STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366094	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Gahanna	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 medical record review, staff interview and review of the facility policy and procedure, the facility failed to maintain a resident's dignity in regard to urinary catheters. This affected one resident (#92) of one resident reviewed for catheters. The census was 88. Findings include:Review of Resident #92's medical record revealed he was admitted to the facility on [DATE] with diagnoses that included encephalopathy, diabetes, cerebral infarction, and high blood pressure.On 05/20/26 at 9:11 A.M. observation revealed Resident #92's urinary catheter bag was observed hanging on the bed uncovered facing the door. Yellow urine was noted in the drainage bag. The urinary catheter bag was in view of staff, residents, and visitors in the hallway.On 05/20/26 at 9:30 A.M. observation revealed Resident #92's urinary catheter bag was hanging on the resident's bed uncovered facing the door. Yellow urine was noted in the drainage bag. The urinary catheter bag was in view of staff, residents, and visitors in the hallway. At the time of the observation, this was verified during interview with Registered Nurse (RN) #101. RN #101 verified it was not dignified for the resident to have his urinary catheter uncovered and in view of others.Review of the facility Catheter Care policy dated 02/2024 revealed urinary catheter bags were to be stored in a privacy bag to maintain dignity.This deficiency represents non-compliance investigated under Complaint Number3007833.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and facility policy review, the facility failed to provide resident privacy during treatment of a pressure wound. This affected one resident (#16) of two residents observed for wound care. The census was 88. Findings include:Review of Resident #16's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included cirrhosis of the liver, depression, HTN, anxiety, urinary retention, adult failure to thrive, and alcohol dependence. Review of the admission minimum data set (MDS) assessment dated [DATE] revealed her cognition was intact. She required set up or clean up assistance with eating, oral hygiene, and was dependent on staff for toileting, shower/bathing, dressing lower body, turning and repositioning and partial/moderate assistance for personal hygiene. The resident was always incontinent of bowel. On 05/21/26 at 9:14 A.M. observation of a dressing change to Resident #16's sacrum revealed Registered Nurse (RN) #101 left the blinds open to the window facing the parking lot while completing the dressing change. Resident #16's partially naked body would have been visible to any person in the facility parking lot. On 05/21/26 at 9:43 A.M. interview with RN #101 verified she had left the blinds open to the parking lot while she completed the dressing change to Resident #16's sacrum. On 05/21/26 at 12:13 P.M. interview with Resident #16 revealed she wanted the blinds closed during her treatment. She would be very upset if someone had seen her from the window while she was exposed. Review of the facility Resident Rights, Dignity, and Privacy Handout not dated revealed staff were to use a closed door, a drawn curtain, or both to shield the resident during all personal care and treatment procedures. This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number 3013153.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of self reported incident (SRI) and the police report revealed the facility failed to prevent staff to resident verbal abuse. This affected one resident (#89) of ten residents reviewed for abuse. The census was 88. Findings include:Review of Resident #89's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included osteomyelitis of the right ankle and foot, ulcers of the foot, diabetes, right BKA, absence of the left leg and disorder of the kidney. Review of the minimum data set (MDS) assessment dated [DATE] revealed his cognition was intact. He required set up or clean-up assistance for eating, oral hygiene, toileting, dressing and personal hygiene, and supervision or touching assistance for shower/bathing. The resident was always continent of bladder and occasionally incontinent of bowel.Review of the Self-Reported Incident (SRI) dated 04/24/26 at 10:00 A.M. revealed the Administrator and Resident #89 were having a conversation regarding the smoking policy. The Administrator stated the resident became aggressive and rolled wheelchair towards his feet while resident was recording incident. The Administrator told Resident #89 he did not have his permission to record him at this time. Resident #89 continued to record and come towards the Administrator. It was at this point the Administrator raised his middle finger towards Resident #89. A staff member intervened to de-escalate the situation and told the Administrator to go outside.The SRI documentation revealed the facility had done the following: Resident #89 requested police notification. Police arrived and interviewed the resident and watched video. Officer reported back to the resident that there was no physical contact viewable on video. The only thing the officer saw was the Administrator raising his middle finger towards the resident. Head to toe assessment completed on resident with no evidence