

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/25/2025
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interviews and facility policy review, the facility failed to honor one resident's preference of no male caregivers. This affected one resident (#17) of three residents reviewed for resident rights. The facility census was 83. Findings Include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the resident's medical record revealed no plan of care addressing the resident's preference of no male caregivers. Review of the resident's psychiatric note dated 01/28/25 revealed the resident was physically abused by her ex-husband and had trust issues. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. On 08/19/25 at 10:48 A.M., an observation of the resident's room during morning medication administration revealed a sign behind the resident's bed indicating she preferred to have no male caregivers. On 08/20/25 at 9:00 A.M. interview with Resident #17 revealed she preferred no male caregivers due to past physical and sexual abuse. The resident revealed the facility was aware of the preference however continued to assign the male Licensed Practical Nurse (LPN) #116 to the resident's room assignment. On 08/20/25 at 12:34 P.M., interview with LPN #116 revealed usual assignment consisted of Resident #17's care. The LPN revealed he was aware the resident preferred no male caregivers. On 08/20/25 at 10:52 A.M., interview with the Director of Nursing (DON) verified she was aware of the resident's preference of no male caregivers. The DON revealed she was unaware the sign specified aides and nurses. Review of the facility policy titled, Resident Rights, dated 04/24 revealed the facility protects and promotes the rights of each resident. The facility staff will uphold the resident's dignity and individuality providing care that fosters their quality of life in a respectful environment. This deficiency is a recite to the complaint and annual survey completed on 03/12/25. This deficiency represents non-compliance investigated under Complaint Number 2597120 and Complaint Number 2595339.		

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to ensure one resident's bed was bariatric in size. This affected one resident (#17) of three residents reviewed for resident rights. The facility census was 83. Findings Include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. On 08/19/25 at 9:00 A.M., observation of Resident #17 revealed the resident was obese and was too large for the standard bed she occupied. Interview with the resident at the time of the observation revealed she had asked for a larger bed, however the room was not large enough. On 08/20/25 at 1:05 P.M., an interview with Director of Nursing (DON) revealed every bed is capable to be a bariatric bed however the resident doesn't want her room moved around so they cannot accommodate the larger bed. Review of the facility policy titled, Resident Rights, dated 04/24 revealed the facility protects and promotes the rights of each resident. The facility will provide a clean, safe, comfortable and home like environment. This deficiency represents non-compliance investigated under Complaint Number 2597120 and Complaint Number 2595339.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to notify the power of attorney (POA) of a change in condition. This affected one resident (#43) of three residents reviewed for notification. The facility census was 83. Findings Include: Review of the medical record for Resident #43 revealed an initial admission date of 07/21/23 with the latest readmission of 03/21/24 with diagnoses including human immunodeficiency virus (HIV), psoriasis, protein calorie malnutrition, dysphagia, seizures, gastro-esophageal reflux disease, asthma, major depressive disorder and anxiety disorder. Review of the plan of care dated 02/15/24 revealed the resident had a seizure disorder. Interventions included give medications as ordered, monitor/document for effectiveness and side effects, give seizure medication as ordered by doctor, monitor/document side effects and effectiveness, obtain and monitor lab/diagnostic work as ordered, report results to physician and follow up as indicated, post seizure treatment, turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure take vital signs and neuro check, seizure documentation, location of seizure activity, type of seizure activity (jerks, convulsive movements, trembling), duration, level of consciousness, any incontinence, sleeping or dazed post-ictal state, after seizure activity, seizure precautions, do not leave resident alone during a seizure, protect from injury, if resident is out of bed, help to the floor to prevent injury, remove or loosen tight clothing, don't attempt to restrain resident during a seizure as this could make the convulsions more severe, protect from onlookers, draw curtain. