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	01/29/2026

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 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** Based on record review, staff interview, review of the facility investigation, review of hospital records, review of police report, and policy review, the facility failed to provide the appropriate supervision for one cognitively impaired resident (Resident #46) who was at high risk for elopement and required the supervision of a secured memory care unit for his safety. Resident #46 eloped from the facility without staff knowledge on 07/05/25. This resulted in Immediate Jeopardy on 07/05/25 at 11:20 A.M. when Resident #46 was taken off the secured memory care unit to go outside with the memory care unit residents who smoke. Resident #46 was brought back in the building and left unattended at the elevator in the lobby on the first floor by Certified Nursing Assistant (CNA) #501, after being outside with the smoke group. Resident #46 was not discovered missing until 12:37 P.M. when staff could not locate the resident on the secured memory care unit. At 3:20 P.M. Resident #46's brother notified the facility the resident was taken to the hospital at 12:55 P.M. Report from the hospital provided at 3:40 P.M. revealed a pedestrian had found Resident #46 on the ground on the sidewalk approximately one mile away from the facility and the pedestrian had called emergency medical services (EMS) who transported the resident to the hospital. Additionally, the facility failed to provide supervision to Resident #159 who was cognitively impaired, high risk for elopement and eloped from the facility on 12/20/25 which placed the resident at potential risk for more than minimal harm that was not Immediate Jeopardy. The facility also failed to ensure a safe environment and placed all facility residents at risk for more than minimal harm that was not Immediate Jeopardy, when a staff member brought a firearm into the facility and the firearm discharged in a common area near resident rooms on the second floor. The facility census was 82.On 01/06/25 at 12:40 P.M. the Administrator, Regional Director of Operations (RDO) #602, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS) #601 were notified Immediate Jeopardy began on 07/05/25 at 11:20 A.M. when Resident #46, who was high risk for elopement, was left at the elevator on an unsecured unit by facility staff. Resident #46 walked out of the facility two minutes later and was discovered missing from the facility until 12:37 P.M. Resident #46 was treated at the hospital for a heart attack, slight dehydration, and acute kidney injury. The Immediate Jeopardy was removed on 07/05/25 when the facility completed the following actions:On 07/05/25 at 3:45 P.M., a Root Cause Analysis was completed by the Administrator with input from the management team.On 07/05/25 4:00 P.M., the Former DON created a list of residents on the secured unit who are smokers and distributed to the staff.On 07/05/25 at 4:00 P.M., DON and Unit Manager Licensed Practical Nurse (UMLPN) # 262 completed whole house elopement risk assessments and updated care plans accordingly.On 07/05/25 at 4:15 P.M., the Administrator had an ad-hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss elopement policy best practices, and supervision of secured unit residents while off the secured unit.On 07/05/25 at 4:15 P.M., Admissions Director #276, after review of current resident room locations and new elopement risk (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessment, updated the bed board to included leave of absence status.On 07/05/25 at 4:30 P.M., Human Resource Director (HRD) #313 educated all staff on the elopement policy best practices and supervision of residents off the secured unit.On 07/05/25 at 4:45 P.M., HR #313 and the former DON updated the staff smoking assignments.On 07/05/25 at 5:00P.M., the Former DON updated facility's elopement binders after review with elopement risk to include resident's name and picture, current smokers list, elopement policy and missing resident best practices.Audits will be conducted three times a week for four weeks to ensure any resident taken off the secured unit are supervised at all times while off the unit.Elopement drills to be conducted once a week on day shift and once a week on night shift for four weeks. Although the Immediate Jeopardy was removed on 07/05/25, the deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings Include:1.Review of Resident #46's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis, severe protein malnutrition, vascular dementia, rheumatoid arthritis and sensorineural hearing loss. Review of Resident #46's Secured Unit Screener assessment, dated 09/18/24 revealed the reason for the screen was an as needed (PRN) review. Resident #46 had a diagnosis of Alzheimer's or related diagnosis or cognitive impairment which put the resident's safety at risk, wanders or would wander out of the facility and would not be able to find way back, less restrictive alternatives have been unsuccessful, resident able to ambulate or is mobile in wheelchair and resident is able to benefit from a structured environment with specialized activities. The conclusion was for Resident #46 to remain on the secured unit. Review of Resident #46's comprehensive care plans dated 09/17/24 and 09/20/24 revealed the resident was an elopement risk/wanderer related to disoriented to place, impaired safety and high risk of elopement; interventions included: identify pattern of wandering, divert as needed and intervene as appropriate and resident resides on the secure unit. Resident #46 also had a care plan which revealed the resident resided on a secured unit related to dementia and resident was an elopement risk related to previous recent history of