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	11/07/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on observation, record review, staff interviews, and resident interviews, the facility failed to ensure all residents received dignified choices to remain in their room. This affected one (Resident #300) out of one resident reviewed for dignity. The facility census was 45. Findings include: Review of the medical record for Resident #300 revealed an admitted [DATE] and diagnoses of hypertension, hyperlipidemia, hypothyroidism, chronic pain syndrome, anxiety disorder, primary insomnia, depression, polyneuropathy, tachycardia, urinary tract infection (UTI), and encephalopathy. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #300 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Resident #300 had no behavioral problems. Review of the care plan for Resident #300 revealed a goal that the resident will be free of falls. The intervention stated, personal alarm when in bed or chair at all times. Review of the physician orders for Resident #300 dated 10/15/24 revealed an order for the resident not to be in room by herself and a personal alarm to chair and bed at all times. Review of the progress note for Resident #300 on 10/16/24 at 3:20 P.M. revealed the Assistant Director of Nursing (ADON) found Resident #300 trying to get out of bed without support and noted she would need to be monitored at all times outside of her room. Additionally, on 10/20/24 at 10:57 A.M. a nursing note stated Resident #300 requested to spend time in her room and she was advised by a nurse that she needed to stay with the group at all times for her safety. On 10/24/24 at 9:06 P.M. a nursing note reported Resident #300 was upset and doesn't understand why she can't be in her room by herself. During an interview on 11/04/24 at 11:26 A.M., Resident #300 became visibly upset and cried, she expressed frustration stating she wanted to return to her room more frequently even if just to use the bathroom. Resident #300 reported she hears the staff whispering, don't let her go back to her room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/05/24 from 1:28 P.M. to 1:55 P.M. revealed Resident #300 sitting in her wheelchair sleeping or watching television (TV) in the common area with her personal alarm attached to her gown. Observation on 11/05/24 at 2:30 P.M. revealed Resident #300 sitting back in the common area watching TV During an interview on 11/05/24 at 2:30 P.M., Certified Nursing Assistant (CNA) #157 stated Resident #300 needs more assistance with one-on-one staffing due to a high fall risk, so staff keep her in the common areas for additional help. She stated they do it for her safety and when the resident isn't at an activity with a group, staff usually have her sit in the common area in front of the TV when staff are busy so they can keep an eye on her.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, staff interviews, and resident interviews, the facility failed to provide a comfortable, homelike environment for Resident #35. This affected one resident (#35) of six residents reviewed for comfortable living spaces. The facility census was 45. Findings Include: Resident #35 had an admitted [DATE] with diagnoses including retention of urine, hypertension, neuromuscular dysfunction of bladder, age related osteoporosis with current pathological fracture of vertebrae, assistance with personal care, muscle weakness, abnormalities of gait and mobility, insomnia, urinary tract infection, and anxiety disorder. Observations on 11/04/24, 11/05/24, and 11/06/24 revealed a minimum of 11, and a maximum of 12 packages of incontinence briefs stacked and stored along the wall in Resident #35's bathroom. Some packages were opened with briefs scattered randomly about the space on the floor and on top of the unopened packages creating a disorderly, and uncomfortable living space for Resident #35. Interview with Resident #35 on 11/04/24 at 9:52 A.M. confirmed that she didn't like her bathroom being used for storage of her personal incontinence briefs because the bathroom isn't a closet. I've asked them several times to put them in my closet. Resident #35 confirmed that she felt the space was disorderly and uncomfortable due to the briefs being scattered about the bathroom. Interview with Certified Nursing Assistant (CNA) #157 on 11/06/24 at 10:07 AM confirmed that Resident #35 had 11 bags of incontinence briefs stacked and stored in her bathroom, with some briefs scattered randomly about the space on the floor and on top of the unopened packages. CNA #157 stated that staff keep the briefs in the resident's bathrooms for easy access, unless they have a closet large enough to store them. CNA #157 stated that Resident #35 had a small closet, so the briefs were stored in her bathroom.