

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

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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 07/08/2026
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 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 record review, interview, and facility policy review, the facility failed to ensure the resident's legal guardian/representative was notified of a significant change in condition and refusal of emergency room/hospital transfer for one resident (#93) of three residents reviewed for change in condition and notification. The facility census was 86. Findings include: Review of Resident #93's clinical record revealed the resident had diagnoses that included chronic respiratory failure, pulmonary hypertension, heart failure, chronic atrial fibrillation, atherosclerotic heart disease, dysphagia, bipolar disorder, major depressive disorder, generalized anxiety disorder, and insomnia. Review of Resident #93's Social Services assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of Resident #93's contact information revealed the resident had a guardian listed as the first emergency contact, and also had another individual listed as the second emergency contact. Review of the Situation, Background, Assessment and Recommendation (SBAR)/change-in-condition documentation dated [DATE] at 10:52 P.M. revealed Resident #93 had a change in condition related to a significant loss of appetite. The SBAR documented the nurse received report that Resident #93 refused breakfast, lunch, and supper due to significant loss of appetite. The SBAR documented the resident reported minor stomach discomfort and loss of appetite. The SBAR further documented the nurse provided the resident with cereal and milk, and the resident ate and took nighttime medication. The SBAR documented Resident #93 refused to go to the emergency room when suggested by the nurse. The SBAR documented the Director of Nursing was notified and directed the nurse to complete a SAR-Cov-2 (COVID-19) test and notify the physician to reassess the resident's situation in the morning. The nurse documented on the SBAR that the second emergency contact was notified on [DATE] at 10:42 P.M. The SBAR did not identify documentation that Resident #93's listed legal guardian, Emergency Contact 1, was notified of the resident's change in condition or refusal of emergency room transfer. Review of a nursing progress note dated [DATE] at 11:23 A.M. revealed the physician assistant gave new orders for an antibiotic and chest X-ray due to suspected pneumonia. Review of a nursing progress note dated [DATE] at 4:14 P.M. revealed the chest X-ray was completed and results were pending. Review of a nursing progress note dated [DATE] at 5:20 A.M. revealed Resident #93 was encouraged to transfer to the emergency room multiple times the previous day but refused each time. The note documented during morning rounds on [DATE], Resident #93 was found unresponsive. Cardiopulmonary resuscitation was initiated while a second staff member provided oxygenation with an Ambu bag. Emergency medical services were notified and arrived at approximately 5:00 A.M. The note documented emergency medical services declared the resident expired. Review of the clinical record did not identify documentation that Resident #93's legal (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guardian was notified on [DATE] or [DATE] of the resident's change in condition, poor intake, suspected infection/pneumonia, refusal of emergency room transfer, or refusal of hospital transfer prior to the resident being found unresponsive on [DATE]. During interview on [DATE] at 1:18 P.M., Resident #93's legal guardian verified she stated the guardianship program received a call from the facility on [DATE] at approximately 5:51 A.M. after Resident #93 was found unresponsive/passed away. The guardian stated the facility did not notify the guardian prior to that time regarding the resident's decline, poor intake, suspected infection, or refusal of emergency room/hospital transfer. The guardian stated Resident #93 could not make her own medical decisions and the guardian would have expected to be contacted for significant medical concerns, refusals, changes in condition, or hospital transfer decisions. The guardian stated the facility could not physically force Resident #93 to go to the hospital nor as the guardian could they make her go to the hospital and stated she believed notification would not have changed the outcome. The guardian confirmed the facility did not notify the guardian of the resident's decline or refusal of hospital transfer prior to the resident being found unresponsive. During interview on [DATE] at 3:58 P.M., the Director of Nursing stated it was her understanding the legal guardian was notified, but acknowledged she was not sure if she could provide documentation to support the legal guardian was notified. The Director of Nursing stated she would look for documentation showing guardian notification. During follow-up interview on [DATE] at 4:48 P.M., the Director of Nursing confirmed she was unable to locate documentation showing Resident #93's legal guardian was notified of the resident's health decline and refusal of hospital transfer prior to the resident being found unresponsive. The Director of Nursing acknowledged she could not provide documentation showing the guardian was notified of the change in condition, poor intake, suspected infection/need for further evaluation, or refusal of emergency room/hospital transfer before the resident's decline progressed. Review of the facility policy titled Change of Condition, revised 08/2025, revealed it was the policy of the facility to ensure changes in a resident's condition were recognized, assessed, communicated, and addressed in a timely and appropriate manner. The policy defined a change in condition as a significant deviation from a resident's baseline status that may indicate actual or potential instability, decline, or need for medical evaluation or intervention. The policy documented changes may include alterations in mental status or level of consciousness, acute pain, distress or new symptoms, changes in respiratory, cardiac, or neurological status, and staff concerns regarding resident safety or stability. The policy further documented nursing staff were to assess the resident, obtain vital signs as clinically indicated, and notify the attending physician or on-call provider promptly of significant changes in condition based on clinical findings and resident status. This deficiency represents non-compliance investigated under Complaint Number 3067299.		