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a moderate cognitive deficit. Review of the mood and behavior revealed the resident rejected care. The assessment indicated seizure disorder was a current diagnosis and received anticonvulsant medications. Review of the resident's monthly physician orders for August 2025 identified orders dated 08/13/25 Levetiracetam oral solution 100 milligrams (mg)/milliliter (ml) with the special instructions to give 10 ml via peg-tube three times a day for seizures. Review of the resident's progress note dated 07/21/25 at 7:09 P.M. revealed the resident had 35 second seizure at 8:42 A.M. Further review revealed no documented evidence the resident's representative was notified of the seizure activity. Review of the progress note dated 07/30/25 at 11:24 A.M. revealed the resident was noted with seizure activity that lasted for two minutes. The resident's physician was notified and no new orders were received. Review of the medical record revealed no documented evidence the resident's representative was made aware of the seizure activity. Review of the progress note dated 08/13/25 at 3:44 P.M. revealed the resident had seizure like activity in the form of hands shaking and stiffness that lasted for one minute and 30 seconds. A new order was obtained for Keppra 100 mg/ml three times a day through hospice nurse that was present. The resident was self-responsible and made aware as well as unit manager. Review of the change of condition progress note revealed the resident was having seizure like activity. The resident was noted to have some shaking and stiffness. The resident's physician was made aware as well as the resident being her own responsible party. Review of the resident's power of attorney (POA), dated 07/07/23 revealed the resident the resident's parents were the resident's POA. On 08/25/25 at 1:34 P.M., an interview with the Director of Nursing (DON) verified the resident's representative was not notified of the seizure activity. Review of the facility policy titled, Change in Condition Communication, last revised 06/19 revealed the purpose of the policy was to improve communication between physicians and nursing staff to promote optimal resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a resident's condition and provide guidance for the notification of the residents and their responsible party regarding changes in condition. The resident and the resident's family member/legal representative will be notified of any changes in medical condition or (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment plan. This deficiency represents non-compliance investigated under Complaint Number 2597120 and Complaint Number 2595339.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, review of the facility's self-reported incidents (SRI) and facility policy review, the facility failed to report an allegation of abuse to the required state agency. This affected one resident (#17) of three residents reviewed for abuse. The facility census was 83. Findings Include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. On 08/20/25 at 9:00 A.M., an interview with Resident #17 revealed Licensed Practical Nurse (LPN) #116 had abused her. She revealed the LPN entered her room to apply cream to her legs and she told him she did not like men touching her and preferred female caregivers. The resident revealed the LPN grabbed her leg and jerked her leg out and applied the cream against her will. The resident revealed the incident was reported but nothing was done and LPN #116 continues to provide care to her. On 08/20/25 at 11:18 A.M., an interview with Resident #17's Case Manager revealed the resident had reported the incident to him while at the facility. The Case Manager revealed the Former Social Worker (FSW) was notified of the incident immediately and was told she would take care of it. The Case Manager revealed he was at the facility at the minimum of weekly and the accused LPN continues to provide care to the resident despite the allegation of abuse and the preference of only female caregivers. Review of the facility's SRI's revealed no reported incident of the allegation of abuse. On 08/20/25 at 1:05 P.M., an interview with the Director of Nursing (DON) revealed the incident was not reported to her and verified LPN #116 continued to provide care to the resident. The DON verified the allegation of abuse was not reported to the required state agency. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, not dated revealed residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property. All incidents and allegations of abuse, neglect, exploitation, misappropriation of resident property and injuries of unknown origin must be reported to immediately to the Administrator or designee. If any form of abuse is alleged or serious bodily injury is identified related to any other reportable injury, the Administrator or his/her designee will notify the Ohio Department of Health (ODH) immediately but not later than two hours after the allegation is made or the serious bodily injury identified. This deficiency represents non-compliance investigated under Complaint Number 2597120 and Complaint Number 2595339. This deficiency is a recite to the complaint survey completed 07/23/25.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews, review of the facility's self-reported incidents (SRI) and facility policy review, the facility failed to investigate an allegation of abuse. This affected one resident (#17) of three residents reviewed for abuse. The facility census was 83. Findings include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. On 08/20/25 at 9:00 A.M., an interview with Resident #17 revealed Licensed Practical Nurse (LPN) #116 had abused her. She revealed the LPN entered her room to apply cream to her legs and she told him she did not like men touching her and preferred female caregivers. The resident revealed the LPN grabbed her leg and jerked her leg out and applied the cream against her will. The resident revealed the incident was reported but nothing was done and LPN #116 continues to provide