elopement; interventions included: secured unit per physician's order. Resident #46 had a communication problem related to vascular dementia, mental disorder, cognitive communication deficit; intervention included: Anticipate and meet needs. Review of Resident #46's physician's orders dated 09/18/24 revealed he may reside on the secured unit related to the diagnosis of vascular dementia. Review of Resident #46's Elopement Risk Review assessment dated [DATE] revealed he was at high risk for elopement. Resident #46 was ambulatory with an assistive device, having intermittent confusion, no history of elopement episodes in the last three months, a diagnosis of vascular dementia and the need to remain on the secure unit. Review of Resident #46's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. He required the use of a walker and staff assistance with transfers and ambulation. Review of the facility investigation and incident report dated 07/05/25 at 4:00 P.M. revealed the resident left the facility unattended. A search of the facility was conducted, and the resident was not found. The DON notified the police, physician's call service, and the resident's responsible parties. Management staff searched nearby streets, the library, Hospital #700 and local businesses. (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 Hospital #800 ED History/patient triage note dated 07/05/25 at 9:28 P.M. revealed Resident #46 was walking on the street with his walker when bystanders saw him fall and called 911. The triage note documented Resident #46 reportedly left the nursing home and was found down on [NAME] Road and since in the ED he had repeatedly told nurses that he was hot and asked for water. Resident #46 had an increase in his Troponin T (laboratory test used to indicate damage or stress to the heart muscle) levels from 41ng/L (nanograms per liter) on 07/05/25 at 1:37 P.M. to 98 ng/L (normal level is less than 10 ng/L) on 07/05/25 at 4:12 P.M. and an abnormal electrocardiogram (EKG). Resident #46 was admitted to the hospital for witnessed falls, acute kidney injury and elevated troponin levels. Resident #46 was started on baby Aspirin (anti platelet) and a Heparin (anticoagulant) drip/infusion for treatment of elevated troponin levels. Resident #46 was discharged back to facility with a diagnosis of non-ST elevation myocardial infarction (NSTEMI) (heart attack) and orders to follow up with primary care provider. Review of google maps revealed the walking distance from the facility to the street where Resident #46 was 1.2 miles. Resident #46 had to cross a street that was high traffic with six to eight lanes to get to where he was found. During an interview on 12/31/25 at 1:50 P.M., Activity Assistant (AA) #270 stated she was working at the time of elopement and was notified by LPN #349 that Resident #46 was missing. Resident #46 went out on a smoke break with CNA #501. CNA #501 then left Resident #46 at the elevator. Resident #46 walked out the front door. She confirmed the time the nurse notified her of the missing resident was 12:37 P.M. and by watching camera footage the facility was able to confirm the resident left out of the front door on 07/05/25 at 11:22 A.M. During an interview on 12/31/25 at 2:20 P.M., LPN #244 stated Resident #46 was taken on a smoke break at 11:15 A.M. by CNA #501. She stated memory care residents have their own nursing assistant to escort them to smoking breaks so they can be supervised. She confirmed Resident #46 was left in the lobby by CNA #501. Resident #46 went out the front door at 11:22 A.M. She stated Resident #46 was alert and oriented with confusion at times and was able to ambulate with a walker with staff assist. LPN #244 verified after Resident #46 eloped, education was provided immediately and again at the monthly staff meeting. During an interview on 01/06/26 at 8:17 A.M., LPN #349 stated she was unsure what time CNA #501 took residents out to smoke. She stated CNA #501 was aware that she had to stay with all the memory care residents the whole time. LPN #349 stated when residents returned to the unit, Resident #46 was not accounted for and she announced a missing resident code via Signal (an internal message center for facility staff). LPN #349 stated she also called the resident's responsible party and Hospital #700 and notified the DON, all administration and manager on duty and began searching for the resident. During an interview on 01/06/26 at 12:38 P.M., RDO #602 stated Resident #46 eloped on 07/05/25 at 11:22 A.M. via the front entrance of the facility. This was confirmed by video footage from facility cameras, and the facility completed an investigation and timeline of events. The camera footage was requested. RDO #602 stated the cameras had been stolen and the facility did not have the footage for review. On 01/07/26 at 7:02 A.M. two attempts were made to CNA #501 without success. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/07/26 at 3:15 P.M., HRD #313 stated CNA #501 was trained on the elopement policy, smoking policy and dementia care upon hire. HRD #313 also confirmed she received education for elopement on 07/05/25 and was terminated for job abandonment. During an interview on 01/12/26 at 10:27 A.M., Nurse Practitioner (NP) #705 stated Resident # 46 eloped from the facility on 07/05/25 and physician's call service was notified per protocol. NP #705 stated she had a follow-up visit on 07/08/25 and had no concerns. Medical Director (MD) #710 stated he was notified of Resident #46's elopement and the resident was treated at the hospital for falls and NSTEMI. 