that measured 8.4 centimeters (cm) long, 4.1 cm wide, and 0.2 cm deep with 100 percent granulation and a moderate amount of serosanguinous (exudate that appears as a light pink, thin, and watery fluid) and bloody exudate. The area was discovered upon admission to the facility.</p> <p>Review of the treatment administration record (TAR) revealed a treatment to cleanse Resident #68's sacrum with normal saline, pat dry, apply collagen (biological dressings derived from natural collagen sources that promotes wound healing by stimulating new tissue growth), and covered with a dressing every Tuesday, Thursday, and Saturday was not documented until 03/20/25.</p> <p>Documentation of weights on 05/13/25 and 05/27/25 revealed Resident #68's highest weight of 160 pounds.</p> <p>A plan of care dated 06/17/25 revealed Resident #68 had a pressure ulcer to the sacrum. Interventions included to administer treatments as ordered and air mattress to bed.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #68 was cognitively impaired and admitted with a stage III pressure ulcer.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bella Terrace Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1520 Hawthorne Avenue Columbus, OH 43203	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The current physician orders on 06/23/25 included a low air loss mattress to be checked for placement and function every shift and the sacrum to be cleansed with normal saline, patted dry, silver alginate (a specialized wound care product that combines the absorbent properties of alginate with the antimicrobial effects of silver, making it effective for managing various types of wounds, especially those with moderate to heavy exudate) applied and covered with a dressing.</p> <p>On 06/24/25 Resident #68 weighed 158 pounds.</p> <p>An observation on 06/25/25 at 8:51 A.M. revealed Resident #68's air mattress was set to 180 pounds.</p> <p>On 06/25/25 at 9:02 A.M. Licensed Practical Nurse (LPN) #353 verified Resident #68's air mattress was set at 180 pounds.</p> <p>On 06/26/25 at 8:17 A.M. the Director of Nursing (DON) verified Resident #68's air mattress was set at 180 pounds and Resident #68's most recent weight was 158 pounds.</p> <p>On 06/26/25 at 2:36 P.M. interview with the DON verified an order for a treatment to Resident #68's right buttock and/or sacrum was not put in place upon admission. The DON verified there were no treatments documented on the TAR until 03/20/25. The DON also verified there was no description of the wounds until an outside wound doctor saw Resident #68 on 03/18/25. The DON verified there was not documentation of the pressure ulcer to the right buttock. The only pressure ulcer identified by the wound doctor was to Resident #68's sacrum.</p> <p>Review of the wound and skin care policy (no date) revealed if a pressure area/ulcer was present, the resident will be placed on a wound program and the area will be measured/tracked weekly and as needed until resolved. A treatment will be initiated as ordered by the physician. Documentation of pressure areas/ulcers include measurement of the width, length, depth, wound margins, undermining, clock hands for tunneling, drainage, amount of drainage including the type, color, and odor. The site of the pressure ulcer will be described.</p> <p>This deficiency identifies non-compliance under Complaint Number OH00166200.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interview, observation and policy review the facility failed to provide a comprehensive, resident centered fall prevention plan and failed to adequately assess residents after a fall. This affected two (Resident #5 and #135) of three residents reviewed for appropriate care and services. Facility census was 90.</p> <p>Findings include:</p> <p>1. Review of the medical record revealed Resident #5 was admitted on [DATE] and readmitted on [DATE] with diagnosis that included generalized idiopathic epilepsy and epileptic syndromes, schizophrenia, hypertension, anxiety disorder, disruptive mood dysregulation disorder, repeated falls, restlessness and agitation, senile degeneration of the brain and glaucoma.</p> <p>Review of the physicians orders dated 05/21/25 revealed a low bed with mat beside the bed was ordered.</p> <p>The plan of care dated 06/17/22 revealed Resident #5 was at risk for falls with an added intervention dated 05/08/25 for a low bed with a mat beside the bed (on the floor).</p> <p>Observations on 06/24/25 at 1:07 P.M., 06/25/25 at 9:26 A.M. and 11:51 A.M. revealed a mattress was on the floor, beside the bed.</p> <p>Interview on 06/30/25 at 3:04 P.M. with the Director of Nursing verified there was a mattress on the floor beside the resident's bed, but the order in the electronic medical record (EMR) reflected a mat to the floor.