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536 Based on observation, resident and staff interview, and record review, the facility failed to document ongoing assessments to evaluate the need for the use of physical restraints. This affected two residents (#28 and #300) of eight residents reviewed for the use of restraints. The facility census was 45. Findings include: 1. Resident #28 had an admitted [DATE] with diagnoses including major depressive disorder, cardiac arrhythmia, hypertension, overactive bladder, gastroesophageal reflux disease (GERD), diverticulosis, cognitive communication deficit, and dementia. Review of the care plan dated 11/09/22 for Resident #28 on 11/07/24 at 12:53 P.M. revealed that Resident #28 was a high risk for fall, and had an intervention listed to place a personal alarm to wheelchair and recliner every shift. Review of the medical record for Resident #28 on 11/07/24 at 11:02 A.M. revealed no initial assessment, nor ongoing assessments for the use of alarm devices and/or restraints. Review of the medical record for Resident #28 on 11/07/24 at 12:53 P.M. revealed a progress note entry dated 09/17/24 at 10:13 A.M., Licensed Dietician (LD) #180 documented that on 9/16/24, LD #180 heard Resident #28's chair alarm sounding. LD #180 entered Resident #28's room and found Resident #28 standing in front of her recliner. LD #180 cautioned Resident #28 to sit down in her recliner and Resident #28 did return to sitting position in her recliner. LD #180 educated Resident #28 on use of the call light to get help instead of standing up. Resident #28 agreed. Observation on 11/05/24 at 1:16 P.M. revealed Resident #28 in her room seated in the recliner with non-slip material and a chair alarm visible and in place. Interview with Resident #28 on 11/05/24 at 1:16 P.M. confirmed Resident #28 was aware of the chair alarm, and felt restricted with her voluntary body movement because the alarm would make a loud, audible signal to alert the staff. Resident #28 stated that she wouldn't stand, because if she stood up, the alarm would make a very loud sound that you can hear in the front of the building and they all come running in here! Resident #28 stated that she can still walk, but the office and the nurses won't allow her to walk by herself, or get up by herself so she doesn't fall. Interview with the Director of Nursing (DON) on 11/05/24 at 4:09 P.M. confirmed that the facility does not complete restraint assessments for alarms, because they aren't considered to be restraints. The DON stated that there are physician's orders for the alarms and the nurses check to ensure that they are in place. The DON confirmed the alarms should be used to notify staff of the resident falling, but should not be used to prevent a resident from getting up. 51068 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for Resident #300 revealed an admitted [DATE] and diagnoses of hypertension, hyperlipidemia, hypothyroidism, chronic pain syndrome, anxiety disorder, primary insomnia, depression, polyneuropathy, tachycardia, urinary tract infection (UTI), and encephalopathy. Review of Resident #300's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #300 had intact cognition with no behavioral problems. Review of Resident #300's physician orders dated 10/15/24 revealed an order for personal alarm to chair and bed at all times. Review of Resident #300's progress note on 10/16/24 revealed Resident #300 was attempting to get out of bed without support. She was found by the Assistant Director of Nursing (ADON) and was immediately redirected to put her feet back on the bed. The resident will need to be monitored at all times outside of her room. Review of Resident #300's assessments from 10/15/24 to 11/07/24 revealed no evidence of a restraint assessment. Observation on 11/04/24 at 11:26 A.M. revealed Resident #300 sitting on the side of her bed with an alarm in place. Interview on 11/04/24 at 11:26 A.M. with Resident #300 revealed the resident did not like the sound the alarms made, stating, they make an awful noise when I stand up. Observation on 11/05/24 from 1:28 P.M. to 1:55 P.M. revealed Resident #300 sitting in her wheelchair with an alarm in place. Interview on 11/05/26 at 4:08 P.M. with the Director of Nursing (DON) confirmed the facility did not conduct a restraint assessment for Resident #300. Observation on 11/06/24 at 9:15 A.M. revealed Resident #300 sitting in her wheelchair with an alarm in place.