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	07/22/2021

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 16453 Based on medical record review, facility policy review, and staff interviews, the facility failed to ensure the physician was notified when blood sugars were outside of ordered parameters. This affected three residents (Resident #32, Resident #34 and Resident #45) of four residents reviewed for blood sugar levels. Findings include: 1. Review of Resident #32's medical record identified admission to the facility occurred on 03/16/21 with medical diagnosis including; diabetes, bipolar disorder and high blood pressure. The [AGE] year old had physician's orders dated 06/17/21 through 09/22/21 to obtain FSBS fasting blood sugars before meals, call physician if less than 60 or greater than 300. Review of the Medication Administration record (MAR) from 09/17/21 through 09/22/21 identified blood sugar levels exceeding 300 occurring on 09/17/21- level was 325 at breakfast; 09/19/21- level was 400 at breakfast and 09/20/21- level was 357 at lunch time. Review of the progress notes from 09/17/21 through 09/22/21 identified no evidence the physician was notified of the elevated blood sugar levels in accordance with the physician order. Interview with the facility Director of Nursing (DON) on 10/05/21 at 9:48 A.M. confirmed the lack of following the physician order and notification of Resident #32's blood sugars that were outside of the parameters for notification. 2. Review of Resident #34's medical record identified admission to the facility occurred on 03/03/19 with medical diagnosis including; dementia, diabetes and epilepsy. The [AGE] year old had physician order dated since 04/16/21 for twice a day blood sugars and to notify physician if greater than 400 or less than 60. Review of the MAR from 09/17/21 through 10/5/21 was completed. On 09/22/21 the bedtime blood sugar levels were documented as 419. Review of the progress notes from 09/17/21 through 10/05/21 identified no evidence of notification to the physician of the 09/22/21 blood sugar level of 419. (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 - Some	Interview with the facility Director of Nursing (DON) on 10/05/21 at 9:48 A.M. confirmed the lack of following the physician order and notification of Resident #34's blood sugars that were outside of the parameters for notification. 3. Review of Resident #45's medical record identified admission to the facility occurred on 04/04/21 with medical diagnosis including; cellulitis, diabetes, anxiety and morbid obesity. Review of the physician orders on 10/05/21, identified no current blood sugar testing parameters for notification. Review of the MAR for October 2021 revealed the facility was checking Resident #45's blood sugars before meals and at bedtime. The record identified on 10/02/21 at dinner her blood sugar level was 398. On 10/04/21 at dinner her level was 306 and a bedtime was 313. The MAR did not contain the parameters when the physician should be notified. Interview with the facility Director of Nursing (DON) on 10/05/21 at 9:48 A.M. confirmed the lack of obtaining an order for Resident #45's blood sugar parameters to require physician notification. Review of the facility policy, Blood Sugar Testing and Parameters, undated, revealed the policy identified blood sugars will be preformed according to the physician order. Upon admission and routinely, the licensed nurse will obtain an order for parameters of when to notify the physician and responsible party. The policy lists an example of Notify the MD when the blood sugar is less than 60 or greater than 300. The licensed nurse will notify the physician if the blood sugar is less than or greater than the established parameters. The nurse will document the episode in the nursing notes.