of bruising, swelling or redness noted. All residents interviewed with a BIMS above 12. All residents reported feeling safe with no concerns regarding staff members. Residents with BIMS 11 or below were assessed and no indications of new redness, bruising or swelling was found. The Administrator was an Interim and would not be returning to the facility. Review of Resident #89's statement dated 04/24/26 revealed he was recording the Interim Administrator, on his phone. Resident #89 reported during the interaction the Administrator made an inappropriate gesture by raising his middle finger toward the camera. Resident further stated the Administrator placed their hands on his shoulders and proceeded to take the phone out of the resident's hands. Review of the Police report dated 04/25/26 revealed no charges were issued at the time as the video did not show an assault, and witness statements advised they did not observe an assault. The resident was unable to send the police investigator the video at the time due to difficulties with files. The resident stated he would forward the videos to his lawyer. The police investigator suggested through email that he download them to USB flash drive or have his lawyer upload them to digital media then he or the lawyer could contact the police investigator via email, on emergency line, or in person to submit the video. All parties were advised that a report would be filed and how to obtain a copy.Interview on 05/26/26 at 1:45 P.M. with the facility social services director (SSD) revealed the SSD felt it was verbal abuse. The SSD stated he had seen the video, and did not see the Administrator put his hands on the resident, but did see the Administrator flip the resident off and try to take his phone. The SSD stated he believed the resident.This deficiency represents non-compliance investigated under Master Complaint Number 3013153.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview and review of facility policy and procedure, the facility failed to ensure comprehensive weekly assessments of residents with pressure ulcers and failed to ensure pressure relief interventions were in place. This affected two residents (#16, #77) of three residents reviewed for pressure ulcers. The census was 88 Findings include:1.Review of Resident #16's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included cirrhosis of the liver, depression, HTN, anxiety, urinary retention, adult failure to thrive, and alcohol dependence. Review of Resident #16's pressure ulcer risk assessment dated [DATE] revealed the resident was identified to be high risk for pressure ulcer development.Review of Resident #16's plan of care dated 03/20/26 revealed the resident has pressure injuries and is at risk for further skin breakdown, infection, worsening of existing pressure injury, new pressure injury for coccyx. Interventions included pressure injury/injuries will show signs and symptom of improvement through the review period, provide low air loss mattress, assist with turning/re-positioning during rounds and PRN, consult Dietitian, consult Wound MD, keep Resident/RP/MD informed of the wound status, monitor resident's response/tolerance to pain associated with wound status, monitor site for s/s of infection, presence of dressing if indicated, or onset of pain, perform treatments per order, provide ordered diet/feedings/supplements and encourage intake to promote wound healing, and use pillows and/or positioning devices for resident positioning and comfort.Review of the admission minimum data set (MDS) assessment dated [DATE] revealed her cognition was intact. She required set up or clean up assistance with eating, oral hygiene, and was dependent on staff for toileting, shower/bathing, dressing lower body, turning and repositioning and partial/moderate assistance for personal hygiene. She was always incontinent of bowel.The resident had a pressure ulcer to the coccyx.Review of the measurements for the coccyx revealed the following:03/24/26- 6.5 centimeters (cm) x 2.5 cm x 0.4 cm03/31/26- 6.5 cm x 2 cm x 0.8 cm04/07/26- 5 cm x 1.5 cm x 0.6 cm04/21/26- 6 cm x 1.5 cm x 1.2 cm05/05/26- 3.5 cm x 1 cm x 1.1 cm05/12/26- 3.9 cm x 1 cm x 0.9 cm05/19/26- 3.5 cm x 1cm x 0.8 cmFurther review revealed comprehensive wound measurements were missing for the week of 04/28/26. On 05/26/26 at 9:59 A.M. interview with Registered Nurse (RN) #101 verified the lack of comprehensive wound measurements for Resident #16.2. Review of Resident #77's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included chronic osteomyelitis of the left foot and ankle, diabetes, atrial fibrillation, high blood pressure, dementia, cellulitis of left foot, non-pressure chronic ulcer of the left foot, congestive heart failure and lymphedema. Resident #77 had a pressure ulcer risk assessment dated [DATE] that identified the resident was at high risk for pressure ulcer development.Resident #77 had a plan of care identifying the resident was at risk for alteration in skin integrity and pressure ulcer formation. Interventions included: assist resident for toileting as indicated, assist resident with incontinent care as indicated, assist with turning/re-positioning during rounds and PRN, perform weekly skin checks, provide pressure reducing device for bed and wheel chair, serve diet as ordered - monitor intake - offer subs if less than 75% of meal is eaten, and