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review, resident family interview, staff interview, and facility policy review, the facility failed to provide the resident or resident representative with a written notice of a bed hold. This affected one (Resident #25) out of two residents reviewed for hospital transfers. The facility census was 45. Findings include: Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses of dementia, chronic kidney disease, type two diabetes mellitus, parkinsonism, hypertension and muscle weakness. Review of the admission Minimum Data Set (MDS) 3.0 assessment completed 10/09/24 revealed Resident #25 was moderately cognitively impaired, exhibited no behaviors, and required partial/moderate assistance with toileting and bathing. The resident required substantial/maximal assistance with bed mobility. Review of progress notes dated 10/09/24 revealed Resident #25's wife shared concerns about finances and the resident's long-term stay. She noted that while they had long-term care insurance, it only covered $100 per day, and she was worried they would run out of funds. Review of progress notes dated 10/17/24 revealed Resident #25's wife expressed frustration with the United States of America's medical system, citing that Resident #25 had medical needs and issues their finances could not fully cover. She stated she was very concerned they would run out of money. Review of progress notes dated 10/18/24 revealed Resident #25 was discharged to the local hospital due to a change in condition. The notes indicate the wife will reach out with any questions. However, there was no confirmation a bed-hold notice was given to the family at the time of transfer. Review of bed-hold notice dated 10/18/24 for Resident #25 revealed residents with Medicare will be charged a bed-hold rate of $373.00 per day. However, the notice did not include a signature confirming the resident or their representative had received the bed-hold notice. Interview on 11/06/24 at 9:53 A.M. with Resident #25's wife denied that she or the resident had received a copy of the bed-hold notice, which should have included the daily rate upon transfer to the hospital. The wife stated had she seen the bed rate, it may have influenced her decision regarding the facility's bed-hold policy. She expressed continued concerns about the financial strain of her husband's stay in the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/06/24 at 10:02 A.M. with Administrative Coordinator (AC) #102 and #103 said nursing staff are responsible for completing the bed-hold notice before a transfer occurs. This notice is then provided to emergency medical personnel, who are responsible for delivering it to hospital staff. AC #102 and #103 confirmed the medical record for Resident #25 did not contain any evidence indicating the bed-hold notice had been properly delivered to the wife. They further explained all residents transferred out of the facility are required to receive a bed-hold notice, and admission staff are expected to contact the resident's family within 24 hours of transfer to review the bed-hold details. AC #102 and #103 confirmed the wife was called; however, they could not provide documentation to support this. Interview on 11/06/24 at 3:11 P.M. with Registered Nurse (RN) #122 confirmed nursing staff are responsible for completing the bed-hold notice prior to transfer. These notices are handed off to emergency medical personnel along with the resident's medications list. However, RN #122 stated she does not follow up with residents to ensure they receive the bed-hold notice and does not have a system in place to confirm delivery. She also denied completing a bed-hold notice for Resident #25, stating long-term residents are not required to receive the notice since they pay on a monthly rate. Review of bed-hold notice upon transfer policy dated 02/18/24 revealed the facility is required to provide the resident and/or resident representative with written notice specifying the duration of the bed-hold policy, as well as explaining the return of the resident to the next available bed. In the event of an emergency transfer, the facility is to provide written notice within 24 hours. The policy also stated the facility will keep a signed and dated copy of the bed-hold notice in the resident's file.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on record review, interview and review of facility policy, the facility failed to develop comprehensive care plans for Resident #10, #12, #15, #34, and #41. This affected five residents (#10, #12, #15, #34, and #41) of 18 records reviewed for care planning. The facility census was 45. Findings include: 1. Review of Resident #34's medical record revealed an admitted [DATE] with diagnoses including major depressive disorder, anxiety disorder, Parkinson's disease, occipital neuralgia, and spondylosis without myelopathy. Review of Resident #34's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed she had a moderate cognitive impairment. Review of Resident #34's physician order dated 06/05/24 revealed an order for Clonazepam (benzodiazepine) 0.5 milligrams (mg) one tablet by mouth for anxiety. Review of Resident #34's physician order dated 09/01/24 revealed an