STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366207	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and medical record review, the facility failed to provide Resident #1 with a care plan for his post surgical wounds. This affected one (Resident #1) out of three residents reviewed for wound care. The facility census was 46 residents. Findings include: Review of the closed medical record for Resident #1 revealed he was admitted to the facility from the hospital on [DATE]. [DIAGNOSES REDACTED]. Resident #1 was discharged from the facility and sent to the hospital on [DATE]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact. His functional status was listed as extensive one person assist for transferring and toileting and all other activities of daily living were listed as one person supervision. Review of the care plan dated 06/15/2020 revealed the facility did not have a care plan addressing post-surgical wound care. Interview with the Administrator on 08/05/2020 at 4:00 P.M. confirmed the facility did not address Resident #1's care of his post-surgical wounds in his care plan. Review of the policy titled, Care Planning dated December 2016 revealed the facility did not implement a plan of care for post-surgical wound care. This deficiency substantiates Complaint Number OH 576.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital documentation, physician interview, and staff interview, the facility failed to implement hospital transfer orders, arrange for follow-up care, and provide timely care/services for Resident #1's post-operative surgical wounds. This affected one (Resident #1) of three residents reviewed for wound care. Facility census was 46 residents. Findings include: Review of the closed medical record for Resident #1 revealed he was admitted to the facility from an out of state hospital on [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #1 was cognitively intact. His functional status was listed as extensive one person assist for transferring and toileting, and all other activities of daily living were listed as one person supervision. Review of the care plan dated 06/15/2020 revealed the facility did not have a care plan addressing surgical wound care. Review of the discharge paperwork from the out of state hospital, dated 06/05/2020, revealed to keep Resident #1's dressings clean, dry, and intact. Do not remove the dressings. Resident #1 was to be non-weight bearing to bilateral lower extremities. Physical therapy was indicated for range of motion exercises and transfers. Follow-up appointment was to be in two weeks. Review of the facility physician orders [REDACTED]. Physician orders [REDACTED]. Review of the progress notes dated 06/05/2020 through 07/29/2020 revealed no documentation for management of care of the surgical wounds or follow-up care as directed in the discharge paperwork from the hospital. Review of the facility Physician #30's note dated 06/24/2020 revealed Resident #1's exam of his musculoskeletal system was right lower extremity in splint, able to slowly wiggle toes; left foot with orthotic. Review of the Nurse Practitioner (NP) #10's daily progress note dated 07/29/2020 revealed staff asked NP #10 to evaluate Resident #1 due to inability to obtain trauma unit or ortho follow-up. Resident discussed traumatic motor vehicle crash in May 2020 out of state. Resident reports having surgery to the left hip right ankle and left wrist and was an inpatient hospitalized for [REDACTED]. He has not yet followed-up with orthopedics or trauma since his hospitalization in May. He continues with orders that include non-weight bearing to left upper extremity (LUE), and bilateral lower extremities (BLE). He reports pain to left wrist and right ankle. Splints remain in place, and he said he has not had splints removed, changed and surgical sites have not been recently evaluated. The resident denied any fevers, increased swelling, or other acute issues or concerns. Exam: Musculoskeletal: right lower extremity (RLE) in splint - able to slowly wiggle toes, left wrist splint, removed complex laceration with significant crusting and scabbing evident, dried peeling skin. Sutures remain in place, appear imbedded to some degree. Attempted to remove RLE splint, unable to remove due to adhesion of webroll dressing that is placed beneath sugartong splint. Notable dried crusted drainage to dressing surrounding right ankle. Review of the hospital emergency room (ER) report dated 07/29/2020 revealed the resident was sent to the ER from the facility due to the dilapidated and crumbling splints on his extremities, which had not been evaluated in several months. Resident was essentially lost to follow-up. Pertinent Exam: in no acute distress. He has crumbling splints on the left wrist with a healing postsurgical scar, with skin flaking and suture material flaking off the aspect of the wrist. There were zip tie dressing on the anterior and medial right lower leg noted after