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	12/16/2022

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41266 Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, review of Nursing Home Guidance from the Centers for Disease Control (CDC), observations of staff and residents, medical record reviews, review of the facility Coronavirus (COVID-19) policies and staff and resident interviews, the facility failed to implement effective and recommended infection control practices, including the implementation of appropriate isolation and quarantine procedures to prevent the spread of COVID-19 within the facility. This resulted in Immediate Jeopardy on 11/21/22 when 11 residents (Residents #2, #3, #12, #26, #36, #43, #44, #54, #65, #66, and #78) on the second floor tested positive for COVID-19. Residents #43 and #78 were roommates and each tested positive on 11/21/22. On 11/25/22, 17 additional residents (Residents #5, #15, #30, #39, #40, #41, #49, #50, #53, #57, #58, #67, #71, #72, #74, #77, and #87) tested positive for COVID-19. On 11/26/22, Resident #47 tested positive for COVID-19. On 11/26/22, Resident #45, who was Resident #47's roommate, was moved to another room and placed with Resident #37 who had not been exposed and had tested negative for COVID-19. The facility failed to place Resident #45 under quarantine due to exposure despite the facility's current COVID-19 outbreak. On 11/27/22, Resident #13 tested positive for COVID-19. Resident #55, who was Resident #13's roommate remained in a room with Resident #55 from 11/27/22 to 11/30/22. On 11/30/22, Resident #55 who was not vaccinated for COVID-19 and was Resident #13's roommate, was moved to another room with Resident #32, who was unvaccinated, had not been exposed to COVID-19, and had tested negative for COVID-19. The facility failed to place Resident #55 under quarantine due to exposure despite the facility's current COVID-19 outbreak. On 11/28/22, Resident #87, who tested positive for COVID-19 on 11/25/22, was transported to the hospital, where Resident #87 remained until 12/06/22. Furthermore, the facility failed to monitor a COVID-19 positive resident (Resident #43) during a smoke break to ensure he did not smoke with Resident #46 who was negative for COVID-19, failed to ensure staff properly utilized personal protective equipment (PPE), failed to dispose of PPE properly, and failed to ensure staff properly sanitized equipment. The lack of current effective infection control practices and prevalence of continued positive cases in the facility placed all 77 residents currently residing in the facility at potential risk for serious life-threatening harm, negative health outcomes/complications, and/or death related to the facility's failure to control the COVID-19 outbreak. (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/01/22 at 5:47 P.M., Director of Operations (DOO) #195, the Director of Nursing (DON), Assistant Director of Nursing (ADON) #172, and Regional Nurse/Infection Preventionist (RN/IP) #189 were notified Immediate Jeopardy began on 11/21/22 when 11 residents (Residents #2, #3, #12, #26, #36, #43, #44, #54, #65, #66, and #78) on the second floor tested positive for COVID-19. On 11/25/22, seventeen additional residents (Residents #5, #15, #30, #39, #40, #41, #49, #50, #53, #57, #58, #67, #71, #72, #74, #77, and #87), who resided on both the first and second floor, tested positive for COVID-19. Following the identification of the COVID-19 positive residents the facility failed to ensure effective infection control practices were implemented to prevent the cohorting of positive and negative residents, to ensure proper transmission-based precautions were implemented timely and failed to ensure staff utilized proper personal protective equipment when caring for residents. The Immediate Jeopardy was removed on 12/02/22 when the facility implemented the following corrective actions: On 12/01/22 by 6:31 P.M., DOO #195 educated all department heads on proper infection control practices, cohorting COVID-19 positive residents, proper practices for residents who are exposed to COVID-19, removal of Transmission Based Precautions (TBP), and proper isolation practices. On 12/01/22 at 6:40 P.M., Resident #46 was assessed for signs and symptoms of COVID-19 and the need for additional precautions due to Resident #46 being exposed to COVID-19 during smoking. Resident #46 remained in a private room. On 