2.Review of Resident #159's medical record revealed the resident was admitted to the facility on [DATE] with pertinent diagnoses including: aphasia following cerebral infarction, chronic obstructive pulmonary disease and heart failure. Review of Resident#159's Elopement Review form dated 12/17/25 for Resident #159 revealed she was assessed to be disoriented at all times and assessed to be high risk for elopement due to her being a new admission in a new room and should be monitored. Review of the facility interim care plan dated 12/17/25 revealed Resident #159 was noted to have cognitive and visual impairment, and Resident #159 would not be able to easily communicate with staff. This document also noted she was assessed to be able to smoke with supervision. The care plan was updated on 12/21/25 to include Resident #159 having an activities of daily living (ADL) self-care performance deficit due to activity intolerance, impaired balance, limited mobility and stroke. Further review of the medical record revealed Resident #159 did not have a care plan for her identified high risk for elopement. Review of Resident #159's physician orders revealed an order to monitor behaviors including wandering dated 12/17/25. Review of the facility Brief Interview for Mental Status (BIMS) completed 12/20/25 revealed Resident #159 was assessed to be moderately impaired. Review of progress note dated 12/20/25 at 6:45 A.M. revealed the nurse passing the morning medications was notified by another (unnamed) resident that they saw Resident #159 had packed her bags and was seen crossing the streets near the facility parking lot. The nurse charted, they looked around the building and outside the parking lot and did not see Resident #159. They notified the physician and the on-call night nurse. The note stated Resident #159 was her own responsible party and that the daughter was notified. Review of progress note for Resident #159 dated 12/20/25 at 8:49 A.M. revealed the facility units, rooms, bathrooms and surrounding grounds searched for the resident at that time and she was not located. Review of the progress note for Resident #159 dated 12/20/25 at 9:05 A.M. revealed they attempted to call the resident's daughter and they spoke with another family member who said the resident had tried to call in the morning, but he missed the call. The note indicated he was unaware of where the resident was and if she reached back out, he will encourage her to return to the facility to sign AMA paperwork. (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 the progress note for Resident #159 dated 12/20/25 at 5:34 P.M. revealed she returned safely to the facility and was given a head to toe assessment. She was given a drug screen, and it was found to be negative. The author noted they updated the physician and family. Review of Columbus Police Report Preliminary Investigation dated 12/20/25 at 10:38 A.M. revealed the facility said they have video footage of Resident #159 leaving the facility at 3:17 A.M. and that she had not come back. The police report noted they had reviewed the footage themselves. Review of the facility discharge Minimum Data Set (2.0) completed on 12/22/25 revealed Resident #159 was independent for eating, toileting, dressing, hygiene and walking 150 feet. Review of hospital documentation obtained from Hospital #577 revealed Resident #159 was admitted to the hospital on [DATE] and remained at the hospital until 12/17/25. Speech pathology note dated 12/08/25 indicated Resident #159 was oriented to person and place and was not oriented to time or situation. This note also stated her functional limitations included: communication deficits, impaired insight, impaired memory. The note's author indicated that due to her aphasia (ability to speak) her words would only be understood at most 25%-50% of the time. Further review of the hospital record revealed on 12/09/25 Physician #588 met with Resident #159 and determined she did not have medical decision-making capacity and had significant verbal and written aphasia. Interview on 1/26/25 at 2:20 P.M. with the Director of Nursing (DON) revealed Resident #159 was alert and oriented times four and she left the faciity on [DATE] and forgot to sign out. She said the resident left around 7:00 A.M. and returned around 5:30 P.M. She said they were only worried because it was cold outside. She said we were in constant communication with the resident, and she just wanted to finish her shopping. Interview on 01/27/25 at 12:33 P.M. with Licensed Practical Nurse (LPN) #805 revealed he was working the night Resident #159 left the facility. He said she went out several times during the evening to smoke and usually she would tell him and he would send an aide to go with her but the last time she went out she didn't tell him. He said someone had told him that she had left but they didn't say what time it was and he was in the middle of medication pass and it was cold outside. He said he didn't go outside to look for her, but he looked out the windows. He said there are several residents who go outside in the middle of the night to smoke. He said they are supposed to sign out but he doubted they do. Interview on 01/27/26 at 8:53 A.M. with Family Member #533 revealed he had received text message on 12/20/25 at 5:00 A.M. in the morning from Resident #159 when he was sleeping and when he saw it later it made no sense to him. He said she left a voicemail at 5:21 A.M. which also made no sense. He said he texted her back in the morning at 8:14 A.M. and told her he was sleeping. He said he received a phone call from the facility around 9:00 A.M. and he told them about her calling him at 5:21 A.M. and he said the facility stated that was the time the resident left the facility. He said they asked if he had heard from her. He texted her and she called him and they talked for about seven minutes. He said he was trying to find out where she was, but he couldn't understand what she was saying and she sounded confused. He said it was really cold that day and he was worried that she was able to just walk out of the