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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** 44068 Based on closed medical record review, facility staff interview and wound clinic staff interview the facility failed to comprehensively assess, provide ongoing monitoring and ensure appropriate treatment was provided for wounds caused by venous insufficiency related to peripheral vascular disease for Resident #73. Actual Harm occurred when Resident #73, who had diagnoses including cellulitis to the bilateral lower legs and peripheral vascular disease, developed a wound to the left great toe, three fourths of the toenail was missing and was observed by the wound clinic to have maggots. The wound to the left toe and the maggots were discovered by the wound clinic at the visit on 06/23/21. There was no documentation by the facility before or after the wound clinic visit on 06/23/21 describing any new wounds to the resident's toes. The facility failed to comprehensively assess, provide ongoing monitoring and ensure appropriate treatment was provided for wounds caused by venous insufficiency. This affected one resident (#73) of three residents reviewed for pressure ulcers/wounds. Findings include: Review of Resident #73's closed medical record revealed discharge notes from the hospital, prior to admission to the facility, dated 05/24/21 and signed by Medical Director #333 from the wound clinic. The plan for the resident was for Venelex (ointment used to promote wound healing) to be applied to open wounds on both the resident's legs, then restore silver to the dorsal foot, and Optilock (super absorbent dressing) to the calf and leg. The wounds were caused by venous insufficiency. The resident was to be seen weekly at the wound clinic. Further review of Resident #73's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged [DATE] to the hospital. The resident had diagnoses including cellulitis of the left lower limb, type two diabetes, obstructive sleep apnea (OSA), hypertension (HTN), chronic combined systolic and diastolic heart failure, chronic atrial fibrillation, sick sinus syndrome, ischemic cardiomyopathy, atherosclerosis of coronary artery bypass graft, chronic kidney disease (CKD) stage three and peripheral vascular disease. Review of a nursing progress note, dated 06/11/21 revealed the resident's anterior left lower leg had cellulitis with deflated blisters, large amount clear drainage and his anterior right lower leg had cellulitis with deflated blisters and a large amount of clear drainage. Progress notes written by the Assistant Director of Nursing (ADON) dated 06/13/21 revealed the resident was out of the facility to the wound clinic. Another note was added on 06/13/21 by the ADON revealing a skin assessment was completed and no new findings were documented. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the encounter note, dated 06/16/21 written by the Nurse Practitioner (NP) #654 revealed she examined the venous ulcer wounds on the resident's bilateral lower extremities (BLE) and documented the wound bed was pink with serous drainage and the peri wound was fragile, excoriated and weeping. The NP wrote in her notes to apply Unna boots for seven days (an Unna boot is a compression dressing made by wrapping layers of gauze around the leg and foot. It is often used to protect an ulcer or open wound. The compression of the dressing helps improve blood flow in the lower leg. Compression also helps decrease swelling and pain). Review of the physician's orders revealed an order, dated 06/17/21 for Unna boots to be applied to the bilateral lower extremities with the instructions to cleanse bilateral lower extremities with normal saline or wound cleanser, pat dry and apply Unna boots every night shift every seven day(s) for cellulitis. Review of the Resident #73's Treatment Administration Record (TAR) for June 2021 revealed the Unna boot treatment was signed off as completed by LPN #765 on 06/17/21 on night shift. The skin assessment, dated 06/21/21 revealed ADON #759 observed the resident's BLE's and noted decreased edema and drainage. The progress note dated 06/23/21 at 8:00 A.M. revealed the ADON charted the resident was out of the facility at the wound clinic for an appointment. Review of the notes from the wound clinic visit on 06/23/21 at 10:22 A.M. revealed Resident #73 presented to the clinic with maggots that were removed from his left great toe wound (the Unna boot would have been in place upon arrival to the clinic from when it was applied on 06/17/21 by the facility). The notes also revealed a new order to apply Bactroban Ointment 2 % (antibiotic ointment) to the left great toe topically daily. The wound clinic notes from 06/23/21 also revealed an order to apply restore contact layer to bilateral anterior feet shallow areas, apply abdominal pad dressing, Kerlix, change the wound dressings twice a day, and apply a gentle ace wrap. The wound clinic notes revealed the resident's right circumferential lower leg was to have abdominal pads secured to the leg with Kerlix and the left circumferential leg was to have an ace wrap from the base of the toes to back of the knee (BLE. not too tight). The progress note dated 06/23/21 at 2:21 P.M. revealed a skin assessment was completed by the ADON, but did not reveal any new wounds. The facility physician order dated 06/23/21 stated to apply the Bactroban ointment every shift to the right great toe (not the left great toe as the wound clinic instructed). A physician's order dated 06/23/21 at 12:21 P. M. was written to cleanse the resident's right lower leg and left lower leg with soap and water, with the instructions to not remove the restore contact silver layer since it is completed at the wound clinic, pat dry, cover with abdominal pad dressing, wrap with Kerlix and then Coban every shift. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the skin and wound evaluation dated 06/27/21 revealed the resident presented with wounds on bilateral legs that were swollen and leaking moderate amount of fluid. There was no mention of any new wounds to the left or right great toe. The progress note dated 06/30/21 revealed a skin assessment was completed but there was no description of the wounds. Review of the weekly skin grid non-pressure dated 07/01/21 revealed ADON #759 documented for the right lower leg, right dorsal foot and the left lower leg orders from wound care to not remove silver dressing. Unable to obtain measurements at this time. Large amount of clear drainage leaking from leg. Review of the skin and wound evaluation dated 07/06/21 revealed it was unfinished by ADON #759. Review of the notes from Resident #73's wound care clinic visit, dated 07/07/21 at 10:15 A.M. revealed the resident was seen in the office and the orders for his BLE changed to cleanse the wounds with gentle/unscented soap, apply restore contact layer silver to all open areas of the legs (those was to be changed weekly or biweekly), apply abdominal pad and secure the dressing with Kerlix roll twice a day. The notes also stated the resident no longer needed to follow up with the clinic, but those orders were never inputted. Interview on 07/19/21 at 11:28 A.M. with MDS LPN #437 and the Administrator revealed there were no skin assessment measurements for the resident's legs or great toe by the wound nurse practitioner (NP) that rounded weekly. Weekly skin assessments were completed to determine any new skin abnormalities and continue to monitor current wounds. On 07/20/21 at 1:41 P.M. interview with Nurse Manager #989 from the wound clinic confirmed Resident #73 was seen in the office on 07/07/21 where his wound was observed, cleaned, and a new dressing was applied. She revealed when the resident came in for an appointment on 06/23/21, he came in as a new patient from the facility with maggots on his toe. On 07/20/21 at 4:00 P.M. interview with the Administrator and ADON revealed both were unaware of the maggots being found in the toe wound by the wound clinic on 06/23/21. The Administrator also revealed ADON #759 started after the maggots were found and was unable to state if the Unna boots were applied covering the toes or if the toes were open and visible. ADON #759 revealed the 07/06/21 skin assessment was not completed since she was pulled away for something else and forgot to complete the assessment but stated she did not look at the resident's toes. Interview on 07/20/21 at 5:30 P.M. with LPN #765 confirmed she applied the resident's Unna boots one time but could not recall the date or if his toes were covered or left open. On 07/21/21 at 9:01 A.M. interview with Wound Clinic Nurse Manager #989 revealed the resident came into the clinic on 06/23/21 with an Unna boot on. She specifically recalled the toe being covered with an undated, large band aide, and when the band aide was removed from the toe it revealed three fourths of his toenail was missing and maggots were present that were about the size of a half a grain of rice. She stated the maggots were so small, it was likely they just hatched. On 07/21/21 at 2:33 P.M. interview with the Administrator revealed LPN #5555 signed off the treatment to Resident #73's BLE on 07/07/21 on nights. That would have been the last dressing change prior to his most recent hospitalization . He also stated he would attempt to find a description of the wounds from the dressing change on 07/07/21 night shift. He never provided this information despite several attempts to obtain the information. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 07/22/21 at 5:30 P.M. interview with the Administrator, DON #999, the ADON, and Quality Assurance (QA) Nurse #987 revealed the facility was unaware of the great toe injury that was discovered at the wound clinic with maggots. The administrative staff also confirmed they were unsure if the right toe or the left toe was affected (since the facility order stated right great toe but the wound clinic notes stated left great toe), and no treatment was ordered for the great toe wound prior to being seen at the wound clinic. The ADON #759 revealed she started her position on 06/21/21. Resident #73's great toe wound was discovered on 06/23/21 by the wound clinic. She had only seen the nurse dress the wound after 06/23/21 and was unsure when the toe wound occurred. There was no investigation completed to determine why the wound on the toe was not identified prior to 06/23/21. This deficiency substantiates Complaint Number OH00124058. This deficiency is also an example of continued non-compliance from the survey dated 06/24/21.