12/01/22 by 7:09 P.M., an ad hoc Quality Assurance Performance Improvement meeting was conducted to review proper infection control practices including TBP, personal protective equipment, COVID-19 cohorting, and smoking of COVID-19 positive residents. On 12/01/22 at 7:30 P.M., all COVID-19 positive residents who smoke were educated on the designated smoke times. On 12/01/22 by 8:45 P.M., a Root Cause Analysis was conducted for the identified issues regarding TBP, COVID-19 cohorting, COVID-19 exposures, and smoking of COVID-19 positive residents. On 12/01/22 by 9:55 P.M., RN/IP #189 reviewed all COVID-19 positive residents and COVID-19 exposed residents to ensure appropriate infection control practices were in place for COVID-19 positive residents and COVID-19 exposed residents. On 12/01/22 by 10:00 P.M., RN/IP #189 or designee educated all staff on proper infection control practices, donning and doffing of personal protective equipment, proper placement of masks and respirator straps, appropriate personal protective equipment (PPE) for COVID-19 positive residents, proper disposal of used PPE in resident rooms, and proper sanitization of equipment. All remaining staff including any agency staff will be educated prior to the start of their next shift. Any newly hired staff will be educated upon orientation, annually, and as needed. On 12/01/22 by 10:00 P.M., all staff were educated by the DON/designee on the smoking designation times for COVID-19 positive residents being different then the smoking designation times for COVID-19 negative residents. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/01/22 at 11:59 P.M., Resident #55 was moved to a private room due to being exposed to a COVID-19 positive resident. On 12/02/22, the DON, RN/IP #189, and/or Administrator began conducting audits to ensure all infection control practices regarding proper personal protective equipment, cohorting of residents, TBP, and smoking of COVID-19 positive residents were in place. The audits were conducted five to seven days for one week, then three times a week for three weeks. Observations conducted on 12/05/22 and 12/07/22 revealed the facility was implementing proper infection control procedures. Interview on 12/06/22 at 11:00 A.M. with Unit Manager #131, on 12/06/22 at 3:00 P.M. with Activities Director #90, and on 12/07/22 at 6:00 P.M. with Licensed Practical Nurse #140, revealed all the staff were knowledgeable regarding proper infection control protocols as well as the facilities infection control policies and procedures. Although the Immediate Jeopardy was removed on 12/02/22, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure ongoing compliance. Findings include: During the entrance conference on 11/30/22 at 10:43 A.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #97 revealed the facility currently had 32 residents who had tested positive for COVID-19. The first 11 residents (Residents #2, #3, #12, #26, #36, #43, #44, #54, #65, #66, and #78) tested positive on 11/21/22. An additional 17 residents (Residents #5, #15, #30, #39, #40, #41, #49, #50, #53, #57, #58, #67, #71, #72, #74, #77, and #87) tested positive for COVID-19 on 11/25/22. Resident #47 tested positive for COVID-19 on 11/26/22. Residents #13 and #70 tested positive for COVID-19 on 11/27/22. On 11/28/22, Resident #87, who tested positive for COVID-19, on 11/25/22, was sent to the hospital for treatment and remained in the hospital. Resident #60 tested positive for COVID-19 on 11/29/22. 1. Review of Resident #47's medical record revealed an admitted [DATE]. Medical diagnoses included COVID-19 (11/26/22), atherosclerotic heart disease of native coronary artery without angina pectoris, and type two diabetes mellitus. Review of the quarterly Minimum Data Set Assessment (MDS) assessment, dated 10/18/22, revealed Resident #47 had moderately impaired cognition. Resident #47 required extensive assistance from one staff to complete ADLs. Review of Resident #47's census revealed Resident #47 was in a semi-private room (with Resident #45 from 11/25/22 until 11/26/22 when Resident #45 changed rooms). Review of the Resident #47's progress notes revealed on 11/26/22 at 2:06 P.M., Resident #47 tested positive for COVID-19. Resident #47's son was notified. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #45's medical record revealed an admitted [DATE]. Resident #45's medical diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, psychomotor deficit following cerebral infarction, major depressive disorder, essential hypertension, personal history of COVID-19 (06/13/22), and hyperlipidemia. Review of the annual MDS assessment, dated 09/11/22, revealed Resident #45 had intact cognition. Resident #45 required extensive assistance from one to two staff to complete ADLs. Review of Resident #45's census revealed on 11/25/22, Resident #45 was placed in a semi-private room with Resident #47 until 11/26/22 when Resident #45 was moved to another semi-private room (with Resident #37). Review of the progress notes revealed on 11/25/22 at 4:14 P.M., Resident #45 was tested for COVID-19 due to testing surveillance and the results were negative. On 11/26/22 at 2:49 P.M., Resident #45 was transferred to a different room due to Resident #45's roommate testing positive for COVID-19. There was no indication Resident #45 was placed under quarantine after being exposed to Resident #47 who tested positive for COVID-19 on 11/26/22. Review of Resident #37's medical record revealed an admitted on 11/07/22. Resident #37's medical diagnoses included pneumonitis due to inhalation of food and vomit, metabolic encephalopathy, chronic venous hypertension with ulcer and inflammation of left lower extremity, hypoglycemia, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), essential hypertension, heart failure, and Type two diabetes mellitus. Review of the admission MDS assessment, dated 11/15/22, revealed Resident #37 had moderately impaired cognition. Resident #37 required limited assistance from one staff to complete ADLs. Review of Resident #37's census revealed from 11/26/22 through 12/01/22, Resident #37 resided in the same semi-private room as Resident #47. Review of Resident #37's progress notes revealed Resident #37 tested negative for COVID-19 on 11/21/22. Observations of Resident #37 and Resident #45's room, on 11/30/22 at 1:45 P.M and 3:35 P.M., and on 12/01/22 at 10:05 A.M., revealed Resident #37 and Resident #45 were not placed under quarantine/isolation despite Resident #45 having been exposed to COVID-19 by Resident #47, who had tested positive for COVID-19. Interview on 11/30/22 at 6:21 P.M. with the Director of Nursing (DON) and Regional Nurse/Infection Preventionist (RN/IP) #189 confirmed Resident #45 was not placed under quarantine following a known exposure to Resident #47 and was placed with Resident #37 who had not been exposed and tested negative for COVID-19. RN/IP #189 stated the current guidance from the Center for Disease Control (CDC) indicated exposed residents were not required to be placed under quarantine. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility undated policy titled Coronavirus (COVID-19) Policy and Procedure, revealed the policy indicated, asymptomatic patients do not require empiric use of Transmission-Based Precautions (TBP) while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. Examples of when empiric TBP following close contact may be considered include: patient is moderately to severely immunocompromised, patient is residing on a unit with others who are moderately to severely immunocompromised, or patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions. The policy also stated, droplet precautions will be implemented for identified residents who are not up to date with COVID-19 vaccination with suspected Coronavirus until after day 10 following the exposure (day 0) if they do not develop symptoms. Review of CDC guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, last updated 09/23/22, revealed examples of when empiric Transmission-Based Precautions following close contact may be considered include: Patient is unable to be tested or wear source control as recommended for the 10 days following their exposure. Patient is moderately to severely immunocompromised. Patient is residing on a unit with others who are moderately to severely immunocompromised. Patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions. 2. Review of Resident #13's medical record revealed an admitted [DATE]. Resident #13's medical diagnoses included COVID-19 (11/27/22), encephalopathy, major depressive disorder, aphasia, schizoaffective disorder, essential hypertension, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of Resident #13's census record revealed Resident #13 resided in the same room as Resident #55 from 11/27/22 through 11/30/22 when Resident #55 changed rooms. Review