STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365988	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Brook Christian Home	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of the self-reported incidents and policy review, the facility failed to ensure an injury of unknown origin was timely reported to the state agency. This affected one (#44) of three residents reviewed who had injuries. The facility census was 40. Findings include Based on medical record review, staff interview, review of the self-reported incidents and policy review, the facility failed to ensure an injury of unknown origin was timely reported to the state agency. This affected one (#44) of three residents reviewed who had injuries. The facility census was 40. Findings Include:Review of the medical record for Resident #44 revealed an admission date of 02/01/22 and death/discharge date of 09/11/25. Diagnoses included vitamin D and B12 deficiencies, dementia with behavioral disturbance, malnutrition and Alzheimer's disease late onset.Review of the care plan dated 02/01/22 revealed Resident #44 had the potential for skin impairment related to fragile skin and decreased mobility with interventions to wear geri-sleeves for bilateral arms. Review of the physician orders dated 10/17/23 revealed Resident #44 should be transferred using the Hoyer lift (mechanical lift). On 11/20/24 revealed an order for geri-sleeves or long sleeves for bilateral hands every shift. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) assessment was not completed as resident was rarely/never understood indicating impaired cognition and Resident #44 was dependent for all activities of daily living and mobility. Review of the progress note dated 09/03/25 revealed a skin tear was noted on Resident #44 in the morning measuring five and a half centimeters by one centimeter (cm). The skin tear was cleansed with normal saline and a foam dressing was applied. Hospice was notified and would be in the facility on 09/04/25 to assess. Review of the incident report dated 09/03/25 revealed a Registered Nurse (RN) #200 was alerted of a skin tear (5.5 cm by 1.0 cm). Preview of the progress note dated 09/04/25 revealed staff spoke with Resident #44's daughter about the skin tear found on 09/03/25. The note stated their was an ongoing investigation to ascertain the cause of it. Review of the skin assessment dated [DATE] revealed a laceration to the right upper extremity measuring 5.5 cm by 0.6 cm by 0.1 cm. Review of the self reported incident dated 09/11/25 revealed Residents daughter alleged Resident #44 received a skin tear due to mistreatment. The investigation summary reported the skin tear was identified on 09/03/25 by the aide during the morning shift and the nurse obtained treatment orders. According to the investigation, the resident had a history of striking out at others during care and had an order for geri-sleeves. Resident #44 also used a Broda chair and the investigation found no evidence of abuse or mistreatment. Interview on 12/23/25 at 8:42 A.M. with RN #200 revealed she was informed of Resident #44 having a skin tear. She revealed at the time of the aide report, she was not aware how it occurred and had not asked the staff present if they knew how she obtained the injury. RN #200 stated she assumed it occurred during the Hoyer transfer but acknowledged she had not asked staff. Interview on 12/23/25 at 9:42 A.M. with Certified Nursing Aide (CNA) #99 revealed she observed some blood on Resident #44's arm after a Hoyer transfer and revealed she informed the other CNA also participating in the Hoyer transfer. They lifted the resident's sleeve and found a large skin tear and they informed the nurse. CNA #99 reported no issues during the transfer and no reason to believe it occurred during the Hoyer transfer. She reported she was unsure how the skin tear occurred. Interview on 12/23/25 at 10:34 A.M. with the Director of Nursing (DON) verified RN #200 was given a written disciplinary action due to a delay in reporting an injury of unknown origin. The DON first revealed she was informed of the injury of unknown origin the next day at the care conference with Residents daughter (09/04/25). The DON verified after review of the self reported incident documentation and staff statements Resident #44's family reported concerns to facility during the care conference on 09/11/25. The DON stated it was believed the resident was cut by a buckle on the Broda chair and after doing the investigation that was the cause determined by the facility. The DON also acknowledged if the injury was not known and observed to occur it should be reported timely and then the investigation would be initiated. A follow-up interview on 12/23/25 at 10:56 A.M. with RN #200 verified she filled out the incident report related to the Resident #44's skin tear but reported she had not completed the section asking what happened. She reported that was filled out by another staff after the investigation was completed. Interview on 12/23/25 at 10:56 A.M. with the Assistance Director of Nursing (ADON) #315 verified she updated the incident report reasoning after facility completed the investigation as they did not know how the injury occurred. Interview on 12/23/25 at 11:20 A.M. with the Regional Administrator #250 and the DON revealed the facility felt they could determine the

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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Interview on 12/23/25 at 10:56 A.M. the Assistance Director of Nursing (ADON) #315 verified she updated the incident report reasoning after the facility completed the investigation as they did not know how the injury occurred. Interview on 12/23/25 at 11:20 A. M. the Regional Administrator #250 and the DON revealed the facility felt they could determine the cause of the injury based on the information obtained in the investigation and Resident #44 had just been transferred by using the Hoyer. She stated it most likely occurred from a buckle from the Broda chair. They acknowledged the Self reported incident (SRI) investigation was not started until after 09/11/25 and verified staff and resident interviews were done after 09/11/25. Interview on 12/23/25 at 1:10 P.M. the CNA #210 reported Resident #44's injury was found after a Hoyer transfer, but reported their was no incident that occurred that would have caused the large skin tear injury during that transfer. CNA #210 reported she was