</p> <p>2. Review of the medical record revealed Resident #135 was admitted on [DATE] and discharged to the hospital on [DATE] with diagnoses that included fracture of pubis, diabetes mellitus, chronic kidney disease stage 3, seizures, bipolar, and major depressive disorder.</p> <p>The Morse Fall scale dated 05/15/25 revealed Resident #135 was at high risk for falls.</p> <p>The plan of care dated 05/16/25 and created on 05/20/25 revealed Resident #135 was at high risk for falls. Interventions initiated on 05/16/25 but created on 05/20/25 included to change Resident #135's bed to low bed with a mat beside the bed and grab bars to allow the resident to change positions in bed, encourage to wear nonskid footwear, keep bed in the lowest position, and keep call light within reach.</p> <p>A Fall and Neuro form authored by Licensed Practical Nurse (LPN) #220 that was not part of the medical record revealed on 05/16/25 at 1:00 P.M. Resident #135 was observed on the floor and had rolled out of bed while sleeping. Resident #135 had a hematoma above the left eye. Under the section for injuries, LPN #220 documented there were no injuries. LPN #220 documented Resident #135's call light was within reach. There were no statements documented. A description of the size and color of the hematoma was not documented.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A general progress note dated 05/16/25 at 1:00 P.M. entered on 05/20/25 at 11:24 A.M. and authored by the Director of Nursing (DON) revealed the nurse observed Resident #135 lying on the floor next to the bed. Resident #135 had a hematoma above the left eye. Resident #135 was assisted back into bed. Neurological checks were started and Resident #135 was provided an ice pack for face. A new intervention for grab bars was put in place. Resident #135's family, the DON, and physician were notified of the fall.</p> <p>An interdisciplinary note dated 05/16/25 at 5:43 P.M. entered on 05/20/25 at 11:44 A.M. and authored by DON revealed Resident #135 had a fall on 05/16/25 at 1:00 P.M. Resident #135 was observed lying on the floor next to the bed. Resident #135 had a hematoma above the left eye. Interventions included to change bed to low bed with a mat beside the bed, and grab bars to allow Resident #135 to change positions in bed. Resident #135 was at high risk for falls.</p> <p>A general progress note (struck out by LPN #220) dated 05/16/25 at 6:09 P.M. revealed Resident #135's daughter stated staff had been told upon admission that Resident #135 was a fall risk. Resident #135's daughter asked why Resident #135 did not have bed rails on the bed. The daughter stated she was not leaving until bed rails were put on Resident #135's bed. A bed with side rails was provided for Resident #135.</p> <p>The discharge/return anticipated Minimum Data Set (MDS) dated [DATE] revealed Resident #135 was independent with cognitive skills, required substantial/maximal assistance with rolling and sitting to lying, lying to sitting, and was dependent from sitting to standing, toileting, and showering.</p> <p>An interview on 06/26/25 at 4:49 P.M. DON stated when Resident #135 fell, the nurse working did the initial report and documented under risk assessments which was not part of the medical record. DON stated only the nurse that documented the note on 05/16/25 at 6:09 P.M. could strike out the note. DON could not say why the note was struck out but possibly due to the note said bed rails instead of grab bars.</p> <p>A general progress note entered on 06/28/25 but dated 05/16/25 at 1:00 P.M. authored by LPN #220 revealed Resident #135 was observed lying on the floor next to the bed. Resident #135 that a hematoma above the left eye that was approximately 1.6 centimeters (cm) in size. An intervention for grab bars was put in place.</p> <p>A general progress note entered on 06/28/25 but dated 05/16/25 at 6:09 P.M. authored by LPN #220 revealed Resident #135 had a hematoma that measured 1.6 cm long and 1.6 cm wide. Resident #135's daughter stated she had told staff on admission at Resident #135 was a fall risk and would not leave until Resident #135 had a bed with rails or grab bars</p> <p>An interview on 06/30/25 at 9:12 A.M. Resident #135's daughter stated she was present when Resident #135 was admitted . The daughter lowered Resident #135's bed and told the staff Resident #135 had fallen out of bed in the past and needed side rails to the bed. The staff stated a physician order would be needed to use side rails or put a mat on the floor next to the bed. Resident #135's daughter stated Resident #135 had a large hematoma and a black eye after fall from bed. When Resident #135 was transferred to the hospital on [DATE], the emergency medical technicians asked