facility in the middle of the night. Interview on 01/27/25 at 9:41 A.M. with family member #522 who said the facility called her on 12/20/25 at around 9:20A.M. or 9:30 A.M. She said she was very surprised that Resident #159 had left so early in the morning and it took them so long to call her. She said she asked them if they had (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	called the police and they hadn't at that time. She said she absolutely did not think Resident #159 was safe to be leaving the facility on her own because you can't understand anything she said. She said she thought the facility should have taken better care of Resident #159 because she can't communicate. She said she didn't think Resident #159 understood what she was doing and the situation was concerning because if Resident #159 needed help she wouldn't have been able to ask for it due to her aphasia. Interview on 01/27/25 at 1:50 P.M. with Family Member #544 revealed she had been called a couple of times regarding Resident #159 having left the facility. She said when Resident #159 was in the hospital, the social worker who was doing the discharge planning had called her several times and had said repeatedly that Resident #159 was not safe to be home by herself. Interview on 01/29/26 at 9:35 A.M. with Missing Persons Detective #566, confirmed they were notified at 10:38 A.M. about Resident #159 leaving the facility unattended. He said when the call came in, the facility had stated Resident #159 had low mental capacity and had a recent stroke. He said they were going to have helicopters and [NAME] looking for her until the officers were on site and found out there was over a seven-hour delay from when Resident #159 left the building and when the police were contacted. He said those measures would not be effective at that point. Review of the weather record from world-weather.info revealed that on 12/20/25 the low temperature in Columbus, Ohio was 21 degrees Fahrenheit and the high temperature was 43 degrees Fahrenheit. Review of the facility policy titled, Elopements, revised December 2007 revealed staff shall investigate and report all cases of missing residents. The policy contained no safety measures or protocols to identify residents at risk for potential elopement. 3. Review of the Columbus Division of Police Preliminary Investigation Report dated 12/01/25 at 2:21 P.M. revealed RN #505 had accidentally discharged a firearm at the facility on 12/01/25 at 3:00 A.M. Per the report, the officer observed a bullet hole in the floor as well as in the wall next to it. The report noted the bullet appeared to have ricocheted off the floor and into the wall of room [ROOM NUMBER]. The report noted management declined to pursue legal action. Interview on 01/06/26 at 12:45 P.M. with RDO #602 it was confirmed a RN #505 entered the facility with a firearm in their coat pocket. RDO #602 revealed RN #505 stated they did not remember the firearm was in his coat pocket when he came to work but prior to getting to his assigned hallway, realized the firearm was in his coat. RN #505 said when he got to his assigned hallway, he hung his coat in the locked medication room to secure it. Then when he took his break, he placed his coat on, put his hand in his pocket and the firearm discharged . RDO #602 stated the staff member did not tell other staff at the time what had happened or what the cause of loud noise and smoke was. It was not until management was made aware and performed an investigation that it was known that a firearm was inside the facility and discharged . Observation on 01/07/26 at 11:32 A.M. of the second floor near the nurses station where, the facility reported the firearm had discharged revealed the holes in the floor and the wall had been repaired. Interview with Resident #94 on 01/07/26 at 11:36 A.M. revealed he had no recollection of the firearm incident. Resident #94 resided in the immediate vicinity of the firearm was discharged . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Resident #74 on 01/07/26 at 11:45 A.M. revealed resident heard the firearm go off but she said she didn't know what the sound was, and stated she found out the next day it was a gun. She said she didn't know anyone who saw it happen. Interview with CNA #381 on 01/07/26 at 1:02 P.M. revealed he didn't see the firearm but heard the sound when it discharged , but did not know what the sound was from at the time. He said he saw RN #505 running up the stairs afterwards and RN #505 had asked him if he had heard the sound. He said there was dust everywhere. He said he did not know of anyone other than RN #505 who was present at the time the firearm discharged . Interview with CNA #323 on 01/22/26 at 5:50 P.M. revealed she was on break when the firearm went off and she heard a loud bang but did not see what happened. She said she saw the hole in the floor and she found bullet casings on the floor. Interview with Licensed Practical Nurse (LPN) #365 on 01/22/26 at 4:55 P.M. revealed she was working that evening in another area of the facility. She did not hear the firearm go off but heard about the incident that evening and saw the damage to the floor. Interview with LPN #805 on 01/26/26 at 10:37 A.M. revealed he heard the sound of the firearm when it discharged but did not see the firearm. Review of personnel file for RN #505 revealed his last day of employment was 12/01/25. Interview on 01/07/26 with Human Resources Manager #313 confirmed RN #505 was terminated on 12/01/25. Review of facility policy titled, Firearms and Other Weapons, revised April 2007 revealed the facility prohibited employees, residents, visitors, vendors or others from possessing firearms or other weapons while in/on facility premises. This deficiency represents non-compliance investigated under Complaint Numbers OH001295678 and OH001295679.

