STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366285	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Shadyside	60583 State Route 7 Shadyside, OH 43947

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview and record review, the facility failed to protect residents dignity. This affected one resident (#25) of the memory care unit. The facility census was 83.Findings include:Review of the medical record for Resident #25, revealed an admission date of 08/06/22. Diagnoses included pneumonia; unspecified dementia, anemia; chronic vascular disorder of intestine; gastrointestinal hemorrhage; dysphagia; unspecified psychosis not due to a substance; delusional disorder; transient cerebral ischemic attack; hyperlipidemia; depression; anxiety disorder; unspecified disorder of vestibular function; atherosclerotic heart disease of native coronary artery without angina pectoris; gastro-esophageal reflux; muscle weakness; difficulty in walking not elsewhere classified; and unsteadiness on feet.Review of the most recent Minimum Data Set (MDS) 3.0 assessment for Resident #25, dated 02/11/26, revealed a Brief Interview for Mental Status (BIMS) of 0 on a 0-15 scale. A BIMS score of 0 suggests severe cognitive impairment. The MDS indicated the resident had unclear speech, could sometimes understand others and make himself understood. He had highly impaired vision.Further review of the MDS indicated the resident's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident was dependent , which meant a helper had to do all of the effort. The resident did none of the effort to complete the activity. He was also dependent with all activities of daily living (ADL), including dressing, bed mobility, bathing/showering, toileting and oral hygiene.Review of a care plan for Resident #25, dated 09/11/25, revealed the resident had a focus of care for Activities of Daily living with a self care performance deficit related to dementia. He required the assistance of two staff to transfer and the amount of assistance he required could vary based on behaviors. On 03/04/26 at 8:55 A.M., an observation of Resident #25 revealed he was sitting alone at a dining table in a wheelchair. He was dressed in a hospital gown, with his back exposed as well as his legs uncovered. He had a full tray with scrambled eggs and ground ham in front of him. He was not feeding himself. This was confirmed by Certified Nurse Aid (CNA) #388 on 03/04/26 at 9:10 A.M.On 03/04/26 at 9:10 A.M., an interview with CNA #388 revealed Resident #25 had to be brought to the dining room because if not he would try to get up in his room. Per CNA #388, there was not enough time or enough people to get the resident dressed before breakfast, so he had to be brought to the dining room in the hospital gown. She reported she knew this was not appropriate dress for the dining room. She then proceeded to leave the dining area without covering the Resident #25 further.On 03/04/26 at 9:40 A.M., an interview with Licensed Practical Nurse #384 revealed she thought it was appropriate for a resident to be in the dining area in a hospital gown. Stated, it is ok for skilled residents to stay in hospital gowns. She did acknowledge Resident #25 could not choose how he was dressed due to his cognitive impairment.On 03/04/26 at 11:55 A.M., an interview with Resident #25's spouse revealed she believed the staff did everything they could considering the ratio of workers to residents. She reported it sometimes took awhile for staff to respond because they were so busy. Review of a facility document titled Dignity, Respect, and Privacy Policy, updated 01/03/26, revealed the facility would provide care to residents while maintaining their dignity and privacy. Residents were to always be treated with respect and cared for in a manner that protected their privacy.This deficiency represents an incidental finding of non-compliance investigated under Master Complaint Number 2746972.

