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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Gahanna	167 North Stygler Road Gahanna, OH 43230

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, review of hospital discharge documents, and policy review, the facility failed to ensure a resident's diabetes was managed when going on Leave of Absences (LOAs). This resulted in Actual Harm on 03/06/26 when Resident #14 went on an undisclosed LOA and went to the Emergency Department (ED) with low blood sugar. This affected one (Resident #14) of one resident reviewed for diabetes management and LOAs. The facility census was 92. Findings Include:Review of Resident #14's medical record revealed an admission date of 04/14/25 and medical diagnoses including anxiety, borderline intellectual disability, cholecystitis, cognitive impairment, developmental delay, diabetes mellitus, gastroparesis, gastroesophageal reflux, irritable bowel syndrome, anemia, diabetic retinopathy of both eyes, chronic kidney disease, nonalcoholic steatohepatitis, pulmonary embolism, and need for a guardian for healthcare decisions. Review of Resident #14's Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was cognitively intact. The resident was independent with transfers and mobility and did not require the assistance of mobility devices. Review of Resident #14's guardianship paperwork revealed Resident #14 was deemed incompetent on 06/16/25 and was appointed a guardian for an indefinite amount of time. Review of Resident #14's care plan, last revised 01/14/26, revealed the resident has impaired thought processes related to being developmentally delayed. Interventions include administering medications as ordered, monitor and document for side effects and effectiveness, communicate with the resident, family, caregiver regarding resident's capabilities and needs, cue reorient, and supervise as needed, monitor and document any changes in cognitive function, specifically changes in decision making ability, memory, recall, and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. The care plan revealed the resident has diabetes mellitus with interventions to administer diabetic medications as orders and monitor and document for side effects and effectiveness, dietary consult for nutritional regimen and ongoing monitoring, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, monitor/document/report as needed (PRN) signs and symptoms (s/s) of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity), stupor, and coma, and monitor/document/report PRN any s/s of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, and staggering gait. There was no documentation in the care plan of interventions related to the LOA. Review of Resident #14's insulin orders revealed, an order dated 02/16/26 for insulin Glargine Solution, inject 15 units subcutaneously two times per day for diabetes. Further review revealed an order dated 12/27/26 for insulin Lispro Injection Solution, inject per sliding scale: 150-200- 1 unit, 201-250- give 2 units, 251-300- 3 units, 301-350- 4 units, 351-400- 5 units, greater than 400 contact the physician, and give 6 units subcutaneously before meals and at bedtime for diabetes. Review of the social services progress note dated 02/20/26 revealed social services met with Resident #14 to discuss expectations and safety guidelines related to LOAs. Resident #14 was educated about adhering to prescribed medications and treatment recommendations and maintaining appropriate contact with the facility as required. Resident #14 was reminded to return (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 0684 Level of Harm - Actual harm Residents Affected - Few	by the agreed-upon time and to notify the facility promptly of any delays. Review of Residents #14's blood glucose monitoring and Medication Administration Record (MAR) for March 03/2026 revealed unstable blood glucose levels with readings as low as 82 on 03/04/26 and a high of 511 on 03/04/26. On 03/06/26, her blood glucose level was 108 in the morning. Review of the MAR revealed 15 units of insulin Glargine was administered in the morning of 03/06/26. Review of Resident #14's meal intakes revealed on 03/06/26 she ate 75 percent of her breakfast. Review of the medical record revealed Resident #14 left on a LOA on 03/06/26 at 7:43 A.M. There was no evidence that the resident was educated on diabetes management while out of the facility. There was no evidence that the resident ate lunch or dinner while out of the facility. Review of the Leave of Absence Form revealed Resident #14 did not sign out on 03/06/26. Review of the progress note dated 03/06/26 at 9:26 P.M. revealed Resident #14 left for a LOA in the morning and did not come