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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 record review, interview, and facility policy review, the facility failed to ensure a resident was free from verbal abuse by staff. This affected one resident (#51) of one reviewed for an allegation of staff-to-resident abuse. The facility census was 86. Findings include: Review of Resident #51's clinical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, essential hypertension, major depressive disorder, oropharyngeal dysphagia, anxiety disorder, muscle weakness, personal history of venous thrombosis and embolism, malignant neoplasm of base of tongue, and other intervertebral disc degeneration of the lumbar region with discogenic back pain only. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had a quarterly assessment completed. The MDS identified the resident as being cognitively intact with a Brief Interview of Mental Status (BIMS) score of 15. Review of a progress note dated 07/07/26 at 8:00 A.M. revealed Resident #51 was seen for follow-up related to pain. The progress note documented the resident was a [AGE] year-old male with a past medical history of hypertension, diabetes mellitus, and hyperlipidemia. The note documented the resident appeared stable on examination, and the plan was to monitor and continue the current treatment regimen. Review of Resident #51's care plan dated 12/10/25 revealed the resident had a behavior of verbal aggression with an intervention for observe for early warning signs of behaviors, to approach in a calm manner, call by name and to remove unwanted stimuli. Review of Self-Reported Incident (SRI) tracking number 276635, dated 07/07/26, revealed the facility reported an allegation of emotional/verbal abuse involving Resident #51 and Housekeeping Supervisor #238. The SRI documented the date of discovery was 07/07/26. The alleged/suspected perpetrator was identified as facility staff or other care provider. The SRI revealed the incident began after Housekeeper (HK) #548 reported an issue involving Resident #51 allegedly placing \$20 in her pocket. HK # 548 stated she attempted to return the money, but Resident #51 became upset. HK # 548 reported the matter to management and was instructed to give the \$20 to Housekeeping Supervisor #238 so it could be returned to Resident #51. The money was placed in an envelope, and staff witnesses were present when the money was handed to Resident #51 by Housekeeping Supervisor #238. When Housekeeping Supervisor #238 handed the envelope to Resident #51, the resident asked what it was. Housekeeping Supervisor #238 explained the envelope contained the \$20 which was given to Housekeeper (HK) #548 and it was being returned to the resident. Resident #51 stated Housekeeping Supervisor #238 was misinformed and stated HK # 548 had asked him to hold the money for her. Housekeeping Supervisor #238 acknowledged the resident's explanation and informed Resident #51 the cash had to be returned to him. Resident #51 became visibly angry, began yelling, used profanity, and made verbal threats toward Housekeeping Supervisor #238. The SRI documented Resident #51 repeatedly stated he was going to beat my ass and fuck me up because, according to the resident, Housekeeping Supervisor #238 was misinformed. The SRI documented Resident #51 ran across the front of the nurses' station toward Housekeeping Supervisor #238, got in his face, and continued yelling and making threats. Housekeeping Supervisor #238 told Resident #51 he was not going to put his hands on him. The SRI revealed it was also alleged that during the incident, Housekeeping Supervisor #238 picked up a vase in a threatening manner toward a resident. The SRI documented that due to Housekeeping Supervisor #238's threatening behavior and the allegations involving a resident, Housekeeping Supervisor #238 was immediately suspended (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pending the outcome of the investigation. Review of the facility investigation summary dated 07/07/26 revealed the facility determined, based on the investigation findings, witness statements, and the severity of Housekeeping Supervisor #238's conduct, Housekeeping Supervisor #238 violated facility standards related to workplace violence, threatening behavior, and professional conduct. The investigation summary documented the facility determined there was credible evidence of verbal threats and aggressive actions toward a resident. The facility terminated Housekeeping Supervisor #238's employment effective 07/07/26. Review of resident interview documentation dated 07/07/26 revealed Resident #51 denied being hit, pushed, grabbed, handled in a way that hurt him, touched in an unwanted way, threatened, injured, or caused pain by someone else. Resident #51 reported he felt safe around staff and other residents. During interview on 07/08/26 at 10:15 A.M., the Administrator confirmed the SRI details regarding the interaction between Resident #51 and Housekeeping Supervisor #238, confirming the altercation involved verbal threats, threatening behavior and aggressive action taken by the facility staff toward Resident #51. The Administrator confirmed the incident involved the return of Resident #51's, \$20 and that Resident #51 became upset during the interaction. The Administrator verified Housekeeping Supervisor #238 held a vase behind him during the incident but did not lift the vase toward Resident #51. The Administrator stated staff interviews also confirmed Housekeeping Supervisor #238 held the vase behind him and did not lift the vase toward the resident. The Administrator stated Housekeeping Supervisor #238 was suspended immediately and later terminated due to the facility's investigation findings related to threatening behavior, verbal threats, aggressive actions, and professional conduct. Review of the facility policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property revealed residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. The policy documented the facility would investigate all alleged violations involving abuse, neglect, misappropriation of resident property, exploitation, mistreatment, and injuries of unknown source. The policy further documented facility staff should immediately report allegations to the Administrator and the Ohio Department of Health in accordance with facility procedures. This deficiency represents an incidental findings discovered during the course of this complaint investigation.		