

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Continuing Healthcare of Gahanna		STREET ADDRESS, CITY, STATE, ZIP CODE 167 North Stygler Road Gahanna, OH 43230	

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 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47985</p> <p>Based on record review, interview, and policy review, the facility failed to ensure resident discharge needs were met. This affected two residents (#22 and #33) of four residents reviewed for discharge planning. The facility census was 83.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction, hypertension, and unspecified injury of head. Resident #22 was discharged from the facility on 12/19/24 to home.</p> <p>Review of a care plan dated 11/04/24 revealed no evidence of discharge goals for Resident #22.</p> <p>Review of a minimum data set (MDS) dated [DATE] revealed Resident #22's cognition remained intact.</p> <p>Review of an order dated 12/18/24 revealed Resident #22 was to discharge home with his family on 12/19/24 with physical therapy, occupational therapy, and skilled services.</p> <p>Review of a Discharge Summary and Instructions assessment dated [DATE] revealed Resident #22 would receive home health services for a nurse, physical therapy, and occupational therapy, and was ordered a wheelchair.</p> <p>Review of a progress note entered on 01/02/25 by Social Services Designee (SSD) #101 revealed Resident #22's mother called and informed SSD #101 the resident had not yet received in home services for therapy. SSD #101's note stated she wished she was made aware so she could have followed up and the facility sent the resident home with a wheelchair and home therapies.</p> <p>Review of a note entered on 01/17/25 and backdated for 01/02/25 by SSD #101 revealed she attempted to reach out to Resident #22 to correct any concerns and left a voicemail.</p> <p>Review of a note entered on 01/17/25 and backdated for 01/03/25 revealed Resident #22 returned to the facility to return the wheelchair he borrowed upon discharge and collected the new wheelchair which had been ordered for him. SSD #101 asked if he had any concerns and Resident #22 reported no concerns.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/17/25 at 12:19 P.M. with Durable Medical Equipment Provider #205 revealed the order for the wheelchair for Resident #22 was received on 12/23/24 and the wheelchair was delivered to the facility on [DATE].</p> <p>Interview on 01/17/25 at 12:22 P.M. with Resident #22 revealed he felt he needed a brace for his leg which was not ordered upon discharge, he had just recently received the wheelchair he was supposed to have at discharge, and he still did not receive therapy services or nursing services at home. Resident #22 stated he was having falls at home and now he has to schedule outpatient therapy but the therapy won't start until 02/12/25.</p> <p>Interview on 01/17/25 at 12:59 P.M. with Director of Rehabilitation (DOR) #104 and Physical Therapy Assistant (PTA) #107 revealed Resident #22 was only recommended to have a wheelchair and in home therapy services upon discharge. PTA #107 stated at this time, the leg brace would not have been beneficial to Resident #22 but was something he could look into in the future once he had progressed more in therapy services.</p> <p>Interview on 01/17/25 at 1:16 P.M. with SSD #101 revealed as soon as she receives a discharge date from therapy, insurance, or the resident, she should begin ordering recommended items for residents who are discharging. SSD #101 stated she does fax or email home health referrals and she tries to follow up to check the status of the referral. When ordering durable medical equipment (DME) for discharges, the company she uses fluctuates in dependency by either delivering within two days or up to two weeks. SSD #101 stated for Resident #22, he was sent home with a facility wheelchair until the chair ordered for him arrived to the facility. Resident #22 was set up for home health, but SSD #101 did not find out until after Resident #22's discharge he was not accepted due to insurance. She stated she sent two more referrals, one which was declined due to an issue with primary care doctor, and the other was unable to reach the resident to initiate services. SSD #101 provided information on who the initial home health referral was sent to.</p> <p>Interview on 01/17/25 at 2:35 P.M. with the Director of Nursing (DON) and Administrator confirmed two notes were entered at the time of the survey and backdated to an earlier date and there was no evidence of care planning for discharge planning. A copy of a soft file was presented and had an email from a company which triages the ordering of DME then send to a DME company best suited for the request showing the wheelchair for Resident #22 was requested on 12/18/24. When informed the DME company which delivered the wheelchair did not receive the order until 12/23/24 and the SSD was aware of concerns, Administrator stated if he had been made aware, they would already be in the process of finding a new provider. The DON confirmed the lack of follow up with home health companies to ensure referrals are accepted prior to a resident discharge.</p> <p>Interview on 01/17/25 at 2:50 P.M. with Home Health Representative (HHR) #201 revealed they were not able to accept the referral for Resident #22 due to an insurance issue. HHR #201 stated the referral for Resident #22 was not received until 12/31/24 and he let the facility know the same day the referral was declined.</p> <p>2. Record review revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including history of falling, type II diabetes, and chronic obstructive pulmonary disease. Resident #33 discharged from the facility on 11/24/24 to home.</p> <p>Review of a care plan dated 10/23/24 revealed no evidence of discharge planning for Resident #33.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an order dated 11/26/24 revealed Resident #33 was to discharge home with physical therapy, occupational therapy, a nursing aide, and nursing services.</p> <p>Review of an MDS completed on 11/25/24 revealed Resident #33's cognition remained intact.</p> <p>Review of a nursing note dated 11/24/24 by Registered Nurse (RN) #220 revealed Resident #33 discharged home.</p> <p>There were no additional progress notes detailing information regarding Resident #33's discharge to home.</p> <p>Review of an incomplete Discharge Summary and Instructions assessment dated [DATE] revealed nursing did not review their section or the medication list and sign the assessment. The incomplete assessment was signed by Resident #33 prior to discharge.</p> <p>Interview on 01/17/25 at 2:35 P.M. with the DON confirmed there were no notes or care plans pertaining to discharge of Resident #33, and the discharge assessment was incomplete.</p> <p>Review of an undated policy titled Discharge/Transfer revealed discharge planning will commence upon admission and be updated throughout the resident's stay, a comprehensive discharge plan will be developed collaboratively with the resident, their family or legal representative, the attending physician, and other relevant healthcare providers, addressing post-discharge care needs including medical care, medications, equipment, and community resources. For planned discharges, the facility will obtain orders from the physician and the Social Services Designee will coordinate the resident's discharge, ensuring the physician orders are following, including arranging home health services, setting up DME, and providing instructions for follow-up appointments, and the discharge summary/instructions will be documented in the electronic health record.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161395.</p>