back to the facility. It was discovered the resident was taken to the local hospital due to hypoglycemia. Review of Resident #14's hospital record from Hospital #1 dated 03/06/26 at 7:55 P.M. revealed Resident #14 presented to the ED by Emergency Medical Services (EMS) for low blood sugar. Resident #14 stated she has type 1 diabetes, took Lantus this morning, and did not eat breakfast. Resident #14 reported her friend called EMS because she was difficult to arouse. Upon arrival, blood glucose was 38. She was alert and eating crackers. At 10:11 P.M. Resident #14 reported she was feeling better and was eating and drinking. At 10:50 P.M. Resident #14 was eating and drinking, feels much better, very bizarre that she is now hyperglycemic. She was given 10 units of Lantus and 8 units of Lispro. Review of medical record revealed history of the resident presenting to the hospital with hypoglycemia then going hyperglycemic. At 4:25 A.M. the resident was accepted to Hospital #2. Resident #14 was sent to Hospital #2 because her endocrinologist was there and they wanted to manage her diabetes. Review of Resident #14 hospital summary report from Hospital #2 dated 3/07/26 revealed Resident #14 was admitted on [DATE] from an outside hospital (unknown) for symptomatic, refractory hypoglycemia and metabolic acidosis. She was found unresponsive by EMS with undetectable blood glucose levels, requiring Emergency Response Team (ERT) intervention upon arrival. Review of hospital course and interventions revealed Resident #14 was treated with IV dextrose and dextrose-containing IV fluids, which restored her mental status. Further review revealed the resident was managed for extremely labile blood sugars (BS). Initial glucose the outside hospital was 38, peaked at 320, and dropped to 23. At Hospital #2, the resident required an insulin drip and subsequent transition to subcutaneous sliding scale and basal insulin (Lantus/Glargine). Review of discharge needs revealed Resident #14 requires frequent blood glucose checks (up to seven times daily) due to history of undetectable lows and highs into the 400s. Resident #14 was hospitalized from [DATE] to 03/13/26. She returned to the facility after hospitalization. During an interview on 04/02/26 at 10:09 A.M., the Director of Social Services stated the facility did not believe Resident #14 had a guardian and were allowing the resident to make her own decisions. During an interview on 04/02/26 at 11:31 A.M., the Director of Nursing (DON) stated Resident #14 was known to leave the facility without signing out and would not inform staff prior to leaving. Resident #14 does not have a personal glucometer and when leaving the facility and Resident #14 was unable to check her blood glucose. When Resident #14 leaves the building, the resident does not take medications with her and would miss scheduled insulin and other medications. The facility was concerned about the resident's ability to self-administer medications and would be very concerned about the resident self-administering insulin. When the resident went on unannounced LOA, the resident would not answer calls from the facility and would only answer calls from her father and the facility relied on the resident's father to contact the resident. During an interview on 04/02/26 at 12:42 P.M., Resident #14's father stated he had concerns about the facility providing regular updates and would only get calls when the facility was unable to locate the resident. He wanted to allow the resident to continue going on LOA but was concerned regarding the facility plan to manage medications and blood glucose when Resident #14 was out of the building. During an interview on 04/06/26 at 9:07 A.M., the Director of Social Services confirmed the facility located (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #14's Guardian paperwork and would begin contacting them for all health-related questions. During an interview on 04/06/26 at 9:37 A.M., the DON stated they did not believe the resident was an elopement risk but now knowing the resident has a guardian and are unable to make medical decisions, they should be considered an elopement risk if they continue to leave the facility without signing out and not notifying staff. During an interview on 04/21/26 at 1:24 P.M., Resident #14 stated she was knowledgeable on how to check her blood glucose levels and how to administer insulin. Resident #14 reported she was able to read the sliding scale orders to see how much insulin was needed based on her blood glucose level. Resident #14 verified the facility does not send her with supplies to check her blood glucose level or administer insulin. Resident #14 reported she has had a diabetes diagnosis for 10 years and lived