the splint was removed at the bedside. There was no appreciable blanching [DIAGNOSES REDACTED]. The resident had intact motor function and sensation of the bilateral lower legs and arms. Interview with the Administrator on 08/03/2020 at 12:30 P.M. revealed Resident #1 needed a referral to the area hospital trauma center before he could be seen. Staff attempted (several times) to reach the out of state hospital medical records and could not get them to pick up the phone. The Administrator revealed she had two different Director of Nurses (DON) and two Assistant (ADON) during Resident #1's stay. She revealed DON #2 attempted to call the out of state hospital and could not reach anyone also. The ADON #2 on 07/29/2020 reached out to the NP #10 concerning a referral and that was when the NP sent Resident #1 to the area hospital emergency room . Interview with ADON #2 on 08/04/2020 at 11:28 A.M. revealed no appointments had been scheduled for Resident #1 regarding a orthopedic consult or follow-up. Procedures were that the nurse that accepted the resident would make the appointments. ADON #2 revealed she just thinks it got missed. She revealed she had only been employed about three weeks when she noticed Resident #1 did not have a follow-up appointment. She revealed she couldn't get a referral from the previous hospital, so she reached out to the NP #10 for a referral. Interview with Resident #1 on 08/04/2020 at 5:00 P.M. revealed he was being transferred to an area hospital's extended therapy unit. He revealed he knew ADON #2 was not having any luck with getting in touch with the out of state hospital, so he tried to reach them but had the same outcome. Resident #1 said he felt the lack of staff was the reason it he didn't receive his appointment. He stated they was just not enough staff and the administration is working the floor and forgetting to make these appointment. Interview with NP #10 on 08/04/2020 at 6:03 P.M. revealed ADON #2 had asked for a referral for Resident #1 on 07/29/2020. She revealed this was the first time she had seen Resident #1. NP #10 revealed she was unable to remove Resident #1's dressings due to dry and crusted scabbing. She revealed his dressings had been on since admission to the facility and he had splints on his right ankle. She also revealed there were two external pins which came out when she tried to remove the dressing on his arm. She then decided to send Resident #1 out to the area hospital to expedite the procedure for him to see an orthopedist. She also revealed a lot of scabbing and crusting to the sutures and the sutures were imbedded into his skin. Interview with the hospital physician on 08/04/20 at 6:15 P.M. revealed Resident #1 was seen in the area hospital's emergency roiagnom on

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

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) [DATE]. She said Resident #1 had been in an accident approximately 12 weeks ago with multiple orthopedic surgeries performed eight to 12 weeks ago before being discharged to the facility. She said the facility did not complete dressing changes, there was no medical management of the resident's orthopedic injuries, and no attempt at coordination of care for follow-up with either our orthopedic department or his original surgeon. Resident #1 had his splints and dressings on for a full eight weeks without anyone assessing the wounds. Resident #1 even said that his splints got completely soaked (sopping wet) and they were not changed or removed at all, which is a risk for infection and skin irritation. Resident #1 had severe contractures of his right ankle and left wrist. There was no attempt at removing the patient's sutures which had overgrown with skin. He had retained pins in his left wrist that have a high risk of infection if they do not receive proper wound care. The only reason they were discovered was they fell out when his dressing fell off. The hospital physician said Resident #1's joints were extremely stiff, and she was watching Resident #1's blood markers for possible infection. Resident #1 was still non-weight bearing for another two weeks but was receiving therapy at this time. Review of the policy titled Policy and Procedures for Long Term Care of Skin and Wound Management dated 07/2017, revealed the facility did not follow their policy for wound monitoring. The policy states: I. During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds. 2. The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. a. Healing may be delayed or may not occur, or additional ulcers may occur because of other factors which cannot be modified. b. It may be appropriate to maintain some or all the existing approaches, if they are pertinent to the resident's medical conditions, other relevant factors influencing wound development or healing, and specific treatment choices made by the resident or a substitute decision-maker. This deficiency substantiates Complaint Number OH 576.