Resident #135 if anyone had assessed Resident #135 due to the facial injuries received from the fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 06/30/25 at 11:58 A.M. DON stated fall interventions upon admission included Resident #135's bed to be in the low position and nonskid socks were to be worn when out of bed. DON verified the documentation did not reveal if Resident #135's bed was in a low position or if nonskid socks were in place. DON also verified LPN #220 entered documentation for 05/16/25 on 06/28/25 to include the size of the hematoma. DON verified there was no other documentation of the size or characterizes of the hematoma in the progress notes, fall investigation, or skin assessment documentation from 05/16/25 to 05/18/25. DON verified fall interventions of grab bars, low bed, and a mat to the floor were not put in place until after Resident #135 had a fall from bed.</p> <p>Review of the fall policy (no date) revealed staff, with physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00166595 and OH00165933.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, work orders, policy and interview, the facility failed to ensure cool air temperatures, functional sinks, functional shower rooms, maintenance of ceilings, walls, floors, window seals and vanities, furniture, mattress, toilet paper holders, and functional hand sanitizer dispensers. This affected 24 (Resident's #24, #26, #27, #28, #32, #37, #38, #39, #40, #49, #52, #53, #56, #57, #58, #59, #60, #68, #73, #75, #76, #78, #185, and #285) of 90 residents in the facility.</p> <p>Findings include:</p> <p>1. Review of quote dated 04/22/25 from heating, ventilation, and air conditioning (HVAC) company revealed cooling tower repairs due to coil froze and burst due to being shut off over the winter. The coil would need replaced for a total of \$79,990. A quote dated 04/24/25 was received from the same HVAC company for temporary cooling tower, temporary pump, piping, electric, and breakers as needed for a total of \$48,659.00. The work was completed and paid for sometime in May.</p> <p>Review of temperature logs from 04/28/25 to 06/12/25 revealed temperatures from 74 degrees to 82 degrees. The temperatures for resident rooms at 80 degrees or above had notation of air conditioner unit being off and/or windows open.</p> <p>A work order dated 06/06/25 revealed the air unit on the second floor (Blue) was not working. On 06/11/25 a work order was placed for a problem with air conditioning in Resident #57's room. On 06/13/25 a work order was placed for air conditioning not working for Resident #60.</p> <p>A timeline of events revealed on 06/22/25 maintenance reported to the facility to assist with elevated temperatures. HVAC company was contacted when complaints were received on increased temperatures. Residents were offered extra fans and portable air conditioning units. On 06/23/25 the facility implemented the Extreme Heat Policy. All residents were monitored for signs and symptoms of heat exhaustion every shift. Residents were offered to transfer to another facility, residents were offered an extra fan and/or portable air conditioner to use, and were educated on hydration, wearing light clothing, and turning off lights in their room. The facility attempted to obtain commercial portable air conditioner units but was unsuccessful due to multiple company's being out of stock.</p> <p>A email dated 06/23/25 at 3:46 P.M. from the HVAC company to [NAME] President of Plant Operations #600 revealed on 06/22/25 a technician arrived on site. An air bleeder on the building loop at the cooling tower was spraying out water. The bleeder was valved off and water was added. The power to the heat pumps on the second and third floor were cycled. A new air bleeder will need to be installed.</p> <p>Observations and interviews on 06/23/25 from 10:25 A.M. to 1:22 P.M. Residents #26, #28, #38, #60, #73, and #75 stated it was hot in the facility. Resident rooms and common areas were warm and multiple fans and portable air conditioners were noted.</p> <p>An observation on 06/23/25 at 1:11 P.M. of the thermostat at the nurses station on the third floor near the elevator showed 84 degrees. An observation on 06/23/25 at 1:12 P.M. of the nurses station on the back unit on the third floor had an electronic thermometer that showed 85 degrees.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 06/23/25 at 1:47 P.M. weather.com revealed the temperature in Columbus, Ohio, was 94 degrees.