order for Sertraline (antidepressant) tablet 75 mg by mouth one time a day for depression and anxiety. Review of Resident #34's physician order dated 09/27/24 revealed an order for Lorazepam (anti-anxiety) 0.5 mg for anxiety. Review of Resident #34's plan of care on 11/04/24 revealed it did not address the resident's use of medications for anxiety and depression. Interview on 11/05/24 at 3:19 P.M. with MDS Nurse #113 verified Resident #34's medications for anxiety and depression were not addressed in the care plan. 2. Review of Resident #10's medical record revealed an admitted [DATE] with diagnoses including chronic respiratory failure, hypertension, chronic pain, osteoporosis, unspecified dementia, and chronic obstructive pulmonary disease. Review of Resident #10's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had impaired cognition. Review of Resident #10's physician order dated 10/10/24 revealed an order for chlorthalidone (a diuretic) 25 milligrams one time a day. Review of Resident #10's skin assessment dated [DATE] revealed she had a vascular wound to her left shin and left posterior calf. Review of Resident #10's skin assessment dated [DATE] revealed the resident had a vascular wound to her left calf and her left shin wound had healed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's skin assessments dated 10/21/24, 10/28/24, and 11/4/24, revealed the resident's vascular wound to her left calf remained. Review of Resident #10's plan of care on 11/04/24 revealed it did not include the use of diuretics and the resident's vascular wounds. Interview on 11/05/24 at 3:19 P.M. with MDS Nurse #113 revealed she updated care plans quarterly with MDS assessments. She verified there were no wound or diuretic care plans for Resident #10 and there should have been. 49039 3. Review of the medical record for Resident #12 revealed an admitted [DATE] with diagnoses of hypertension, hypothyroidism, anemia, major depressive disorder, gastro-esophageal reflux disease, and muscle weakness. Review of the quarterly MDS assessment completed 09/13/24 revealed Resident #12 had minimal difficulty with hearing when wearing a hearing aid or other hearing appliance and is moderately cognitively impaired. Review of progress notes dated 10/05/24 revealed Resident #12 is scheduled to see the Audiologist on 11/11/24. Review of Resident #12's care plan does not note the current hearing impairment, nor does it include interventions to address or manage this issue. Interview on 11/04/24 at 11:31 A.M. with Resident #12 revealed the resident voiced concerns about her hearing aid, stating that it has been broken for some time and that she has not received any updates regarding its repair or replacement. Resident #12 was unable to provide further details due to severe hearing impairment without the hearing aid. Interview on 11/05/24 at 9:33 A.M. with Scheduling Certified Nursing Assistant (CNA) #133 confirmed that Resident #12 had a hearing aid and requires some assistance with its use. CNA #133 also confirmed the resident is currently experiencing issues with the functioning of the hearing aid. CNA #133 noted Resident #12 is very social and struggles with communication when the hearing aid is not working, as it is extremely difficult for her to engage without it. Interview on 11/05/24 at 3:23 P.M. with MDS Nurse #113 confirmed Resident #12's care plan did not include her hearing impairment, nor were there interventions in place to manage or prevent complications related to her hearing impairment. 4. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses of dementia, metabolic encephalopathy, dysphasia, cerebral infarction, muscle weakness, and insomnia. Review of the MDS assessment completed 10/01/24 revealed Resident #41 is severely cognitively impaired, requires partial/moderate assistance for walking 10 feet and wheeling 50 feet, and had no wander alarms in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Wandering Risk assessment completed 07/28/24 and 10/01/24 revealed Resident #41 cannot follow instructions, can move independently in a wheelchair, cannot communicate, and had a medical diagnosis of dementia, placing him at high risk for wandering. Review of the care plan revealed no interventions were implemented to prevent Resident #41 from wandering or eloping from the facility. Review of physician orders dated 10/05/24 for Resident #41 revealed new orders stating the resident should never be left alone in his room while in the wheelchair. Interview on 10/07/24 at 9:08 A.M. with ADON #115 revealed Resident #41 was assessed on 07/28/24 and 10/01/24 as being at risk for wandering. ADON #115 confirmed the care plan should reflect the risk of elopement due to wandering, along with interventions to prevent it. 37100 5. Resident #15 was admitted to the facility on [DATE]. Her diagnoses were atrial