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 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 review of medical records, review of facility policies, observation, and interview, the facility failed to maintain the privacy of personal health information for three residents (#7, #42, and #79) of 83 residents residing in the facility. The facility census was 83.Findings include:1.Review of the medical record for Resident #7 revealed admission to the facility on [DATE] for diagnoses including chronic resp failure, chronic lung disease, morbid obesity, diabetes, bipolar disorder (mood disorder), right sided weakness following a stroke, high blood pressure, and poor circulation to legs. Review of the medical record for Resident #42 revealed admission to facility on 11/23/22 for diagnoses including dementia (memory impairment) with mood disturbance, anemia (low blood count), constipation, insomnia (sleep disorder), depression, restless leg syndrome, and difficulty with walking. Observation on 03/04/26 between 9:53 A.M. and 10:30 A.M. revealed the facility's Nurse Practitioner (NP) #500 and registered nurse (RN) #346 in the east hallway near room [ROOM NUMBER] discussing medications with Resident #7. Further observations revealed NP #500 and RN #346 proceeding to the activities room where there were six residents seated at a table playing a dice game. NP #500 approached Resident #42 and began to discuss medical conditions related to her ankle pain and that NP #500 would prescribe new medication. The NP #500 and RN #346 did not ask Resident #42 if she was okay with being assessed at her current location with the other five residents present. There were no observed accommodations made by NP #500 or RN #346 to remove Resident #42 from the table where the other five residents were sitting. Interview on 03/04/26 at 10:40 A.M. with RN #346 revealed verification that RN #346 and NP#500 had assessed Resident #42 in the activities room with other residents present. Review of Resident #42's medical record revealed a general progress note dated 03/04/26 at 10:34 A.M. and authored by RN #346. The progress note revealed that Resident #42 was seen by NP #500 and new orders were received related to c/o pain in legs. Interview on 03/05/26 at 9:22 A.M. with RN #346 revealed that the NP #500 and did not assess Resident #7 on 03/04/26 and that NP #500 was approached by Resident #7 in the hallway asking the NP #500 questions regarding medications that were prescribed by the physician the day prior. Note- there was no evidence NP #500 had directed Resident #7 to a private location to review and discuss her questions about her medications. Review of the facility policy titled Dignity, Respect, and Privacy Policy, updated on 01/03/25 revealed unnecessary individuals shall be asked to leave residents room while care is provided, and the purpose of policy was To provide care to residents while maintaining their dignity and privacy. Residents are to always be treated with respect and cared for in a manner that protects their privacy. Their individual preferences are to be evaluated, and reasonable accommodations made, and care and treatment are to be delivered in a way that always maintains their dignity. 2. On 03/04/26 at 12:28 P.M., observation of the lunch meal revealed Speech Therapist (ST) #503 speaking with Resident #79 in the dining area. There were two visitors and 11 residents, along with two Licensed Practical Nurses (LPN)s in the dining room. ST #503 could be heard asking Resident (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#79 about his doctor appointment the day prior. When he could not provide the information due to cognitive issues, ST #503 yelled to LPN #384 and asked, how was his appointment yesterday? LPN #384 proceeded to describe the resident's physician appointment loud enough the surveyor could hear from the other side of the room. On 03/04/26 at 12:40 P.M., interview with LPN #384 confirmed ST #503 had requested resident private medical information in the full dining area. She further confirmed she had replied and given a report to the ST regarding the resident's physician appointment the day before. She agreed this was private resident information and should not be shared in a public dining area, regardless of whether or not it was a memory care unit, and acknowledged there were two visitors in addition to the 11 residents and the surveyor present at the time of the interaction. This deficiency represents non-compliance investigated under Complaint Number 2667202.