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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** 44068 Based on observation, medical record review and staff interview the facility failed to provide the ordered pressure ulcer treatment for Residents #61 and failed to provide care to prevent the development of a pressure ulcer for Resident #44. This affected two residents (#44 and #61) of three residents reviewed for pressure ulcers/wounds. Findings include: 1. Review of the medical record for Resident #44 revealed an admitted [DATE] with diagnoses including fibromyalgia, cervical disc degeneration, intervertebral disc degeneration in the lumbar region, type two diabetes, chronic diastolic heart failure, muscle weakness and major depressive disorder. Review of the care plan, dated 01/18/21 for Resident #44 revealed the resident had an alteration in activities of daily living (ADL) performance/participation related to generalized weakness, decreased strength and endurance, and decreased activity tolerance, impaired mobility, and incontinence. Interventions included preventative skin care as needed and monitor for any skin breakdown and turning and repositioning as needed. Resident #44 also had a plan of care for alteration in elimination related to bowel and bladder incontinence. Interventions included to monitor for skin redness and irritation. The care plan also revealed the resident was at risk for impaired skin integrity related to generalized weakness, decreased strength and endurance, decreased activity tolerance and impaired mobility. Interventions included to inspect skin during routine daily care, pad and protect skin as needed, skin assessment as ordered and turn and reposition as needed. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had intact cognition with a Brief Interview for Mental Status (BIMS) score of 15 of 15 (intact cognitive response) and no behaviors. The resident required extensive one to two person assist with bed mobility, dressing, toilet use and personal hygiene. The assessment revealed the resident was totally dependent on two or more staff for transfers and did not ambulate. Review of the treatment administration record (TAR) revealed an order, dated 04/19/21 to encourage/assist with turning and repositioning frequently every shift. Review of the Braden Scale assessment dated [DATE] revealed Resident #44 was at high risk for pressure ulcer development with a score of 10. Review of the weekly skin assessment dated [DATE] and 07/13/21 revealed Resident #44's skin was intact and free from abnormalities. Review of the physician's orders for July 2021 revealed orders to apply moisture barrier topically to perineal area/buttocks every shift and as needed (PRN) to maintain skin integrity every shift, to encourage/assist with turning and repositioning frequently every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/14/21 at 12:23 P.M. interview with Resident #44 revealed she had a sore area on her buttocks the aide was treating with barrier cream. The resident had verbalized the sore buttocks and her need for a new bed, to multiple staff members which she was unable to name, during her move from the first floor to the second floor. The resident was unable to recall when she had moved rooms. The resident revealed she slides down and the bar in the middle of the bed put pressure on the sore area on her buttocks. When she moved from the first floor to the second floor an unnamed maintenance personnel informed her she needed a new bed but nothing was ever done about it. She complained she had to call staff frequently to pull her up in bed because of the pain the bed caused on her sore buttock. On 07/14/21 at 12:40 P.M. observation of Resident #44 with the Director of Nursing (DON) revealed the resident had a small, quarter sized, non-blanchable, open area to the right buttock with an area in the middle that felt harder than the surrounding skin. At the time of the observation, the resident was observed wearing an incontinence brief that was saturated with urine. Interview with the resident revealed she had last been checked for incontinence before breakfast (breakfast was served around 8:30 A.M.). At that time, incontinence care was provided and the resident was repositioned. The resident denied being provided incontinence care and/or assistance with repositioning since that time. The findings were confirmed with the DON. In addition, the DON also revealed the open area to the resident's right buttock was a new area. The DON reported she was unsure how the resident would have developed a pressure ulcer if pressure prevention measures were in place and completed as ordered. The DON verified Resident #44 needed incontinence care and indicated she would inform the State tested Nursing Assistant (STNA). On 07/14/21 at 