fibrillation, pain in shoulder, rhabdomyolysis, lymphedema, hypertension., hyperlipidemia, candidiasis, and heart failure. Review of her MDS assessment, dated 10/01/24, revealed she was cognitively intact. Review of Resident #15's current physician orders found that she was prescribed Zoloft (anti-depressant) 25 milligrams (mg) at bedtime for depression, This order was started in June 2024. Review of Resident #15's current care plan revealed no care plan to identify the use of Zoloft (anti-depressant), no interventions or documentation to identify targeted behaviors for the use of an anti-depressant. Interview with MDS Nurse #113 on 11/05/24 at 3:15 P.M. confirmed there was no care plan for the use of Zoloft. She confirmed there should have been a care plan for this medication. Review of the policy, Care Plans-Comprehensive, undated, revealed an interdisciplinary team should develop and maintain a comprehensive care plan for each resident that identified problem areas, incorporate risk factors associated with identified problems, reflecting treatment goals and objectives, identifying the professional services that are responsible for elements of care, prevented declines in the resident's functional status, and enhance the optimal functioning of the resident by focusing on a rehabilitated program. The comprehensive care plan should be developed within seven days of the completion of the resident's comprehensive assessment Care plans were to be revised as changes in the resident's condition dictates.

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F 0684 Level of Harm - Minimal harm or potential for 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** 43064 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure Resident #34's dressing changes for a skin tear were completed as ordered. This affected one resident (#34) of two residents reviewed for skin conditions. The facility census was 45. Findings include: Review of Resident #34's medical record revealed an admitted [DATE] with diagnoses including major depressive disorder, anxiety disorder, Parkinson's disease, occipital neuralgia, and spondylosis without myelopathy. Review of Resident #34's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had moderate cognitive impairment. Review of Resident #34's progress note dated 10/26/24 revealed she had a fall and obtained an 'area on the left hand.' She was sent to the hospital due to a different injury. Review of Resident #34's fall investigation dated 10/26/24 revealed she had a fall and received first aide, there was a dressing on the left hand. Review of Resident #34's progress note dated 10/27/24 revealed she returned from the hospital. There were no mentions of her left hand injury. Review of Resident #34's physician order dated 10/28/24 revealed an order related to the left hand skin tear. Nursing was to cleanse the area with normal saline, pat the area dry, apply xeroform and then a nonadherent dressing, and wrap with Kerlix. This was to be done every Monday, Wednesday, and Friday. Review of Resident #34's skin assessment dated [DATE] revealed she had two skin tears to her left palm. One measuring 2.2 centimeters (cm) by 0.2 cm by 0.1 cm and one measuring 3.0 cm by 0.4 cm by 0.1 cm. Observation on 11/04/24 at 9:02 A.M. of Resident #34 revealed her left hand was wrapped in gauze dated 10/30/24. Interview on 11/04/24 at 9:12 A.M. with Certified Nursing Assistant (CNA) #126 verified her bandage was dated 10/30/24. Interview on 11/04/24 at 9:17 A.M. with Licensed Practical Nurse (LPN) #129 reported the treatment nurse was supposed to change her dressing on Monday, Wednesday, and Friday. Interview on 11/07/24 at 9:16 A.M. with the Director of Nursing (DON) verified there were no wound measurements until 10/28/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy 'Wound Treatment Management' dated 02/18/24 revealed wound treatments were to be provided in accordance with physician's orders including frequency of dressing changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50536 Based on observation and record review the facility failed to ensure the resident environment remained free of accident hazards by safely storing portable oxygen per the facility policy/procedure. This had the potential to affect one (Residents #38) of one resident reviewed. The facility census was 45. Findings include: Observation on 11/04/24 at 9:22 A.M. revealed three portable oxygen tanks stored in Resident #38's room. Two of the tanks were stored using a transport cart, one tank was freestanding and unsecured, leaning against the wall. Interview with Certified Nursing Assistant (CNA) #157 confirmed the oxygen tanks stored in Resident #38's room were not currently in use, and the one oxygen tank that was freestanding and unsecured, should be on a cart. CNA #157 confirmed the three oxygen