care to her. On 08/20/25 at 11:18 A.M., an interview with Resident #17's Case Manager revealed the resident had reported the incident to him while at the facility. The Case Manager revealed the Former Social Worker (FSW) was notified of the incident immediately and was told she would take care of it. The Case Manager revealed he was at the facility at the minimum of weekly and the accused LPN continues to provide care to the resident despite the allegation of abuse and the preference of only female caregivers. Review of the facility's SRI's revealed no reported incident of the allegation of abuse. On 08/20/25 at 1:05 P.M., an interview with the Director of Nursing (DON) revealed the incident was not reported to her and verified LPN #116 continued to provide care to the resident. The DON revealed the allegation of abuse was not investigated as required. Review of the facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, not dated revealed residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property. Once the Administrator and the Ohio Department of Health (ODH) are notified, an investigation of the allegation violation will be conducted. This deficiency represents non-compliance investigated under Complaint Number 2597120 and Complaint Number 2595339. This deficiency is a recite to the complaint survey completed 07/23/25.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interviews, the facility failed to identify, assess and implement care and services to prevent triggers of past trauma. This affected one resident (#17) of three residents reviewed for preferences. The facility census was 83. Findings Include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the resident's initial social service assessment dated [DATE] revealed the resident had no Trauma Informed Care Triggers. Review of the resident's psychiatric note dated 01/28/25 revealed the resident was physically abused by her ex-husband and had trust issues. The resident also reported having medical conditions that had caused trauma her life like a brain aneurysm. The assessment indicated the resident reported the development of emotional and behavioral symptoms in response to an identifiable stressor occurring within three months of the onset of the stressor. The resident reported that being in the facility was hard on her. The plan was to continue the resident's current psychotropic medications as prescribed, engage in therapeutic behavioral services (TBS) to address symptoms related to adjustment disorder. The resident was given the diagnoses adjustment disorder with mixed anxiety and depressed mood. Review of the resident's quarterly social service assessment dated [DATE] revealed the resident had trauma informed care triggers. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. Review of the mood and behavior revealed the resident had no indicators of depression and displayed no behaviors. The assessment indicated depression, anxiety or post-traumatic stress disorder (PTSD) was not a current diagnosis. On 08/20/25 at 9:00 A.M., an interview with the resident revealed she had past trauma of sexual abuse and identified the reason for preferring no male caregivers. Observation during the time of the interview revealed a sign hanging on the wall behind the bed indicating the resident preferred no male caregivers. On 08/20/25 at 10:04 A.M., interview with the Licensed Social Worker (LSW) #240 verified the resident had no trauma assessment reflecting the past trauma, identification of triggers or plan of care for the trauma. On 08/20/25 at 11:18 A.M., an interview with the resident's Case Manager #245 revealed he was aware of the sexual abuse she endured as a child. He revealed she spoke to the Former Social Worker (FSW) #241 regarding the preference of no male caregivers and the reasoning behind the request. This deficiency is a recite to the complaint and annual survey completed 03/12/25. This deficiency represents non-compliance investigated under Complaint Number 2597120 and Complaint Number 2595339.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This affected one resident (#17) of three residents reviewed for preferences. The facility census was 83. Findings Include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the resident's psychiatric note dated 01/28/25 revealed the resident was physically abused by her ex-husband and had trust issues. The resident also reported having medical conditions that had caused trauma her life like a brain aneurysm. The assessment indicated the resident reported the development of emotional and behavioral symptoms in response to an identifiable stressor occurring within three months of the onset of the stressor. The resident reported that being in the facility was hard on her. The plan was to continue the resident's current psychotropic medications as prescribed, engage in therapeutic behavioral services (TBS) to address symptoms related to adjustment disorder. The resident was given the diagnoses adjustment disorder with mixed anxiety and depressed mood. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. Review of the medical record revealed no documented evidence TBS was arranged and provided for the resident. On 08/20/25 at 1:05 P.M., interview with the Director of Nursing (DON) verified the resident had not received the TBS services as recommended by the Psychiatric Nurse Practitioner. This deficiency represents non-compliance investigated under Complaint Number 2597120 and Complaint Number 2595339.		

