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	07/01/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm 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 policy review, observation, resident and staff interviews, and record review ,the facility failed to ensure staff provided adequate supervision to prevent a resident, with altered mental status and was an elopement risk, from leaving the facility unsupervised. This affected one (Resident #33) of two residents reviewed for elopement risk. The facility census was 87. Findings include:Review of hospital documentation dated from 05/31/26 to 06/09/26 revealed Resident #33 was hospitalized with a primary diagnosis of dementia and was alert and oriented to self at baseline.Review of the medical record revealed Resident #33 was admitted to the facility on [DATE]. Diagnoses included nonˆtraumatic subdural hemorrhage, cerebral infarction, dementia, and hearing loss.Review of the care plan dated 06/10/26 revealed Resident #33 was identified as an elopement risk. Interventions included to monitor location frequently throughout the shift, maintain safety during wandering, initiate elopement procedures if the resident became missing, provide engaging activities, offer fluids and snacks during wandering, encourage rest breaks, and provide comfort measures such as familiar objects, music, or sensory activities.Review of the physician visit note dated 06/11/26 revealed Resident #33 had significant dementia, a history of stroke with rightˆsided weakness, chronic kidney disease, a recent spinal fracture after a mechanical fall, and incidental findings of extensive right pulmonary embolic disease and acute partial deep vein thrombosis (DVT).Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #33 had severe cognitive impairment, was dependent on staff for transfers, had no evaluation for walking, and did not utilize a mobility device.Review of the physical therapy encounter dated 06/24/26 revealed Resident #33 ambulated three hundred feet on uneven surface with setup or cleanup assistance using a fourˆwheeled walker.Review of the Medication Administration Record dated 06/28/26 at 9:00 P.M. revealed missed doses of atorvastatin (treats high cholesterol) and mirtazapine (treats depression).Review of the vital signs summary dated 06/28/26 at 9:38 P.M. by Licensed Practical Nurse (LPN) #228 revealed the resident's vital signs were taken at 9:31 P.M.Review of the progress note dated 06/28/26 at 11:15 P.M. revealed Certified Nursing assistant (CNA) #240 reported she was unable to locate Resident #33. Documentation indicated the Director of Nursing (DON) arrived at 11:20 P.M. and was informed Resident #33 had been located in a nearby parking lot and returned to the facility. Resident #33 was found outside the facility between 11:10 P.M. and 11:15 P.M., approximately 0.2 miles away.Review of the elopement risk assessment dated [DATE] at 12:08 A.M. revealed Resident #33 was not confined to bed or chair, had a cognitive deficit with intent to elope, had Alzheimer's dementia, received multiple medications, and had a history of elopement.Review of the skin assessment dated [DATE] at 1:00 A.M. revealed no new skin impairments.Review of the physician orders dated 06/29/26 at 7:00 A.M. revealed an order for a wander management device application with function checks every shift.Review of the smoking break schedule dated 04/23/26 revealed scheduled breaks were at 6:00 A.M., 10:00 A.M., 2:00 P.M., 6:00 P.M., and 10:00 P.M.Interview on 06/29/26 at 11:50 A.M. with the DON revealed she believed Resident #33 exited through the smoking area during a scheduled smoke break for the residents and the back gate lacked (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 - Minimal harm or potential for actual harm Residents Affected - Few	a lock, allowing Resident #33 to exit the property without any notification to staff. The DON stated Resident #33 was later found in a plaza near a restaurant, and police were not contacted. The DON confirmed Resident #33 had severe cognitive impairment and was careˆplanned for elopement risk. She stated an elopement investigation was underway.Interview on 06/29/26 at 12:03 P.M. with CNA #240 revealed she last saw the resident at approximately 7:30 P.M. when she provided a sandwich. CNA #240 returned at approximately 10:15 P.M., observed Resident #33 was not in bed or the restroom, and initiated a search. CNA #240 stated she had not received report that Resident #33 was an elopement risk or that he was able to ambulate. Resident #33 was found in the plaza behind the facility and he was dressed street clothes, had on grippy socks for footwear, and had been out of the facility for approximately one and a half hours.Interview on 06/29/26 at 1:10 P.M. with Resident #33 revealed he stated went outside last night because he was going to the movie theater. Interview on 06/29/26 at 1:15 P.M. with LPN #129 and CNA #139 revealed neither staff member had knowledge of the resident's elopement risk and reported the resident had not previously demonstrated exitˆseeking behavior.Observation on 06/29/26 at 2:13 P.M. of the patio revealed the patio exit door required input of a code, the patio area opened into a courtyard leading to a large gate labeled Exit, which opened easily and allowed direct access off the property.Interview 06/29/26 at 4:04 P.M. with Physician #333 revealed he was notified late in the evening and stated the resident was ambulatory in some capacity but unsafe to be outside alone. Physician #333 confirmed a wander management device was ordered after Resident #33 returned to the facility.Interview on 06/30/26 at 8:04 A.M. with CNA #152 revealed she worked the night of the incident and stated she did not know the resident could ambulate without assistance. She stated she completed a wholeˆhouse head count and believed the resident was out of the facility for thirty to fortyˆfive minutes. She denied knowing who opened the patio door.Interview on 06/30/26 at 2:35 P.M. with the DON revealed the elopement occurred because a staff member opened the secured patio door during smoke time, allowing Resident #33 who was at risk for elopement to exit unattended. The DON stated that once outside, the resident accessed an unsecured gate marked Exit and left facility property. The DON confirmed Resident #33 was last seen at 9:38 P.M. and located at approximately 11:10 to 11:15 P.M.Attempts to interview LPN #228 during the survey was unsuccessful.Review of the elopement policy dated 05/2024 revealed requirements for routine risk assessments, supervision based on risk, alarm checks, missing resident profiles, pdated assessments, complete progress notes, physician notification, responsible party notification, and updated care plans.