</p> <p>On 06/23/25 room temperatures were conducted with [NAME] President of Plant Operations #600 revealed the following temperatures:</p> <p>At 1:50 P.M. Resident #78's room was 81.8 degrees</p> <p>At 1:51 P.M. Resident #76's room was 82.9 degrees</p> <p>At 1:52 P.M. Resident #59's room was 82.2 degrees</p> <p>At 1:52 P.M. Resident #40's room was 82 degrees</p> <p>At 1:56 P.M. Resident #52's room was 81.1 degrees</p> <p>At 1:57 P.M. the common area on the locked unit was 81.8 degrees</p> <p>At 2:14 P.M. Resident #68's room was 83.3 degrees</p> <p>At 2:15 P.M. Resident #75's room was 84.2 degrees</p> <p>At 2:16 P.M. Resident #38's room was 84 degrees</p> <p>At 2:17 P.M. Resident #73's room was 81.1 degrees</p> <p>At 2:23 P.M. the nurses station on the third floor near the elevators was 85 degrees</p> <p>At 2:24 P.M. Resident #57's room was 85 degrees</p> <p>At 2:31 P.M. the therapy room was 84 degrees</p> <p>An interview on 06/23/25 at 3:50 P.M. [NAME] President of Plant Operations #600 revealed the cooling tower fan was running backwards and caused breakers to trip which resulted in the air conditioning not working properly.</p> <p>An interview on 06/24/24 at 10:19 A.M. Occupational Therapist #501 verified therapy was being completed in resident rooms because the therapy room was hot. An interview on 06/24/24 at 10:22 A.M. Therapy Director #505 verified therapy was only done in the therapy room if residents wanted therapy done there because the therapy room was hot. Therapy Director #505 stated a portable air conditioner and two fan were placed in the therapy room to help with the heat.</p> <p>An additional interview on 06/30/25 at 8:47 A.M. [NAME] President of Plant Operations #600 verified in April a temporary chiller was used until a part could be made. The end of May the part was available and the cooling tower was fixed. On 06/22/25 there were complaints of the air conditioning not working properly. The HVAC company was called and it was discovered the high voltage was wired wrong and caused the units to trip and an air bleeder was found.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Excessive heat policy dated 11/30/14 revealed air conditioning will be utilized. If air conditioning was not appropriate or feasible, fans would be utilized to provide air circulation. Fluid hydration would be encouraged and cool fluids would be passed to residents on a regular basis. Window treatments would be closed to block out the sun where appropriate, residents would be encouraged to relocate and spend time in the cooler sections of the building, residents would be monitored closely for signs of dehydration, respiratory difficulties, and transferred to appropriate facilities if indicated. The facility must maintain temperature range of 71 to 81 degrees.</p> <p>2. Observations 06/23/25 between 10:33 A.M. and 2:13 P.M. revealed the following:</p> <p>Resident's #53 and #58's bathroom did not have a roller to hold their toilet paper.</p> <p>Resident's Resident #37 and #49's bathroom did not have a roller to hold their toilet paper.</p> <p>One third of the vanity surrounding Resident #49's sink was missing.</p> <p>Resident #39's recliner was heavily worn with the fabric off on the headrest, arms and seat.</p> <p>Resident #24's sink had a note on it that it was out of order. The resident's had [NAME] and [NAME] bathrooms and a sink in their room. There was no evidence of hand sanitizer in the room in lieu of the sink being out of order.</p> <p>Three of four wall mounted hand sanitizers in the Behavior Unit did not dispense sanitizer when activated.</p> <p>Resident's #32 and #56's bathroom floor had 14 damaged, discolored floor tiles.</p> <p>Resident #27's overbed table and sink vanity were delaminating. The air conditioner was not working.</p> <p>Resident #52's sink and window seal were delaminating and chipped. The air conditioner was frozen and not cooling the room.</p> <p>The hall window outside room [ROOM NUMBER] had approximately two feet of the window seal missing.</p> <p>The Behavior Unit's shower room was patched and not painted near the corner of the sink over an approximately three feet in length and one foot in width area.</p> <p>Resident #185's overbed table was delaminating.</p> <p>Resident #78's room sink had laminate broken off leaving jagged edges. There were holes in the linoleum of the bathroom floor. The bedroom and bathroom doors were heavily scraped and damaged. The paint was scraped off the thresholds of the bedroom and bathroom doors. The air conditioner was not working. The knobs were off the air conditioner controls. The bedroom ceiling had an approximate four foot by two foot area damaged yellowish in color. The sink bowl was rusty colored.</p> <p>The temperature in the second floor lounge was 85 degrees at 11:40 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The paint of the front of the second floor nurse station was scraped and dirty.</p> <p>There was a yellow stain in the ceiling tile of the between the elevator and second floor nurse station.