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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 observation, medical record review, interview and facility policy review, the facility failed to ensure medications were administered as physician ordered. This affected one resident (#17) of three residents observed for medication administration. The facility census was 83. Findings Include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the plan of care dated 10/24/24 revealed the resident had hypertension. Interventions included to administer hypertensive medications as ordered, monitor for side effects and effectiveness, obtain blood pressure readings every shift and as needed and take the blood pressure under the same condition each time. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. Review of the resident's monthly physician orders for August 2025 identified an order dated 07/02/25 Losartan Potassium 50 milligrams (mg) with the special instructions to administer two tablets by mouth daily for hypertension. On 08/19/25 at 10:48 A.M., observation of Licensed Practical Nurse (LPN) #202 administer Resident #17's morning medications revealed the LPN removed a clear plastic cup from the top drawer of the cart with Resident #17's name written on the side. The plastic cup had one small round yellow pill (Aspirin 81 milligrams (mg)), a round white pill (Vitamin D3 1.000 units), and one orange round pill (Multivitamin). The LPN then added to the cup Metformin 500 mg, Norvasc 10 mg, Coreg 25 mg, Ferrous Sulfate 325 mg and Losartan Potassium 50 mg one tablet. The LPN walked into the resident's room, obtained the resident's blood pressure and set her medications down and exited the room without ensuring the resident ingested the medications. On 08/19/25 at 10:51 A.M., an interview with LPN #202 verified only one Losartan Potassium 50 mg tablet was administered to Resident #17 instead of the physician ordered two tablets. Review of the facility policy titled, Administration Procedures for All Medications, dated 09/18 revealed medications will be administered in a safe and effective manner. At a minimum review the five rights at each of the following steps of medication administration. Prior to removing the medication from the container check the label against the order on the medication administration record (MAR). This deficiency is a recite to the complaint and annual survey completed on 03/12/25. This deficiency represents non-compliance investigated under Complaint Number 2594301 and Complaint Number 2564232.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, interview and facility policy review, the facility failed to ensure medications were not left at bedside during medication administration. This affected one resident (#17) of three residents observed for medication administration. The facility census was 83. Findings Include: Review of the medical record for Resident #17 revealed an initial admission date of 10/08/24 with the diagnoses including but not limited to other specific arthropathies right shoulder, hypertension, hyperlipidemia, diabetes mellitus, pain in right shoulder and gastro-esophageal reflux disease. Review of the resident's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had no cognitive impairment. On 08/19/25 at 10:48 A.M., observation of Licensed Practical Nurse (LPN) #202 administer Resident #17's morning medications revealed the LPN removed a clear plastic cup from the top drawer of the cart with Resident #17's name written on the side. The plastic cup had one small round yellow pill (Aspirin 81 milligrams (mg)), a round white pill (Vitamin D3 1,000 units), and one orange round pill (Multivitamin). The LPN then added to the cup Metformin 500 mg, Norvasc 10 mg, Coreg 25 mg, Ferrous Sulfate 325 mg and Losartan Potassium 50 mg one tablet. The LPN walked into the resident's room, obtained the resident's blood pressure and set her medications down and exited the room without ensuring the resident ingested the medications. On 08/20/25 at 8:54 A.M., observation of LPN #200 administer the resident's morning medications revealed the LPN prepared the following medications Aspirin 81 mg, Ferrous Sulfate 325 mg, Vitamin D3 1,000 units, Multivitamin one tablet, Metformin 500 mg, Norvasc 10 mg, Losartan 50 mg two tablets and Coreg 25 mg. The LPN then entered the resident's room and set the medications down in two individual cups on the resident's bedside table. The LPN obtained the resident's blood pressure and exited the resident's room without ensuring the ingested the medications. On 08/20/25 at 9:05 A.M., LPN #200 entered the room and stated, checking to make sure you took your medications. The LPN verified she had not observed the resident ingest the medications. Review of the facility policy titled, Administration Procedures for All Medications, dated 09/18 revealed medications will be administered in a safe and effective manner. After administration, return to cart, replace medication container and document administration in the medication administration record (MAR) or treatment administration record (TAR) and the controlled substance sign out record, if necessary.		