12:45 P.M. interview with Registered Nurse (RN) #444 revealed she was unaware of any pressure areas or any skin abnormalities on Resident #44. Further interview with RN #444 revealed the STNA staff provided incontinence care and repositioned the residents, but she did not. When asked if the STNA staff were to report any skin issues, she stated they were. 2. Review of the medical record for Resident #61 revealed an initial admitted [DATE] and a readmitted after a hospital stay of 06/27/21 with diagnoses including sacroiliitis, chronic kidney disease (CKD), type two diabetes, hypertension, gout and anemia. Review of the admission packet dated 05/26/21 revealed Resident #61 was admitted to the facility with two coccyx pressure areas measuring 2.5x2 and 10.5x4, and a blackened left heel area without measurements. This assessment revealed Resident #61 was at risk for impaired skin integrity and interventions included barrier cream/ointment after each incontinent episode as needed, elevate heels off mattress, explain all procedures prior to care, inspect skin during routine daily care, skin assessment as ordered, turn and reposition as ordered, and treatments per order. The Braden scale within the admission packet revealed the resident scored 14, reflecting the resident was at moderate risk for developing a pressure ulcer. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 05/30/21 and the uncompleted readmission MDS dated [DATE] revealed the resident had intact cognition with a BIMS score of 15 of 15 (intact cognition). The assessments revealed the resident required one-person physical assistance with bed mobility, transfers, toilet use, personal hygiene and dressing and had no behaviors or mood issues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the readmission packet after a hospital stay dated 06/27/21 revealed the resident was readmitted to the facility with one coccyx pressure ulcer and a pressure ulcer on the left heel, no measurements were provided but it was determined that Resident #61 was at risk for impaired skin integrity and interventions included Barrier cream/ointment after each incontinent episode as needed, elevate heels off mattress, explain all procedures prior to care, inspect skin during routine daily care, skin assessment as ordered, and treatments per order. The Braden scale within the admission packet revealed the resident scored 14, reflecting the resident was at moderate risk for developing a pressure ulcer. Review of June 2021 physician's orders for Resident #61 revealed an order, dated 06/30/21 to cleanse coccyx with normal saline, apply Santyl (debriding agent) and a gauze cover and cover with an abdominal (ABD) pad on every day shift for the treatment of the unstageable pressure ulceration. An order was obtained 06/30/21 to clean left heel with normal saline, apply Santyl and Mepilex pad every day shift for Stage II pressure ulceration (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed was viable, pink, or red, moist, and may also present as an intact or open/ruptured blister). Review of the skin assessment dated [DATE] revealed the coccyx wound bed was 100 percent covered with slough with moderate amount of purulent drainage and some odor. The area to the right heel contained a pink wound bed with a small amount of drainage but no odor. There were no measurements documented. Review of the skin assessment dated [DATE] revealed the coccyx wound bed was 50 percent covered with slough with moderate amount of purulent drainage and some odor. The area to the right heel contained a pink wound bed with a small amount of drainage but no odor. There were no measurements documented. Review of the treatment administration record (TAR) for Resident #61 for July 2021 revealed the treatment ordered for her coccyx on 06/30/21 was not completed on 07/08/21. On 07/14/21 at 1:18 P.M. observation of Resident #61 with Licensed Practical Nurse (LPN) #614 revealed the resident was lying supine in bed, in her gown, not dressed for the day. Resident #61 was assisted to her right side and a saturated dressing with cream-colored drainage was hanging off her coccyx, exposing a saturated cream-colored packing. At the time of the observation, interview with Resident #61 revealed her dressing had not been changed for two days. On 07/14/21 at 1:26 P.M. interview with LPN #614 confirmed the dressing was saturated with drainage from the wound, the dressing was not in place, the dressing was undated and it needed changed. LPN #614 was unsure when the dressing had last been changed. Record review revealed no evidence the treatment to the coccyx or left heel was completed as ordered on 07/13/21. This deficiency substantiates Complaint Number OH00124058. This deficiency is also an example of continued non-compliance from the survey dated 06/24/21.