of Resident #13's progress notes revealed on 11/27/22 at 4:18 P.M., Resident #13 remained in a private room related to a positive COVID-19 test on 11/27/22. All services and meals were to be provided in the room. Review of the Medicare 5-Day MDS assessment, dated 12/01/22, revealed Resident #13 had moderately impaired cognition. Resident #13 required extensive assistance to total dependence from one to two staff to complete ADLs. Resident #13 was under isolation/quarantine. Review of Resident #55's medical record revealed an admitted [DATE]. Resident #55's medical diagnoses included acute respiratory failure with hypoxia, other pulmonary embolism without acute coronary pulmonale, and unspecified asthma. Review of the admission MDS assessment, dated 11/18/22, revealed Resident #55 had intact cognition. Resident #55 required supervision to limited assistance from one staff to complete ADLs. Review of Resident #55's census revealed the resident was admitted to a semi-private room, with Resident #13, on 11/08/22. Resident #55 remained in the room with Resident #13 from 11/27/22 through 11/30/22. On 11/30/22, Resident #55 was moved to another semi-private room with Resident #32, who was negative for COVID-19 and unvaccinated. Review of Resident #55's immunizations revealed the resident was unvaccinated for COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #55's progress notes, dated from 11/01/22 to 12/01/22, revealed there were not any notes related to the resident's room move or any indication Resident #55 had been placed under quarantine following exposure to Resident #13. Review of Resident #32's medical record revealed an admitted [DATE]. Resident #32's medical diagnoses included encephalopathy, acute respiratory failure with hypoxia, major depressive disorder, hyperlipidemia, essential hypertension, and cognitive communication deficit. Review of the admission MDS assessment, dated 10/31/22, revealed Resident #32 had severely impaired cognition. Resident #32 required extensive assistance from one staff to complete ADLs. Review of Resident #32's census revealed the resident was in a semi-private room with Resident #55 on 11/30/22 and 12/01/22. Review of Resident #32's immunizations revealed the resident was unvaccinated for COVID-19. Review of Resident #32's progress notes, revealed on 11/25/22 at 11:45 A.M. Resident #32 was noted to test negative for COVID-19. Observations on 11/30/22 at 1:45 P.M and 3:35 P.M., and on 12/01/22 at 10:05 A.M., confirmed Resident #32 and Resident #55 were roommates. There were no indications the room was under quarantine or any TBP were implemented. Interview on 11/30/22 at 1:55 P.M. with ADON #172 confirmed Resident #32 and Resident #55 were roommates. ADON #172 stated Resident #55 was moved to another room with Resident #32 when Resident #55's roommate, Resident #13, tested positive for COVID-19. ADON #172 confirmed Resident #32 and Resident #55's room was not under quarantine or any TBP. Interview on 11/30/22 at 6:21 P.M. with the Director of Nursing (DON) and Regional Nurse/Infection Preventionist (RN/IP) #189 confirmed Resident #55 was not placed under quarantine following a known exposure to Resident #13 and was moved into a room with Resident #32 who had not been exposed, was unvaccinated, and tested negative for COVID-19. RN/IP #189 stated the current guidance from the Center for Disease Control (CDC) indicated exposed residents were not required to be placed under quarantine. Information obtained via email on 12/01/22 at 12:23 P.M. from Regional Nurse/Infection Preventionist (RN/IP) #189 confirmed Resident #55 was unvaccinated for COVID-19. Review of the facility undated policy titled Coronavirus (COVID-19) Policy and Procedure, revealed the policy indicated asymptomatic patients do not require empiric use of Transmission-Based Precautions (TBP) while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. Examples of when empiric TBP following close contact may be considered include: patient is moderately to severely immunocompromised, patient is residing on a unit with others who are moderately to severely immunocompromised, or patient is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions. The policy also stated, droplet precautions will be implemented for identified residents who are not up to date with COVID-19 vaccination with suspected Coronavirus until after day 10 following the exposure (day 0) if they do not develop symptoms. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. On 11/30/22 at 1:45 P.M., STNA #182 was observed to enter Resident #47's room. The door of the room had a red sign posted on which indicated Droplet Precautions. There was a cart filled with personal protective equipment (PPE) placed outside of the Resident #47's door. STNA #182 did not don an isolation gown or gloves prior to entering the room. At 1:47 P.M., STNA #182 exited Resident #47's room with a meal tray and placed it on the meal cart. STNA #182 then used the hand sanitizer which was located on the wall in the hallway. Interview on 11/30/22 at 1:50 P.M., with STNA #182 revealed STNA #182 was an agency aide but had worked at the facility four or five previous times. STNA #182 confirmed she entered Resident #47's room without donning an isolation gown or gloves. STNA #182 confirmed the room door had a sign which indicated Droplet Precautions. STNA #182 stated she was told in report, Resident #47's roommate had tested positive for COVID-19 and had been moved to another room. STNA #182 stated she was not aware Resident #47 who resided in the room was positive for COVID-19. Review of the facility undated policy titled Coronavirus (COVID-19) Policy and Procedure, revealed the policy indicated Personal Protective Equipment included face mask (procedure or N95), face shield or goggles, gown, and gloves. For COVID-19 positive residents, staff should wear full PPE: N95 mask, gown, gloves, and face shields for care of residents who are known COVID positive for all resident contact. 4. Review of Resident #70's medical record revealed an admitted [DATE]. Resident #70's medical diagnoses included COVID-19 (11/27/22), neutropenia (an abnormally low count of a type of white blood cell), other nonspecific abnormal finding of lung field, solitary pulmonary nodule, and osteoarthritis. Review of the Medicare 5-day MDS 3.0 assessment, dated 11/28/22, revealed Resident #70 had mildly impaired cognition. Resident #70 required extensive assistance from one to two staff to complete ADLs. Resident #70 was in isolation/quarantine. Review of Resident #70's progress notes revealed on 11/27/22, Resident #70 tested positive for COVID-19. Resident #70's guardian was made aware. On 11/30/22 at 4:43 P.M. STNA #127 was observed to remove her N95 respirator and eye protection and placed them face down, with the front of the respirator and eye protection touching the top of the PPE cart. STNA #127 donned a new N95 respirator, gloves, isolation gown, and eye protection, and entered Resident #70's room, (a room of a resident in droplet precautions). At 4:45 P.M., STNA #127 exited room [ROOM NUMBER]. STNA #127 used hand sanitizer located on the wall in the hallway. STNA #127 then donned the N95 respirator and eye protection that had been laying on top of the PPE cart. STNA #127 did not sanitize the top of the PPE cart before placing the PPE on top of it or after re-donning the PPE. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/30/22 at 4:45 P.M., STNA #151 was observed to don gloves from the PPE cart, removed her N95 respirator and eye protection, and placed them along the hand railing outside of Resident #13's room, (the resident was in droplet precautions). With the same gloves on, STNA #151 then donned a new N95 respirator, isolation gown, and eye protection. STNA #151 then entered Resident #13's room. At 4:57 P.M., STNA #151 exited Resident #13's room without any PPE on. STNA #151 then donned a new N95 respirator and donned the eye protection that was laying against the hand railing. STNA #151 took the N95 respirator that had been laying against the railing in her hand and carried it to the nurse's station to throw it into a trash can and then washed her hands at the sink behind the nurse's station desk. STNA #151 did not sanitize the hand railing before placing the PPE against it or after removing the PPE. On 11/30/22 at 5:00 P.M., STNA #127 was observed to respond to a call light for Resident #70's room. STNA #127 removed her N95 respirator and eye protection and placed them face down, with the front of the respirator and eye protection touching the top of the PPE cart. STNA #127 donned a new N95 respirator, gloves, isolation gown, and eye protection. STNA #127 did not don the PPE in the proper sequence and did not sanitize the top of the PPE cart before placing PPE on top of the cart or after removing the PPE from the top