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	01/29/2026

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 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** Based on medical record reviews and interview the facility failed to ensure physician's orders were followed when administering medications. This affected two (Residents # 56 and # 94) of five residents reviewed for medication administration. Facility census was 82.Findings include: 1. Review of Resident # 56's medical record revealed an admission date of 05/01/25 with diagnoses including vertebral fracture (thoracic) T11-T12, vertebral fracture (lumbar) L1, radiculopathy, idiopathic peripheral autonomic neuropathy, low back pain and right shoulder pain, and right rotator cuff repair. Review of Resident # 56's care plans dated 05/15/25 revealed a care plan for chronic pain related to neuropathy, low back pain and thoracic and lumbar fractures; interventions include to administer medications as ordered. Review of Resident # 56's Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 and he required assistance from staff with hygiene, dressing and transfers. Review of Resident # 56's physician's orders dated December 2025 revealed the following orders: Aspercreme Lidocaine Patch 4% (Lidocaine), apply to posterior right shoulder topically one time a day for pain, one patch and remove per schedule; Percocet (opioid) Oral Tablet 7.5-325 mg (milligrams), give one tablet by mouth every six hours as needed for pain. Further review revealed the order for Percocet started on 12/23/25 and ended on 12/29/25. Review of Resident # 56's prescription from Orthopedic Surgeons dated 12/23/25 revealed order and instructions for Percocet 7.5-325 mg per tablet, take one tablet by mouth every six hours as needed for pain (Days supply per fill: 10). Review of Resident # 56's Medication Administration Record (MAR) for December 2025 revealed Percocet 7.5-325 mg was administered daily from 12/24/25 to 12/29/25. Review of Resident # 56's progress notes dated 12/29/25 revealed DON received orders from NP # 705 to discontinue Percocet 7.5-325 mg. Review of Resident # 56's Percocet 7.5-325 mg individual patient-controlled substance administration record dated 12/24/25, revealed the medication was administered at least daily from 12/24/25 to 12/30/25. Interview on 12/31/25 at 8:39 A.M. with Resident # 56 revealed he received a prescription on 12/23/25 from the Orthopedic Surgeon for Percocet for 10 days for his shoulder. He confirmed he received the medication as requested until 12/31/25 when RN # 256 stated his order was discontinued. Interview on 12/31/25 at 8:45 A.M. with RN # 256 confirmed the order for Percocet 7.5-325 mg was discontinued on 12/29/25. Interview on 12/31/25 at 9:15 A.M. with DON revealed the resident had multiple narcotic medication changes handled by Orthopedic provider since his recent shoulder surgery. Stated NP # 705 reviewed orders and on 12/29/25 ordered to discontinue current Percocet due to resident's drug seeking history. Interview on 12/31/25 at 9:20 A.M. DON verified Resident # 56 received Percocet 7.5-325 mg until 12/30/25 with no physician's order. 2. Review of Resident # 94's medical record revealed he was admitted on [DATE] with diagnoses including insomnia, epilepsy, schizophrenia, anxiety and senile degeneration of the brain. Review of Resident # 94's Minimum Data Set (MDS) dated [DATE] revealed he was cognitively impaired with a Brief Interview for Mental Status (BIMS) of 4. He required assistance from staff with hygiene, dressing and transfers. Review of Resident # 94's progress notes dated 08/01/25 revealed resident was sent out to hospital # 700 for evaluation due to a medication error of resident receiving excessive dose of Melatonin. Review of Resident # 94's hospital emergency department (ED) note dated 08/01/25 revealed resident was evaluated for drug overdose after he was accidentally administered approximately 22 mg (milligrams) of Melatonin at the facility. Further review revealed MD noted Melatonin was not expected to cause concern based on his discussion with the poison center, stated resident was asymptomatic and he returned the facility on 08/01/25 with no orders. Review of Resident # 94's Physician's Orders dated 07/15/25 to (continued on next page)

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	366207	A. Building B. Wing	01/29/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/13/25 revealed no orders for the medication Melatonin. Interview on 01/08/26 at 12:20 P.M. with DON confirmed Resident # 94 was sent to the hospital after nurse administered approximately seven, melatonin three mg. Stated resident was at the hospital for a few hours for observation and was sent back to the facility with no new orders. Review of policy titled Administering Medications dated December 2012 revealed medications must be administered in accordance with the orders, including any required time frame, the individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones and the individual administering the medication must check the label three times to verify the right resident, right medication, right dose, right time and right route of administration before giving the medication.