on her own prior. Resident #14 reported on 03/06/26 she remembers going to the hospital, but doesn't remember all the details, other than she was tired. Resident #14 verified she has not received education on how to handle diabetes management when on LOAs. During an interview on 04/21/26 at 1:37 P.M., Medical Director (MD) #700 verified Resident #14 is a very brittle diabetic. MD #700 stated he cannot hold her in the facility against her will. If the guardian told the facility she was not allowed to go on LOAs, he would honor that, but the guardian is OK with her going on LOAs. #700 was unsure if the resident was able to administer insulin on her own. The facility has taken steps to get a Dexcom (continuous glucose monitoring (CGM) system used by people with diabetes to track blood sugar levels in real-time without daily finger pricks) for the resident. During an interview on 04/21/26 at 1:40 P.M., the Assistant Director of Nursing (ADON) verified Resident #14 was deemed incompetent by the court to make medical decisions. The ADON verified Resident #14 was unable to administer insulin. The ADON stated the resident was asked to show how to administer insulin and was unable to do so. The ADON verified the facility is working on a risk agreement with the resident and trying to get the guardian to come in to review. The ADON said the guardian has not been available to come to the facility to review and sign. Review of the facility policy titled Day Outings/Therapeutic Leaves of Absence, last revised June 2019, revealed If facility staff is not notified when the resident leaves or the resident does not return to the facility within a reasonable time as determined by the circumstances surround the patients/resident's leave of absence, the facility will defer the to the Elopement policies and procedures. Review of the facility policy titled Elopement, last revised May 2024, revealed If the search fails to locate the missing resident, the Administrator/Designee will notify the Police Department, Responsible Party, and Regional Support Team.' Review of the facility policy titled Blood Glucose Monitoring, dated 01/26 revealed it was the policy of the facility to provide safe, accurate, and timely blood glucose monitoring and appropriate response to abnormal blood glucose values in accordance with physician orders and resident condition.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on employee file reviews and interviews, the facility failed to do annual evaluations for Certified Nursing Assistants (CNAs) and to provide a minimum of 12 hours of in-service for the previous year. This affected three (CNAs #242, #324, and #325) of the three employee files reviewed for CNAs employed for more than one year. This has the potential to affect all residents in the facility. The facility census was 91. Review of employee files for CNAs #242, #324, and #325 revealed no annual evaluations were completed in the last 12 months. There was also no documentation of in-service education.Interview on 04/07/26 at 1:00 P.M. with the Director of Nursing (DON) confirmed there was no record of CNA education (12 hours for the last year) and there was no record of performance evaluations in the past 12 months for the CNAs whose employee files were reviewed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident medical record review, review of medication regimen reviews, interview, and review of facility policy, the facility failed to complete medication regimen reviews (MRR). This affected four residents (Resident #02, #03, #93, and #99) out of five reviewed for unnecessary medication. The facility census was 91.Findings include: 1. Review of the medical record for Resident #93 revealed an admission date of 03/01/24 with diagnoses of, but not limited to, bipolar disorder, heart failure, and major depressive disorder. Review of Minimum Data Set (MDS) 3.0 dated 03/02/26 reveled Resident #93 had a Brief Interview of Mental Status (BIMS) score of 12 indicative of cognitive impairment. Review of the MRR's provided by the facility revealed no MRRs for April, May, July, and August of 2025 for Resident #93. 2. Review of the medical record for Resident #99 revealed an admission date of 06/29/23 with diagnoses of, but not limited to, epilepsy, major depressive disorder, and unspecified systolic heart failure. Review of the MDS 3.0 dated 12/29/25 revealed Resident #99 had a BIMS score of 15 indicative of the resident being cognitively intact. Review of the MRR's provided by the facility revealed no MRRs for May, June, July, and August of 2025 for Resident #99. Interview with the Director of Nursing (DON) on 04/07/26 at 3:00 P.M. confirmed the facility did not have complete MRR records for April, May, June, and July of 2025. During an additional interview on 04/07/26 at 4:00 P.M. the DON confirmed Resident #99 also did not have an MRR for August of 2025. 