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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Worthington Christian Village		STREET ADDRESS, CITY, STATE, ZIP CODE 165 Highbluffs Blvd Columbus, OH 43235	

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THIS IS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on record review, staff interview, facility investigation report review, and policy review, the facility failed to provide adequate physical assistance with bed mobility. This resulted in Actual Harm to Resident #43 when one staff person was changing the bed sheets and rolled Resident #43 out of bed onto the floor, resulting in a leg fracture. Resident #43 required the assistance of two staff for bed mobility. This affected one (Resident #43) of two residents reviewed for falls. The census was 32.Findings Include:Resident #43 was admitted to the facility on [DATE]. Pertinent diagnoses included Parkinson's disease, hereditary and idiopathic neuropathy, cerebrovascular disease, spondylosis, degenerative disease of nervous system, and fibromyalgia.Review of Resident #43's minimum data set (MDS) assessment, dated 08/14/24, revealed she was cognitively intact, and required substantial/maximal assistance for rolling left and right in the bed, and returning to lying in bed. Review of Resident #43's fall risk assessment, dated 08/14/25, revealed she was at moderate risk for falling.Review of Resident #43's care plan, dated 05/26/22, revealed she was at risk for activities of daily living (ADL) decline related to impaired mobility. Interventions included the assistance of two people with all bed mobility, turning and repositioning for comfort.Review of Resident #43 Investigation Summary, dated 09/20/25, documented Registered Nurse (RN) #150 was called to Resident #43's room by Certified Nursing Assistant (CNA) #200 after Resident #43 fell from the bed. RN #150 assessed Resident #43 and she was in pain. The physician was contacted as Resident #43 had requested to go to the hospital and the physician agreed to send Resident #43 to the hospital. The investigation did not include a description of the injuries Resident #43 suffered from the fall.Review of CNA#200's written statement dated 09/20/25 revealed she was changing Resident #43's bed sheet by herself while Resident #43 was in bed. She rolled Resident #43 to the left side of the bed, away from herself to assist with changing the sheet. CNA #200 looked up after starting to change the sheet and saw Resident #43 holding on to the bed rail, and she continued changing the bed sheet. Then, CNA #200 stated she saw Resident #43 fall from the bed. CNA #200 reported the bed was in a high position while she was changing the bed sheet and Resident #43 fell.During an interview on 01/21/26 at 2:55 P.M., the Director of Nursing (DON) confirmed the facility did an investigation after the fall and confirmed CNA #200 was in Resident #43's room by herself, changing the bed sheet. Resident #43 was supposed to have two staff in the room when bed mobility tasks were being performed. She stated she was not given specific details about the nature of Resident #43's injury, only that she had fractured her leg because of the fall.During an interview on 01/22/25 at 10:28 A.M., RN #150 stated she was called to Resident #43's room by CNA #200, after Resident #43 fell from her bed. RN #150 stated the resident was in pain and did not want an X-ray performed at the facility. RN #150 stated she sent Resident #43 to the hospital after Resident #43 requested it, and after she spoke with the primary care physician. She confirmed CNA (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 0689 Level of Harm - Actual harm Residents Affected - Few	#200 was the only staff person in Resident #43's room at the time of the fall.On 01/21/26 at 1:56 P.M. an attempt was made to interview CNA#200 via telephone. The number was disconnected and CNA #200 was no longer employed at the facility. Review of facility Fall Prevention Program, dated 01/28/25, revealed the facility will protect residents from injury by falls. If the admission Fall Assessment indicates a risk for falls, the unit nurse will immediately initiate an acute care plan for fall prevention.The deficiency was corrected on 09/22/25 when the facility implemented the following corrective action:On 09/20/25, Resident #43's attending physician, hospice nursing staff, and resident representatives were notified immediately after the fall occurred.On 09/20/25, Resident #43 was sent to the hospital for further assessment of potential injuries. It was deemed she had a fracture to her leg (specifics were not available other than a leg fracture.)On 09/20/25, facility maintenance staff audited and physically checked mobility bars on all residents' beds to ensure they were secure and safe; no issues were found.On 09/20/25, the facility added bolsters to Resident #43's bed/mattress for safety if she returned to the facility.From 09/20/25 to 09/22/25, Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an assessment of all residents to determine which residents needed the assistance of two people. No new residents were found to need two-person assistance.From 09/20/25 to 09/22/25, the DON or designee provided all CNAs education on the residents who needed the assistance of two people for bed mobility and where to find that information in the electronic medical records.From 09/20/25 to 09/22/25, all CNAs completed a competency, observed by DON or designee, to ensure proper procedures were followed for changing bed sheets and care for residents who required two-person assistance for bed mobility.Starting 09/22/25, the DON or designee will audit all resident Kardex/tasks on electronic medical records to ensure accuracy, five times a week for four weeks, and then weekly for two months.Starting 09/22/25, the DON or designee will complete random certified nursing aides (CNA) performance/safety audits of bed mobility and resident care five times per week for four weeks, and then monthly after for two months.Results of the audits were presented to the Quality Assurance Performance Indicators (QAPI) on 10/29/25 to review the plan of correction; no changes or issues were noted.This deficiency represents non-compliance investigated under Complaint Number 2628187.