of the cart. At 5:04 P.M., STNA #127 answered a call light for Resident #51's room, a resident who was not in any type of transmission-based precautions (TBP). Interview on 11/30/22 at 5:05 P.M. with STNA #127 and STNA #151 confirmed each STNA had donned PPE in the wrong sequence by donning gloves before donning all other PPE. Both STNAs confirmed the proper PPE sequence was posted on the isolation room door sign. STNA #127 and STNA #151 each confirmed they had not sanitized the top of the PPE cart or the hand railing before placing PPE on/against it and had not sanitized the same items after removing the PPE. Review of the facility undated policy titled Coronavirus (COVID-19) Policy and Procedure, revealed the policy indicated, standard cleaning and disinfection procedures (e.g., using cleaners in water to preclean surfaces prior to applying disinfectants to frequently touched surfaces or objects or indicated contact times) will be used for Coronavirus environmental control in all settings within the facility including those resident care areas in which aerosol generating procedures are performed. Review of undated CDC guidance titled Sequence for Putting On Personal Protective Equipment (PPE), revealed the type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE. The guidance listed the gown as number one and stated fully cover torso from neck to knees, arms to end of wrists, and wrap around back. Fasten in back of neck and waist. The guidance listed the mask or respirator as number two and stated secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Fit-check respirator. The guidance listed goggles or a face shield as number three and noted place over face and eyes and adjust to fit. The guidance listed gloves as number four and noted extend to cover wrist of isolation gown. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	5. On 11/30/22 at 6:30 P.M. two small trash cans were observed in Resident #70's room. One of the trash cans was located just inside Resident #70's door and the other was located across the room, underneath the window, closer to Resident #70's bed. Both trash cans had clear trash bags in them and were open. Both trash cans had used PPE in them which included isolation gowns, masks, and gloves. A large red biohazard bag was also observed to be open and laying on the floor inside Resident #70's door next to the unused bed in the room. There was used PPE in the large red biohazard bag including isolation gowns, masks, and gloves. There were no containers with lids present in Resident #70's room. None of the bags were tied closed at the time of the observation and PPE including masks and gloves were observed to have overflowed onto the floor. Interview with Resident #70 at the time of the observation confirmed the trash cans and contents of the cans and red bag were present in the room. Interview and observation on 11/30/22 at 6:55 P.M. with agency Licensed Practical Nurse (LPN) #197 confirmed there was used PPE in the open trashcans and the open red biohazard bag which was sitting on the floor. Interview and observation on 12/06/22 at 1:20 P.M. with Resident #70 revealed there was a large open red biohazard bag filled with used PPE which was sitting on top of the unused mattress on the spare bed in Resident #70's room. Interview and observation on 12/06/22 at 1:30 P.M. with STNA #127 confirmed there was used PPE in the large, open, red biohazard bag sitting on Resident #70's spare bed mattress. STNA #127 stated, it is not supposed to be like that. We are supposed to use yellow bags for linens/sheets/towels/washcloths and red bags for trash and used PPE. The bags are supposed to be in containers with either the bags tied shut or the containers should have lids. Review of the facility undated policy titled Coronavirus (COVID-19) Policy and Procedure, revealed the policy indicated management of laundry, food service utensils, and medical waste will also be performed in accordance with standard procedures. 