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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** 44068 Based on closed medical record review and staff interview the facility failed to timely diagnose and treat Resident #72 for a urinary tract infection (UTI) following the identification of signs and symptoms the resident was exhibiting. This affected one resident (#72) of three residents reviewed for UTIs. Findings include: Review of the medical record for Resident #72 revealed an admitted [DATE] and a discharge date of [DATE] to the hospital. The resident had diagnoses including fracture of the left femur, idiopathic epilepsy, Alzheimer's Disease, pre-diabetes, chronic systolic heart failure, hypertension, hyperlipidemia and anemia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had adequate vision and hearing, had clear speech, was understood, and understood verbal communication. She had impaired cognition with a Brief Interview of Mental Status (BIMS) score of six of 15 (severe cognitive impairment). The resident required extensive assistance of two or more staff for bed mobility and transfers. Ambulation did not occur. She required extensive assistance of one for dressing and personal hygiene, was independent with set up for meals, and was totally dependent for toilet use. She was always incontinent of bowel and bladder and did not have a toileting program. Review of the nurse progress notes, dated 06/10/21 revealed Resident #72 voided a malodorous, white, milky substance during a physical therapy session. On 06/10/21, a new order to obtain a urine sample via straight catheter for a urinalysis with a culture (a method used to grow and identify bacteria) and sensitivity (allows providers to choose the best antibiotic based on the bacteria grown) was ordered. Review of the physician orders for June 2021 confirmed the order. Review of the laboratory requisition dated 06/10/21 revealed Licensed Practical Nurse (LPN) #456 was notified the urine sample was not picked up due to it being unavailable. LPN #456 agreed to call the laboratory when the urine specimen was ready to be picked up. Review of a progress note, dated 06/20/21 at 5:41 P.M. revealed Resident #72 was assisted to the bathroom where her incontinence brief was observed to be saturated with thick, deep red and malodorous urine. Once again, a new order was received to obtain a urine sample for a urinalysis with a culture and sensitivity on 06/20/21. Review of the physician orders for June 2021 confirmed the order. Review of the progress note, dated 06/21/2021 at 7:10 A.M. revealed a urine sample was not obtained, the physician was notified, and the information would be passed to the oncoming shift. Review of the progress note, dated 06/21/2021 at 8:57 P.M. revealed an attempt was made to obtain a urine sample for urinalysis, but Resident #72 was unable to void an adequate amount. Fluids were encouraged and the physician and the night shift nurse were notified. (continued on next page)

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	07/22/2021

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the laboratory results report, dated 06/25/21 at 2:31 P.M. revealed Resident #72's urine was collected on 06/22/21 (12 days after her initial signs and symptoms of a urinary tract infection (UTI)) and was positive for bacteria in her urinary tract. Review of progress note, dated 06/25/2021 at 2:52 P.M. revealed the laboratory results were provided to the physician who ordered a broad-spectrum antibiotic. A new order was received to start the broad-spectrum antibiotic, Keflex 500 milligram (mg) three times per day for seven days for the positive urinary tract infection while awaiting the sensitivity. The positive laboratory test was received and the resident was treated for a UTI 15 days after her initial UTI signs and symptoms began. Review of the physician orders for June 2021 confirmed the order. Interview on 07/14/21 at 5:12 P.M. with STNA #740 revealed Resident #72 had milky white urine for quite some time. She stated multiple nurses were notified of the abnormal urine and believed it had been at least a couple weeks before a urine sample was attempted to be collected. She revealed she was unable to recall what nurses were notified but knew it was more than one nurse who was notified. Interview on 07/19/21 at 11:28 A.M. with the Administrator and MDS LPN #437 confirmed Resident #72 was ordered a urinalysis with a culture and sensitivity on 06/10/21 and the sample was not obtained until 06/22/21. The Administrator initially stated there was not enough urine for the sample, but then confirmed the urine could have been obtained through a straight catheter. He also confirmed LPN #456 did not obtain the urine sample and was no longer employed at the facility. The Administrator could not provide a reason why the urine sample was not obtained by a day or night nurse between 06/10/21 (when the first signs and symptoms were reported) and 06/22/21 (when the urine sample was obtained). This deficiency substantiates Complaint Number OH00123952. This deficiency is also an example of continued non-compliance from the survey dated 06/24/21.