</p> <p>The activity room had flooring missing in an approximate one and one half foot by one foot area and an approximate two inch by three inch corner.</p> <p>The activity room bathroom toilet had a black mold looking color around the water line. The floor was visibly dark, dirty. The walls were patched and not painted and the molding was off the wall.</p> <p>The bottom half of the elevator under the handrail was heavily scraped with the paint off. The back wall of the elevator above the handrail had large areas of plaster missing and was not painted.</p> <p>The hall wall from the dining room to the lobby below the handrails was heavily marred with dark scraped areas and damaged drywall.</p> <p>On 06/25/25 at 9:55 A.M. the Regional Director of Operations #602 and [NAME] President of Plant Operations #600 toured the above areas and verified the described areas had not been maintained.</p> <p>Observation 06/30/25 at 02:55 P.M. revealed there was a hole in the ceiling of Resident #78's room approximately eight inches by three inches. The ceiling had a liquid dripping into a fracture pan below.</p> <p>Interview 06/30/25 at 02:55 P.M. with Resident #78 revealed his ceiling started to leak on Saturday 06/28/25. He revealed there was also a leak in the middle of the room over the weekend. He put a Styrofoam cup on a table to catch the drips however, it was next to his bed which made it difficult to get out of bed.</p> <p>Interview 06/30/25 at 02:59 P.M. with Regional Director of Maintenance #702 verified the leak, He came in the room and started to pull the wet loose ceiling down. He opened an approximate one foot by one foot in the ceiling and stated the resident would need to be moved to another room.</p> <p>Interview 06/30/25 at 03:10 P.M. with Certified Nurse Assistant #244 revealed Resident #24 who's sink was out of order goes to the bathroom himself. She included he needs help wiping. She verified the resident did not have hand sanitizer or wipes in his room and verified his sink was not working. She did not know how he was washing his hands.</p> <p>3) An observation on 06/25/25 at 4:30 P.M. of the large shower room located on the unit 3-Out revealed the toilet and sink were covered with plastic sheeting to prevent use. There was a hole in the tile surrounding the shower handle approximately three inches long by two inches wide to the left of the handle with wall material exposed. There was a dark substance noted to the bottom of the walls in the front corners of the shower and along the top part of the rubber kick plate behind the sink and the toilet.</p> <p>(continued on next page)</p>

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  07/02/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview on 06/26/25 at 2:05 P.M. with the [NAME] President of Maintenance (VPM) #600 revealed the facility had notified him on 06/16/25 concerning the large shower room on 3-Out was out of order related to ruptured water pipe. VPM #600 was unsure of how long the shower had been out of order before the facility had notified him.</p> <p>An interview on 06/26/25 at 4:25 P.M. with LPN #240 confirmed the plastic sheeting on the toilet and sink, the hole in the tile by the shower handle and the dark substance in the corners of the shower and behind the sink and toilet. LPN #240 stated this shower room had been out of use for several months due to a water pipe that had leaked and ruptured.</p> <p>4) A review of Resident #285's medical record revealed admission date 06/18/25 with the following diagnoses including but not limited to aftercare following joint replacement of left hip, high blood pressure, and depression. Resident #285 was cognitively intact and required standby assist by staff to complete activities of daily living (ADL) tasks including transfers and bed mobility.</p> <p>An observation on 06/23/25 12:49 P.M. of Resident #285's bed revealed the bed frame was too long for the mattress. The mattress was touching the footboard which allowed for an approximately two-foot-wide gap between the headboard and the top of the mattress. Further observations on 06/24/25 at 10:00 A.M., 06/25/25 at 1:10 P.M., 06/26/25 at 9:15 A.M. and on 06/30/25 at 3:25 P.M revealed Resident #285's mattress continued to be too short for the bed frame.</p> <p>An interview on 07/01/25 at 8:15 A.M. with LPN #240 confirmed Resident #285's mattress was too short for the bedframe which resulted in a large gap between the headboard and the top of the mattress. LPN #240 stated either the housekeeping staff, or the clinical staff will notify central supply concerning mattresses that need replaced.</p> <p>These deficiencies represents non-compliance investigated under Master Complaint Number OH00166595, OH00166200, OH00165971, and OH00165933.</p>		