6. On 12/01/22 at 9:40 A.M. Receptionist #147 was observed sitting at the front desk with her goggles sitting on the top of her head. The receptionist was talking with a visitor. The visitor left the desk area, and the surveyor approached the desk to sign-in. Receptionist #147 greeted the surveyor and talked for a couple of minutes while her goggles remained on the top of her head. Interview on 12/01/22 at 9:42 P.M. with Receptionist #147 confirmed she was not wearing her eye protection properly. The receptionist pulled the goggles down over her eyes after surveyor intervention. On 12/01/22 at 9:46 A.M. Housekeeper (HKP) #142 and Registered Nurse (RN) #154 were observed to have a surgical mask under their N95 respirator mask with both straps of their N95 respirators worn down around their necks. Interview on 12/01/22 at 9:48 A.M. with HKP #142 and RN #154 confirmed they had a surgical mask under their N95 respirator and both straps of the N95 respirators were worn down around their necks. On 12/01/22 at 9:50 A.M. HKP #145 was observed with a surgical mask under her N95 respirator with both straps of her N95 respirator mask worn down around her neck. (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	12/16/2022

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on 12/01/22 at 9:52 A.M. with HKP #145 confirmed she had a surgical mask under her N95 respirator and both straps of her N95 respirator were worn down around her neck. Review of the facility undated policy titled Coronavirus (COVID-19) Policy and Procedure, revealed the policy indicated, during the care of any resident, all staff shall adhere to standard precautions, which are the foundations for preventing transmission of infectious agents in all healthcare settings. Procedure mask or N95 (if potential for splash or contamination a procedure mask can be used to cover N95). Face shield or goggles to protect eyes and face as needed. For COVID-19 positive residents, staff should wear full PPE: N95 mask, gown, gloves, and face shields for care of residents who are known COVID positive for all resident contact. Review of CDC guidance titled How to Use Your N95 Respirator, last updated 03/16/22, revealed under section three titled Put on the N95, the guidance noted hold the N95 in your hand with the nose piece bar (or foam) at your fingertips. If yours does not have a nose piece, use the text written on it to be sure the top end is at your fingertips. Place the N95 under your chin with the nose piece bar at the top. Pull the top strap over your head, placing it near the crown. Then, pull the bottom strap over and place it at the back of your neck, below your ears. Do not crisscross the straps. Make sure the straps lay flat and are not twisted. Place your fingertips from both hands at the top of the nose piece. Press down on both sides of the nose piece to mold it to the shape of your nose. 7. Review of Resident #43's medical record revealed an admitted [DATE]. Resident #43's medical diagnoses included COVID-19 (11/21/22), retention of urine, benign prostatic hyperplasia with lower urinary tract symptoms, and hypotension. Review of the Medicare 5-Day MDS assessment, dated 11/24/22, revealed Resident #43 had mildly impaired cognition and Resident #43 was under isolation. On 12/01/22 at 10:35 A.M. observation during a smoke break revealed Resident #43, who tested positive for COVID-19 on 11/21/22 and who was in droplet precautions on this date, was outside on the smoking patio sitting on a bench. Another resident, (later identified as Resident #46), who was negative for COVID-19, was observed sitting in her wheelchair next to Resident #43. Resident #46 and Resident #43 were observed to be within three feet of each other. There was one staff person observed standing in front of Resident #43 and Resident #46 with a N95 respirator and eye protection in place. The staff was observed talking with the residents. There were no observed attempts to separate the residents. Resident #43 and Resident #46 were not wearing any PPE at the time of the observation. Interview on 12/01/22 at 10:40 A.M. with STNA #127 confirmed Resident #43 and Resident #46 were within three feet of each other. STNA #127 stated the two residents were not supposed to be smoking together but Resident #46 was non-compliant with the scheduled smoking breaks and wanted to go outside anytime she saw any other residents out on the smoking patio. STNA #127 stated since it is Resident #46's right to smoke, we let her smoke when she wants to. Review of the facility undated policy titled Coronavirus (COVID-19) Policy and Procedure, revealed the policy indicated For COVID-19 positive residents, residents with suspected or confirmed Coronavirus will be placed in a private room or area. The policy did not address smoking. This deficiency represents non-compliance investigated under Complaint Number OH00137922.