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, and interview, the facility failed to have sufficient nursing staff to maintain the highest practicable psychosocial well-being of each resident when a resident was brought to the dining room in a hospital gown which was opened in the back or to assist the resident with breakfast in a reasonable time. This affected one resident (#25) of six residents residing on the memory care unit. The facility census was 83.Findings include:Review of the medical record for Resident #25, revealed an admission date of 08/06/22. Diagnoses included pneumonia; unspecified dementia, anemia; chronic vascular disorder of intestine; gastrointestinal hemorrhage; dysphagia; unspecified psychosis not due to a substance; delusional disorder; transient cerebral ischemic attack; hyperlipidemia; depression; anxiety disorder; unspecified disorder of vestibular function; atherosclerotic heart disease of native coronary artery without angina pectoris; gastro-esophageal reflux; muscle weakness; difficulty in walking not elsewhere classified; and unsteadiness on feet.Review of the most recent Minimum Data Set (MDS) 3.0 assessment for Resident #25, dated 02/11/26, revealed a Brief Interview for Mental Status (BIMS) of 0 on a 0-15 scale. A BIMS score of 0 suggests severe cognitive impairment. The MDS indicated the resident had unclear speech, could sometimes understand others and make himself understood. He had highly impaired vision.Further review of the MDS indicated the resident's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident was dependent , which meant a helper had to do all of the effort. The resident did none of the effort to complete the activity. He was also dependent with all activities of daily living (ADL), including dressing, bed mobility, bathing/showering, toileting and oral hygiene.The MDS revealed the resident was on a mechanically altered diet which required a change in texture of food or liquids. There were no days during the MDS evaluation period when the resident received any restorative nursing programs for eating and/or swallowing.Review of a care plan for Resident #25, dated 09/11/25, revealed an intervention for fall risk related to a history of falls. Interventions included eating meals in all purpose room as he would allow (05/27/24) and when awake bring to all purpose room for closer monitoring (08/10/25).Review of a progress note for Resident #25, dated 02/05/26 at 4:48 P.M., revealed the resident was admitted to [NAME] Memorial Hospital with a diagnosis of pneumonia.Review of a History and Physical for Resident #25, completed by NP #500, dated 03/03/26, revealed a new diagnosis of dysphagia was added. Plan for this diagnosis was to monitor therapy and effectiveness.Review of a Speech Therapy note for Resident #25, dated 03/03/26, revealed the resident's diet was upgraded from pureed to mechanical soft diet with thin liquids. He was to be up in a chair for meals. The resident was to be assisted with intake. On 03/04/26 from 8:55 A.M. until 9:23 A.M., an observation of the dining area of the memory care unit revealed four residents sitting at dining tables with trays in front of them. Two residents were sitting away from the tables in wheelchairs, and one resident was wandering around the dining area, talking to herself. There was no staff present or interacting with the residents.On 03/04/26 at 8:55 A.M., an observation of Resident #25 revealed he was sitting alone at a dining table in a wheelchair. He was dressed in a hospital gown, with his back exposed as well as his legs uncovered. He had a full tray with scrambled eggs and ground ham in front of him. He was not feeding himself. This was confirmed by Certified Nurse Aide (CNA) #388 on 03/04/26 at 9:10 A.M.On 03/04/26 at 9:10 A.M., an interview with CNA #388 revealed Resident #25 had to be brought to the dining room because if not he would try to get up in his room. Per CNA #388 there was not enough time or enough people to get the resident dressed before breakfast, so he had to be brought to the dining room in the hospital gown. She reported she knew this was not appropriate dress for the dining room. She then proceeded to leave the dining area.On 03/04/26 at 9:23 A.M., an observation revealed CNA #306 arrived to the dining room. She stood beside Resident #25 and fed him a couple bites of breakfast without re-heating the food, and then sat and fed (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident the remainder of his breakfast. This was confirmed immediately with CNA #306.On 03/04/26 at 9:35 A.M., an interview with CNA #306 revealed she assisted with residents eating on the memory care unit once she completed other duties on a different unit. She thought the resident sometimes fed himself, but she did not know why he had not been fed. She thought breakfast trays arrived at 8:00 A.M.On 03/04/26 at 9:40 A.M., an interview with Licensed Practical Nurse (LPN) #384 revealed breakfast arrived on the memory care unit at a few minutes before 8:00 A.M. Nurses helped feed residents when they could, however morning was a very busy time with medication pass. She thought it was appropriate for a resident to be in the dining area in a hospital gown. LPN #384 stated, it is ok for skilled residents to stay in hospital gowns. She did acknowledge Resident #25 could not choose what he wore due to his cognitive impairment.On 03/04/26 at 11:55 A.M., an interview with Resident #25's spouse revealed she believed the staff did everything the could considering the ratio of workers to residents. She reported it sometimes took awhile for staff to respond because they were so busy. She would come and feed the