

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365988	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER Willow Brook Christian Home		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Lazelle Rd 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. (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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(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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital record review, interview, observation, review of the mechanical lift instructions, and policy review, the facility failed to use appropriate slings for the mechanical lift and failed to maintain the mechanical lift per the manufacturer's instructions resulting in significant resident injury with mechanical lift transfers. Actual harm occurred on 07/20/25 when Resident #4, who required extensive assistance from two staff members and a mechanical lift with transfers, experienced a fall during a mechanical lift transfer when staff used the incorrect sling and the sling straps broke. The resident was transferred to the emergency room for evaluation and subsequently admitted to the surgical trauma intensive care unit overnight due to multiple rib fractures and a right occipital scalp contusion and hematoma. Additionally, an incident of actual harm occurred on 07/18/25 when Resident #1, who required extensive assistance from two staff members and the use of a mechanical lift with transfers, was transferred from her bed to her wheelchair and was struck in the forehead with the swivel bar of the mechanical lift after the transfer was completed. The resident sustained a laceration to the forehead requiring four staples. This affected two (Resident #1 and Resident #4) of three residents reviewed for falls. The facility census was 48. Findings include: 1. Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, diabetes mellitus, Parkinson's disease, kidney failure, congestive heart failure, syncope and collapse, and mild cognitive impairment. Review of the care plan, dated 07/21/25, revealed the resident had activities of daily living (ADL) self-care deficits related to general decline and collapse and was dependent upon staff for transfers with a mechanical lift. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 05/27/25, revealed the resident had intact cognition and required physical staff assistance for transfers and mobility. Review of a nursing progress note, dated 07/20/25 at 9:05 A.M., revealed Registered Nurse (RN) #70 was called into the room by a Certified Nursing Assistant (CNA) and observed Resident #4 on the floor, lying on his left side. The CNA (unidentified) stated while using the mechanical lift, the sling broke/ripped and the resident fell to the floor, on his left shoulder, head, neck, left ribs, and left hip. The resident stated it hurt to take a deep breath, and he was tearful. Nine-one one (911) was called. The physician and family were notified. The resident was transported to the Emergency Department (ED). Review of the Fall Investigation/Incident Report revealed on 07/20/25 at 9:05 A.M. revealed Resident #4 was being transferred into bed with a mechanical lift when suddenly the sling broke and the resident fell onto the floor, hitting the left side of his head, neck, ribs, shoulder and hip. The sling being used was not the appropriate mechanical lift sling and was a thin, hospital sling. The immediate intervention implemented was to ensure the correct sling is used. All thin, hospital slings were removed to ensure they would not be used again. Review of the After Visit Summary from the ED dated 07/20/25-07/21/25 revealed the resident was admitted to the Surgical Trauma Intensive Care Unit (ICU) due to fracture of multiple ribs. Imaging tests included computed tomography (CT) of the cervical spine, chest, abdomen, pelvis, maxillofacial, and head, and x-rays of the chest, pelvis, and right knee. The resident sustained an acute mildly displaced fracture of the left sixth lateral rib. There were multiple additional remote bilateral rib fractures. Upon discharge back to the facility, the resident was prescribed oxycodone for pain control. Interview on 08/29/25 at 11:20 A.M. with Resident #4 revealed he fell from the Hoyer lift when the sling broke and he hit his head and broke his rib. Interview with CNA #72 on 08/29/25 at 1:18 P.M. revealed she and another CNA were transferring Resident #4 with the wrong type of sling when it broke during the transfer resulting in the resident falling (from the lift) and caused the resident to hit the floor. CNA #72 stated the sling was already beneath the resident (when they secured the sling to the mechanical/Hoyer lift) and they didn't change the sling to a correct one. Interview on 08/29/25 at 11:59 P.M. with the Assistant Director of Nursing (ADON) confirmed Resident #4 fell during a mechanical lift transfer due to the night shift staff placing an incorrect, thin hospital sling under him. The day shift staff utilized the incorrect sling, and it broke during the transfer resulting in Resident #4 suffering fractured ribs. Review of the manufacturer's pamphlet titled, Electric Patient Lift, revealed specific slings are made for the Electric Patient Lifts. For the safety of the patient, do not intermix slings and patient lifts of different manufacturers. Review of the facility's policy titled, Safe Resident Handling/Transfers, revision date of 07/18/25, revealed it is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in</p>		