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	366207	A. Building B. Wing	01/29/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview and staff interview, the facility failed to ensure a safe, sanitary and home-like environment. This had the potential to affect all 85 residents in the facility. Facility census was 85.Findings include:1. Observation on 12/30/25 at 12:37 P.M. of the third-floor dining cart revealed it was held together with duct tape along the edges and meals were being dispersed in polystyrene foam (disposable) containers and residents were eating with plastic utensils.Interview on 12/31/25 at 8:59 A.M. with Resident #88 shared that it was difficult to cut food with a plastic fork on the disposable containers.Interview on 01/06/26 at 9:53 A.M. with Resident #76 noted he was tired of eating on disposable plates.Interview on 01/08/26 at 8:39 A.M. with Dietary Supervisor #238 confirmed they had been using disposable plates because the boiler was being repaired.2. Observation on 12/31/25 at 9:30 A.M. in the hallway of the memory care unit revealed an approximately four foot by four foot area where the ceiling tiles were missing. Interview on 12/31/25 at 9:34 A.M. with Maintenance Director #258 confirmed the ceiling had collapsed and the area was missing the tiles. He said he would fix it when he could be he had to prioritize fixing the heater first.3. Observations on 12/30/25 between 12:10 P.M. and 1:15 P.M. revealed the following:a. In the main elevator on all three sides, there were extensive scratches on the wood railing and on the painted wall area below. The painted area had gouges missing as well. There was a grid ceiling and there was extensive dust collected on the grid.b. The hallway to the left of the lobby had extensive scuffing along the wall below the railing.c. By the vending machine, there was ceiling tile missing above it and it appeared that the ceiling had fell next to the vending machine. In the center of the room by the post, three ceiling tiles had brownish water stains and the tiles were ripped. The floors were extensively scuffed and dirty.d. On the first floor in the bathroom, off of the dining room, revealed an out of order sign, indicating that the bathroom was not working. On the second floor the bathroom door across from room [ROOM NUMBER] had an out of order sign, indicating that the bathroom was not working, and the door had streaks several inches long where the wood was marred. On the third floor, the bathroom outside room [ROOM NUMBER] had an out of order sign, indicating that the bathroom was not working. e. Next to the elevator on the third floor, outside of the nursing station there were extensive scuff marks on the paint below the railing and missing wood and paint around the bottom of the blue pillars by the station.f. Across from room [ROOM NUMBER], the bottom of the post and the area under the railing was extensively scuffed and missing paint.g. Observation and interview on 01/05/26 at 9:27 A.M. with Resident #87 in room [ROOM NUMBER] confirmed that she only had a desk in her room and no dresser and that her sink was draining slowly.h. Observations on 01/07/26 between 8:57 A.M. and 9:15 A.M. revealed: In the second-floor shower room above the showerhead area, a ceiling tile appeared to be crumbling and the empty area above was exposed.In the second-floor hallway there was a pile of wet blankets on the floor up against the wall and a yellow caution sign.On the first floor in the chapel room, there was a pile of wet blankets, a bucket, a yellow caution sign and an active water leak from a burst pipe.Interview on 01/07/26 at 9:25 A.M. with the [NAME] President of Plant Operations #511 stated the building had very old cast iron pipes and they were only able to fix them as they broke. He said there was no way to proactively fix them because they were behind drywall. He confirmed the ceiling was crumbling in the second floor bathroom and said the pipes linked through all three floors and that there was a different pipe that just broke above where the towels were.i. Observation on 01/07/26 at 11:26 A.M. of the back elevator (across from room [ROOM NUMBER]) had out of order sign on it, indicating it was not in working order. Observation on 01/22/26 at 12:35 P.M. There was (continued on next page)

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	366207	A. Building B. Wing	01/29/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	still an out of order sign on the back elevator.j. Observation and interview on 01/07/26 at 11:45 A.M. with Resident #74 in room [ROOM NUMBER] confirmed the door to her room was swollen and it took considerable effort to open it. She said the door had been like that for a while and she had told multiple staff members about it. Her sink also wasn't draining and the lamination around the edge of the sink was loose.k. Observation and interview on 01/07/26 at 2:12 P.M. with Resident #56 in room [ROOM NUMBER] revealed the resident demonstrated that the foot of his bed would not raise up and the headboard was detached. There was a telephone outlet dangling from the wall with exposed wires. The resident said that he had told maintenance about the bed previously and it was not fixed.On 01/08/26 between 4:30 P.M. and 5:00 P.M., the Maintenance Director #258 and the Regional Director of Culinary Operations #515 toured the above areas and verified the described areas had not been maintained. Maintenance Manager #258 said the bathrooms on the three floors were out of order because of a previously burst pipe. He also confirmed the back elevator was now out of order because someone had damaged the panel on the third floor. 4. Observations on 01/12/26 between 10:23 A.M. and 5:10 P.M. revealed the following: a. Resident #41's room [ROOM NUMBER] had a rusty sink bowl and drain.b. Resident #45's room [ROOM NUMBER] with all lights on, was very dim.c. Resident #46 was in room [ROOM NUMBER]. The sink was rusted, the baseboard cover under the sink was missing and the wall under the sink was crumbling. There was what appeared to be food substance on the wall by the bed.d. Resident #48 was not in their room [ROOM NUMBER], however, the sink was observed to be rusted around the drain and the bowl was missing laminate.e. room [ROOM NUMBER] where Resident #49 resided, had very loose grab bars by the toilet, rust around the base of the plumbing, and a rusted sink.f. room [ROOM NUMBER] where Resident #50 resided had extensive wall damage around the sink in the room.g room [ROOM NUMBER] where Resident #51 resided had long gashes in the door to his room. h. room [ROOM NUMBER] had a side bar on the wall next to the bed that was falling off and a rusted sink.i. room [ROOM NUMBER] had a side bar on the wall next to the bed that was falling off, a rusted sink, and in the corner behind the sink there was exposed cable and apparent water damage with dark staining potentially resembling mold. There was also a chip in the tile flooring.j. room [ROOM NUMBER] had rusty sink.k. room [ROOM NUMBER] had grime build up on the floor around the bottom of the trash can.l. room [ROOM NUMBER] had rust on the sink, a chipped bedside table, and missing paint on the wall.m. The bedside table in room [ROOM NUMBER] was old and in