use padding between areas of pressure and positioning devices for proper body alignment. Review of the admission MDS assessment dated [DATE] revealed cognition was moderately impaired. She required supervision or touching assistance for eating, substantial/maximal assistance for oral hygiene and turning and repositioning, dependent on toileting, shower bathing, dressing and personal hygiene. The resident was always incontinent of bowel and bladder. Observations revealed on 05/21/26 at 9:49 A.M. Resident #77's heels were not elevated off the bed. On 05/21/26 at 2:15 P.M. observation revealed Resident #77's feet were on the mattress and not elevated. On 05/26/26 at 9:45 A.M. observation revealed the resident's heels were on the bed and were not elevated. On 05/26/26 at 9:59 A.M. interview with Registered Nurse (RN) #101 verified Resident #77's her heels were on the mattress and should be elevated off the mattress to promote (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healing and prevent future development of pressure ulcers. Review of the facility policy, Wound Documentation dated 06/2019, revealed on admission and or discovery, the nurse initiates the wound documentation process. Wound evaluation and treatments are documented in point click care and on the appropriate form. Tracking of all wounds will be completed weekly and on the wound tracking sheet. This deficiency represents non-compliance investigated under Complaint Number 3007833.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and review of facility policy and procedure, the facility failed to ensure a resident with impaired skin integrity received the necessary care and treatment to promote healing of wounds on her foot. This affected one resident (#7) of three residents reviewed for wounds. The census was 88. Findings include:Review of Resident #7's medical record revealed she was admitted to the facility on [DATE]. Diagnoses included aphasia, high blood pressure, hemiplegia and hemiparesis, and idiopathic peripheral neuropathy. Review of physician orders revealed an order dated 05/12/26 to conduct weekly skin evaluations. Staff were to document under assessments - Skin Observations. Staff were to notify the physician of new skin conditions one time a day every Tuesday for skin assessment.Review of Resident #7's admission skin assessment dated [DATE] revealed two areas were noted on the bottom of the right foot. The areas were noted as hard calloused areas that were not open. There was no additional information provided including size or color of the areas. There was no evidence the resident's physician was aware of the areas.Review of Resident #7's medical record revealed no additional skin assessments were completed of the hard calloused areas of the resident's right foot. There was no evidence of any skin treatments being provided,On 05/21/26 at 9:43 A.M. observation revealed Resident #7 stopped Registered Nurse (RN) #101 and pointed at her right foot. The resident implied it was painful. RN #101 put on gloves and removed the resident's nonskid sock; two areas were noted on the bottom of the resident's right foot. The areas appeared as two white calloused areas that were approximately 1.5 cm in diameter. The areas appeared closed with no drainage. At the time of the observation, RN #101 stated the resident came in with those last week (Note- per the medical record, the resident was admitted to the facility with the areas on 05/12/26, nine days earlier). RN #101 stated that she was padding them to protect them but was waiting for the doctor to see the resident. At the time of the observation, there was no padding in place and nothing to protect the areas.On 05/26/26 at 9:59 A.M. interview with RN #101 verified Resident #7 had no treatment started, no physician notification of the areas, and no weekly measurements of the area since 05/12/26 upon the resident's admission. Review of the facility policy and procedure, Wound Documentation dated 06/2019, revealed tracking of all wounds will be completed weekly on the Wound Tracking Worksheet. This deficiency represents non-compliance investigated under Complaint Number 3007833.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and staff interview, the facility failed to ensure a resident with an urinary catheter received appropriate care and services. This affected one resident (#92) of two residents reviewed for urinary catheters. The census was 88. Findings include:Review of Resident #92's medical record revealed he was admitted to the facility on [DATE]. Diagnoses included encephalopathy, diabetes, cerebral infarction, and high blood pressure. The resident had an indwelling urinary catheter. Review of the resident's medical record revealed no evidence of any physician orders for the resident's urinary catheter and no evidence of any orders for catheter care. In addition, review of the medical record revealed no evidence any care was provided to the resident's indwelling urinary catheter.On 05/20/26 at 9:11 A.M. observation revealed Resident #92's urinary catheter was draining yellow urine.On 05/26/26 at 11:25 A.M. interview with the Director of Nursing verified no evidence of physician orders for the indwelling urinary catheter and no evidence catheter care was provided for Resident #92. This deficiency represents an incidental finding of non-compliance investigated under Complaint Number 3007833.