resident lunch every day, however he always needed assistance with eating since his hospitalization in January (2026) for pneumonia. His food texture had changed because the hospital told her aspirating his food had caused his pneumonia. They pulled hunks out of his lungs with a tube. She indicated for some time the resident had not had use of his right arm and hand. He was left handed and had forgot how to use silverware, so with the new diet of ground food, he required feeding assistance with all meals.Review of a facility document titled Dignity, Respect, and Privacy Policy, updated 01/03/26, revealed the facility would provide care to residents while maintaining their dignity and privacy. Residents were to always be treated with respect and cared for in a manner that protected their privacy.This deficiency represents non-compliance investigated under Master Complaint Number 2746972.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, the facility failed to accurately reflect on the facility assessment the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each resident's needs as identified through resident assessments and care plans. This had the potential to affect all residents of the facility. The facility census was 83.Findings include:Review of a document titled Facility Assessment Tool, which was updated 02/13/26, revealed the facility would conduct, document, and review a facility wide assessment which included both the resident population and resources the facility needed to care for the residents at least annually. The facility average daily census was 83. The locked memory care unit had a 32 bed capacity, with an average daily census of 28. The facility identified care needs of the memory care unit as activities of daily living (ADL), mobility and fall risk, bowel and bladder, skin integrity, mental health and behavioral, medications, pain management, infection prevention and control, management of medical conditions, therapy, nutrition, and person-centered/directed care: psycho/social/spiritual support. The facility identified it estimated needing 12-14 licensed nursing staff to provide direct care, 20-25 nurse aides, and three nursing personnel (with administrative duties) to provide care for the population of residents at the facility. This was confirmed with Regional Administrator #502 on 03/05/26 at 1:44 P.M.On 03/05/26 at 1:44 P.M., an interview with the Regional Administrator #502 revealed the estimated range of staff needed, which was documented on the Facility Assessment, was incorrect. When she was determining the number of licensed nurses providing direct care, she had included the administrative nurses as well, which included the Director of Nursing, Assistant Director of Nursing, and the Minimal Data Set (MDS) nurse. When she had determined the number of Nurse aides, she had included such individuals as the staff in administrative roles, such as admissions and medical records. She reported she needed to look at how she determined these numbers across all facilities she assisted with.This deficiency represents an incidental finding during the investigation of Master Complaint Number 2746972.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and policy review, the facility failed to maintain an environment free from risk of infection by allowing a dog to be at the lunch table with residents eating their meal. This affected two residents (#77, #65) sitting together in the memory care dining area at lunchtime. The facility census was 83.Findings include:On 03/04/26 at 12:00 P.M., observation of the dining area of the memory care unit revealed a small table with Resident #77 and Resident #65 seated. Each resident had a visitor also sitting at the table. The visitor for Resident #77 was holding a small dog, who would lay it's head on the table. When the lunch tray for Resident #77 arrived, the visitor holding the dog did not wash her hands and continued holding the dog, while feeding Resident #77 her lunch. This was confirmed by Licensed Practical Nurse (LPN) #384 on 03/04/26 at 1:00 P.M.On 03/04/26 at 1:00 P.M., an interview with LPN #384 confirmed the visitor for Resident #77 was holding the dog and feeding the resident. She confirmed the visitor had been there prior to lunch and had not done hand hygiene or put the dog down at any point.On 03/04/26 at 1:15 P.M., an interview with the Director of Nursing (DON) confirmed it would be an infection control issue to have a dog at the table while residents were eating. It also would be against the facility infection control policy to be holding a dog and feeding a resident, especially if the visitor did not wash their hands.Review of a facility document titled Infection Control Prevention Policy, updated 01/11/25, revealed it was the policy of the facility to provide resident care in a safe environment that promoted health and reduced the risk of acquiring infections. This policy was confirmed by the Director of Nursing on 03/04/26 at 1:15 P.M. This deficiency represents an incidental finding of non-compliance during the investigation of Master Complaint Number 2746972.