disrepair, and there was an apparent water stain across the length of the ceiling.n. Observation and interview on 01/12/26 at 3:17 P.M. with Resident #32 who was laying in bed in room [ROOM NUMBER] revealed the call light was pulled out from the wall. When asked how she got assistance, Resident #32 said she had to yell out. She also had missing drywall around her sink area, her bedside table was old and in disrepair, and her front door was marred. Interview on 01/12/26 at 3:23 P.M. with Unit Manager #262 revealed she was unaware the call light was broken [for room [ROOM NUMBER]] and that she would put in a work order request.o. Observation and interview on 01/12/26 at 3:25 P.M. with Resident #35 in his room [ROOM NUMBER] revealed the wall around the sink was missing drywall and under the sink there was no baseboard and a crack in the wall. The bedside table was old and in disrepair. Resident #35 said a wingnut fell off the table and he told a staff member about it for repair and he felt they blew him off. He said the wall and the area under the sink bothered him.p. Observation and interview on 01/12/26 at 3:36 P.M. with Resident #36 in room [ROOM NUMBER] revealed Resident #36 shared that he didn't like the marred corner area by the sink or the marks on the wall by the footboard and he noted the wall area by the headboard needed touched up. His sink also had rust around the drain.q. room [ROOM NUMBER] had a bar on the wall next to the bed that was falling off, the laminate on the edge of the sink was worn off, and the door to the bathroom (continued on next page)

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	366207	A. Building B. Wing	01/29/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wouldn't close.r. Observation and interview on 01/12/26 at 4:28 P.M. with Resident #81 in room [ROOM NUMBER] revealed Resident #81 said when he turned his sink on, water came out on the floor. This was verified in the moment as well as the entire sink and cabinet were not attached to the wall and a light touch would tilt it forward.s. room [ROOM NUMBER] had missing laminate around the edge of the sink and rust in the sink. The light over the sink was missing the cover and just a light bulb was exposed.t. The hallway across from room [ROOM NUMBER] had chunks of the wall and paint missing on two corners.u. room [ROOM NUMBER] had a chip in the floor tile in the front of the room, near the door, that was approximately a half an inch by an inch.v. Observation and interview on 01/12/26 at 4:52 P.M. with Resident #11 in room [ROOM NUMBER] revealed Resident #11 confirmed the room felt dim to him and he would like more light for the evenings.w. Observation and interview on 01/12/26 at 5:00 P.M. with Resident #12 in room [ROOM NUMBER] confirmed her wardrobe drawers were stuck together, and she wasn't able to open one without both opening. She also said it would be helpful to have the top sliding door on her wardrobe. Additionally, the lights were all on and it was still very dim.x. room [ROOM NUMBER] had damaged laminate around the sink, torn paint on the wall near the entrance, water damage on the ceiling on the back right corner, and holes in the wall outside the room from where an apparent soap dispenser was removed. y. Observation and interview on 01/12/26 at 5:10 P.M. with Resident #16 in room [ROOM NUMBER] revealed he would like more light. He had all the lights on in the room and it was still very dim.On 01/13/26 between 10:12 P.M. and 11:28 A.M. the Maintenance Director #258, the Regional Maintenance Director #605 and the Regional [NAME] President of Plant Operations #511 toured the areas mentioned and verified the described areas had not been maintained.5. Observations on 01/13/26 between 9:04 A.M. and 9:24 A.M. revealed the following:a. Observation and interview on 01/13/26 at 9:04 A.M. with Resident #18 in room [ROOM NUMBER] revealed a very loose handrail by the toilet and rust near the pipe. Resident #18 confirmed he did use that bathroom. The sink was missing enamel, and the edge of the sink was sharp. There was exposed dry wall on the corner by the sink, the wall was missing paint, and the drywall was ripped in the back area. There were stains on the ceiling right above the head of the bed and Resident #18 said they were unsettling because he didn't know what they were. The light above the sink was also missing the cover.b. Observation and interview on 01/13/26 at 9:24 A.M with Resident #22 who was in bed in room [ROOM NUMBER] revealed the sink did not have hot water. The wall around the sink had a two-inch strip around the side and the back of the sink that was unpainted. The resident wasn't sure why they didn't have a chair in the room anymore either, but they wanted one.c. room [ROOM NUMBER] was missing drywall on the corner by the sink and the trim was loose. There was paint missing across the length of the bed. The front door had significant scuff marks.d. In the common area outside of room [ROOM NUMBER], there were chunks of wall missing by the bookcase, the hallway railing was marred for the length of the railing and spots of paint were missing on the wall. On 01/13/26 between 10:12 P.M. and 11:28 A.M. the Maintenance Director #258, the Regional Maintenance Director #605 and the Regional [NAME] President of Plant Operations #511 toured the areas mentioned and verified the described areas had not been maintained.6. Observations on 12/30/25 at 12:10 P.M. in the front lobby and hallway areas, there was approximately two inches of dark grime along the edge of the flooring by the walls in the main lobby and hallway by the elevator to the resident's rooms. This grime was observed to be present on the floor each day until 01/12/26 09:58 A.M. when the housekeeper was observed to be scraping the floor.Interview on 01/12/26 at 9:58 A.M. with Housekeeper #232 confirmed the grime along the edge of the floor in the lobby and adjacent hallways. He said it was buildup of wax accumulation and that it hadn't been there long.7. Observation and interview on 01/12/26 at 10:10 A.M. of the shower room in the memory care area (continued on next page)

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	366207	A. Building B. Wing	01/29/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	revealed there was an approximately two foot by 5 inch area on the wall with white paint in the corner of a tan wall and an overhead fan covered in dust. Certified Nursing Assistant #337 verified both. She said she didn't know who was responsible for cleaning the fan dust.Observation and interview on 01/13/26 at 9:40 A.M. in shower room on the third floor revealed there were five wet towels piled on the floor in the shower area. Certified Nursing Assistant (CNA) #248 confirmed the towels were there. She said a resident must have taken a shower overnight. She said the staff normally would remove them if they were told about them.Observation and interview on 01/22/26 at 1:05 P.M. in the shower room on the third floor there was a pile of wet towels in the room. Certified Nursing Assistant (CNA) #248 confirmed the towels were there. She said she didn't know who was covering the area.These deficiencies represent non-compliance investigated under Master Complaint Number 2699666, 2591930, 1295681, and 1295679.