3. Review of the medical record for Resident #3, revealed an admission date of 01/14/25. Diagnoses included but were not limited to fracture of left femur, cardiac arrest, atrial fibrillation, cognitive communication deficit, anxiety disorder, heart failure, and major depressive order. Review of the MDS 3.0 assessment dated [DATE] revealed a BIMS score of three, indicating cognitive impairment. Resident #3 received 5 days of insulin during the look back period. Resident #3 received antipsychotic, antidepressant, anticoagulant, antibiotic, antiplatelet, and anticonvulsant with indications documented. Review of the MRRs for the previous year revealed there were no pharmacy reviews with or without recommendations for the months of April, May, June, or July of 2025. Interview on 04/06/26 at 3:00 P.M. with the DON confirmed there were no MRR records available for April, May, June, or July 2025. 4. Review of Resident # 02's medical record revealed she was admitted on [DATE] with diagnoses that included anxiety, bipolar disorder, dementia and depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 02's MDS assessment dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. She was coded as receiving antipsychotic, antidepressant and antianxiety medications in the look back period with indications for usage for each. Review of MMRs for March 2025 to March 2026 revealed no resident reviews for April, May, June or July 2025. Interview on 04/06/26 at 3:00 P.M. with the DON confirmed there were no pharmacy medication regimen reviews available for April, May, June or July 2025. Review of the facility policy titled Medication Administration and Management, revised 06/2019, revealed the facility's nursing and pharmacy services will assess, monitor, and evaluate the effectiveness of the medication regimen.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on review of resident medical record, physician orders, medication administration record, interview, and policy review, the facility failed to follow physician orders for blood pressure medication. This affected one resident (Resident #93) of five reviewed for unnecessary medications. The facility census was 91.Findings include:Review of the medical record for Resident #93 revealed an admission date of 03/01/24 with diagnoses of, but not limited to hypertension, heart failure, and chronic atrial fibrillation.Review of Minimum Data Set (MDS) 3.0 dated 03/02/26 reveled Resident #93 had a Brief Interview of Mental Status (BIMS) score of 12 indicative of a moderate cognitive impairment.Review of the physician orders for Resident #93 revealed an order for metoprolol tartrate oral tablet 50 milligrams (MG) give one tablet by mouth two times a day for hypertension, with parameters to hold for a systolic blood pressure under 110 or heart rate under 60.Review of the Medication Administration Record (MAR) for January 2026 revealed the medication was administered during the following dates with the corresponding blood pressure readings: 01/01/26 with a blood pressure of 102/60, 01/06/26 with a blood pressure of 106/58, 01/19/26 with a blood pressure of 103/61, 01/20/26 with a blood pressure of 102/61, 01/24/26 with a blood pressure of 106/58, 01/25/26 with a blood pressure of 102/64, and 01/26/26 with a blood pressure of 109/65.Review of the MAR for February 2026 revealed the medication was administered during the following dates with the corresponding blood pressure readings: 02/02/26 with a blood pressure of 109/64, 02/03/26 with a blood pressure of 103/61, 02/12/26 with a blood pressure of 108/67, 02/13/26 with a blood pressure of 108/67, 02/23/26 with a blood pressure of 104/58, and 02/26/26 with a blood pressure of 108/68.Review of the MAR for March 2026 revealed the medication was administered during the following dates with the corresponding blood pressure readings: 03/07/26 with a blood pressure of 108/64, 03/13/26 with a blood pressure of 107/63, and 03/19/26 with a blood pressure of 107/62.Interview with Licensed Vocational Nurse (LVN) #319 on 04/06/26 at 9:09 A.M. revealed if a medication has parameters, the medication should be held if vitals are outside of the ordered parameters, and the physician should be notified. LVN #319 confirmed Resident #93's metoprolol tartrate should have been held on the days where her systolic blood pressure was below 110.Review of the facility policy titled, Medication Administration Management, revised 06/2019, revealed authorized staff administering medications are to identify and confirm the physician order prior to administering a medication.