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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 record review, interview, and facility policy review, the facility failed to ensure blood pressure and pain medications were administered within the ordered parameters. This affected one resident (#17) of two reviewed for pain management. The facility census was 32.Findings include: Review of Resident #17's medical record revealed an admission date of 12/24/25 with diagnoses including, but not limited to, spinal stenosis, essential hypertension, alcohol dependence, and hyperlipidemia. Review of Resident #17's admission Minimum Data Set (MDS) 3.0 completed 12/31/25 revealed no cognitive deficit.Review of Resident #17's physician order dated 12/24/25 revealed an order for Carvedilol (used to lower heart rate and blood pressure) oral tablet 25 milligrams (mg) one tablet by mouth two times a day related to primary hypertension, with parameters to hold the medication if the systolic blood pressure (SBP) is less than 110 millimeters per mercury (mmHg) or the pulse is less than 60 and to notify the physician or nurse practitioner (NP). Review of Resident #17's physician order dated 12/25/25 revealed an order for Hydrochlorothiazide (diuretic) oral tablet 25 mg one tablet by mouth one time a day related to essential primary hypertension, with parameters to hold if the SBP is less than 110 mmHg and to notify the physician or NP. Review of Resident #17's physician order dated 12/25/25 revealed an order for Lisinopril (used to lower blood pressure) oral tablet 40 mg one tablet by mouth one time a day related to primary hypertension with parameters to hold if the SBP is less than 110 mmHg and to notify the physician or NP.Review of Resident #17's physician order dated 01/09/26 revealed an order for Oxycodone HCl (opioid) oral tablet five mg give one tablet by mouth every four hours as needed for mild to moderate pain (pain levels one to five). Review of the Resident #17's Medication Administration Record (MAR) 01/01/26 to 01/20/26 revealed Carvedilol, Hydrochlorothiazide, and Lisinopril were administered on 01/05/26 with a documented SBP of 108 mmHg. Additional review of the MAR for Resident #17 revealed Oxycodone was administered on 01/13/26 with a documented pain level of zero.Review of the progress notes for Resident #17 on 01/05/26 revealed no documentation of physician or nurse practitioner notification. Interview with Director of Nursing (DON) 01/22/26 at 8:45 A.M. revealed if a resident's blood pressure falls outside of parameters it should not be given unless the physician gives an order to administer the medication, in which case it should be documented in the medical record. The DON confirmed the resident was given all three blood pressure medications outside of parameters on 01/05/26. Continued interview with DON revealed as needed pain medications should only be administered within the parameters given by the physician or documented if the physician ordered them outside of parameters. The DON confirmed the resident should not have been given Oxycodone on 01/13/26 if reporting a pain level of zero. Review of the facility policy titled Medication Administration, effective January 2025, revealed the Unit Nurse will check special instruction and contradictions, including checking what vital signs should be monitored or other assessments, prior to the medication being given. Further review of the policy revealed when an as needed medication is administered the Unit Nurse must document in the MAR and resident chart why the medication was given. This represents noncompliance investigated under complaint 2568645.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of hospice provider contract, and facility policy review, the facility failed to ensure hospice documentation was reviewed and consistent with facility orders and plan of care for a resident. This affected one resident (#6) reviewed for hospice. The facility census was 32.Findings include:Review of Resident #6's medical record revealed an admission date of 12/20/24 with diagnoses including but not limited to cerebral atherosclerosis, vascular dementia, anxiety disorder, hypertension, and bipolar disorder.Review of Resident #6's annual Minimum Data Set (MDS) dated [DATE] revealed severe cognitive impairment. Review of MDS revealed the resident held food in their mouth/cheeks and/or had residual food in mouth after meals and complained of difficulty or pain when swallowing.Review of Resident #6's physician orders revealed a diet order dated 12/20/24 for a regular diet, mechanical soft texture and honey thick liquids.Review of quarterly nutrition reviews dated 06/30/25, 10/20/25, and 12/29/25 revealed the resident held food in their mouth/cheeks or residual food in mouth after meals and was coughing or choking during meals or when swallowing medications.Review of Resident #6's hospice reports dated 12/24/24, 12/26/25, and 12/27/25 revealed documentation of the residents' diet to be soft/puree and honey thick liquids.Interview on 01/21/26 at 1:09 P.M. with Hospice Nurse #202 revealed the orders hospice had on file for diet were soft/puree texture and honey thick liquids.Interview on 01/22/26 at 8:45 A.M. with the Director of Nursing (DON) revealed when hospice records are sent to the facility the medical records department reviews them.Interview on 01/22/26 at 8:50 A.M. with Medical Records (MR) #145, with DON present, confirmed their department receives the records and orders from hospice and uploads them into the documentation system, however they do not review the contents of the documents.Further interview on 01/22/26 at 9:16 A.M. with the DON confirmed the medical record department was not reviewing the records from hospice and was unable to confirm whether someone has been reviewing them.Interview on 01/22/26 at 10:20 A.M. with the DON revealed hospice verified they were documenting the incorrect diet and confirmed the resident was on a mechanical soft, honey thick liquid diet.Review of the hospice agreement between the facility and hospice, signed 12/19/24 and 12/20/24, revealed both facility and hospice will provide each other with plans of care and make any necessary modifications to it for the consistency of the hospice plan of care and facility plan of care.Review of the facility's hospice policy, revised 1/28/25, revealed the facility will collaborate with hospice to ensure the most recent hospice plan of care specific to each patient and will ensure the facility communicates with the hospice regarding the residents' plan of care.