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	366207	A. Building B. Wing	01/29/2026

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of work orders, the facility failed to maintain an environment free from a pest's infestation. This had potential to affect all 82 residents.Findings include:Observation on 12/30/25 at 12:26 P.M. in the first-floor dining room of multiple dead insects (a variety of insects including insects that resembled spiders and cockroaches (roaches)) along the walls near the windows.Interview on 12/31/25 at 8:59 A.M. with Resident #88 who said the roaches aren't living with us, we are living with them. She said they put roach traps around and are trying to [eradicate the cockroaches]. She said the roaches come out when the housekeeper mops. She said she sees the roaches climbing up the walls and she has fears they will fall down on her.Interview on 12/31/25 at 9:34 A.M. with Maintenance Director #258 revealed they had an issue with cockroaches, but he felt it was getting better. He said they switched [pest] companies three months ago and now he no longer had cockroaches running across his desk.Observation on 12/31/25 at 9:35 A.M. of the second-floor common area revealed multiple dead insects (a variety of insects including insects that resembled spiders and cockroaches (roaches)) on the windowsill by the entrance to memory care. Interview on 01/05/26 at 9:27 A.M. with Resident #87 revealed she saw the cockroaches in her room and in the hallways and she saw them come out of the kitchen. She said she was killing half a dozen a day. She said it had slowed down some, but she wished they would have fumigated the whole place.Interview on 01/05/26 at 7:22 A.M. with Resident #56 revealed he would have one or two cockroaches in his room but mostly he saw them in the hallways.Interview on 01/05/26 at 2:48 P.M. with Resident #90 revealed she felt the insect issues were bad, but they had gotten better.Interview on 01/05/26 at 4:10 P.M. with Regional Maintenance Director #605 revealed the resident in room [ROOM NUMBER] was a hoarder. He said when the resident was away from his room, they went in to get rid of the trash including empty shampoo bottles and empty grocery bags and he said they found a cockroach infestation in there and brought the exterminators in on this day for that room. He said they were German cockroaches.Observation and interview on 01/06/26 at 10:36 A.M. revealed a cockroach crawling up the wall in the third-floor shower room. Regional Maintenance Director #605 was present and confirmed that it was a German cockroach.Interview on 01/07/26 at 11:45 A.M. with Resident #74 revealed she didn't have too many bug issues where she was on the third floor. She said on the first and second floors they [cockroaches] were everywhere.Observation and interview on 01/08/25 at 8:29 A.M. revealed two cockroach traps in the kitchen by the door. Dietary Supervisor #238 said they had issues with cockroaches, but he felt it had gotten better.Interview on 01/12/26 at 10:36 A.M. with Resident #50 revealed she didn't want housekeeping to come in her room because she believed they brought the insects in with their mops.Interview on 01/12/26 at 2:39 P.M. with Resident #27 revealed the place was roached out. He elaborated and stated they were everywhere and they came out at night. He noted he saw one two days ago. Interview on 01/12/26 at 3:04 P.M. with Resident #268 revealed she saw roaches come out from under her bed.Interview on 01/12/26 at 3:25 P.M. with Resident #35 revealed his biggest complaint was the cockroaches because they were repulsive.Observation on 01/13/26 at 11:07 A.M. revealed the exterminator approaching maintenance managers and asking them where he should focus.Review of pest control work orders dated 09/09/25, 09/29/25, 10/06/25, 10/17/25, 10/22/25, 10/29/25, 12/08/25, 12/16/25 and 01/05/26 revealed they were treating both individual rooms and common areas and the primary issue and focus on the visits were the eradication of cockroaches. This deficiency represents non-compliance investigated under Master Complaint Number 2699666, 2593662, 2591930, 1295681, and 1295679.