tanks should be returned to the designated oxygen storage room. Review of the facility's policy titled, Oxygen Safety dated 02/18/22, and revised on 02/18/24, on revealed the facility's policy was to provide a safe environment for residents, staff, and the public. Compliance guideline number four stated oxygen storage locations shall be in an enclosure, or within an enclosed interior space with doors or gates that can be secured against unauthorized entry. Cylinders should be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review and interview the facility failed to document nutritional supplement intake and complete an annual nutrition assessment. This affected three (Resident #25, #36 and #41) of eleven reviewed for the use of nutritional supplements. The facility census was 45. Findings include: 1. Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses of acute kidney failure, dementia, type two diabetes mellitus, protein calorie malnutrition and parkinsonism. Review of the Minimum Data Set (MDS) assessment completed 10/09/24 revealed Resident #25 was moderately cognitively impaired and required setup or clean-up assistance with eating. Review of weight summary dated 09/25/24 revealed Resident #25 weighed 200 pounds, and on 11/01/24, Resident #25 weighed 189 pounds, reflecting a 5.5% weight loss over a two-month period. Review of Nutrition - Fluids plan of care response history revealed no documented fluid intakes from 10/07/24-11/07/24 for Resident #25. Review of physician orders dated 10/10/24 revealed Resident #25 was ordered to receive Glucerna (nutritional supplement) with meals, with dietary to provide the shake at each meal. Review of the care plan dated 10/10/24 revealed Resident #25 had a nutritional problem or potential nutritional problem. Interventions include providing and serving supplements as ordered: 8 ounces of Glucerna three times a day with meals. Review of Mini Nutritional Assessment completed 10/08/24 revealed Resident #25 had a moderate decrease in food intake, is bed/chair bound, had mild dementia, and a basal metabolic rate of 31 (overweight). These factors placed Resident #25 at a high risk for malnutrition. Interview on 11/06/24 at 11:40 A.M. with Registered Nurse #117 confirmed Resident #25 received Glucerna supplements. She was not responsible for administering the supplement, as dietary staff provided it during meal tray pass. She confirmed she has no way to verify whether the resident actually received the supplement or how much was consumed. The nurse noted that dietary staff documents the amount of food the resident eats, but the amount of the supplement consumed was not recorded. The nurse explained on some days, Resident #25 drinks all of the supplement, while on other days, the resident may drink half or none. Interview on 11/07/24 at 8:57 A.M. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #115 revealed that intakes, specifically the amount of Glucerna consumed, are not available in the electronic medical record. Staff do not document how much of the supplement is consumed; only the percentage of food and drinks the resident eats is recorded. The DON and ADON acknowledged the gap in tracking the resident's complete nutritional intake and confirmed this omission could potentially affect the ability to monitor Resident #25's nutritional progress and needs accurately. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/07/24 at 9:06 A.M. with Dietician #111 revealed Resident #25's medical record does not include specific documentation of the amount of supplement consumed. Dietician #111 confirmed that for an accurate reflection of the resident's nutritional status and to ensure appropriate adjustments to the care plan, the intake of supplements should be documented. She confirmed the lack of detailed documentation could result in missed opportunities for timely intervention or adjustments in the resident's care. 2. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses of dementia, metabolic encephalopathy, dysphasia, cerebral infarction, muscle weakness and protein-calorie malnutrition. Review of the MDS assessment completed 10/01/24 revealed Resident #41 is severely cognitively impaired and requires setup or clean-up assistance with eating. Review of Weight Summary revealed on 08/02/24 Resident #41 weighed 142.0 pounds and on 10/25/24 he weighed 145.5 pounds. Review of Nutrition - Fluids plan of care response history revealed no intakes documented from 10/07/24-11/07/24 noting the resident's fluid intakes. Review of physician orders dated 07/30/24 for Resident #41 revealed an order for a Magic cup (nutritional supplement to add calories and protein for those experiencing involuntary weight loss) with meals and an additional order placed on 09/27/24 for Resident #41 to receive Ensure (nutritional supplement) at bedtime. Review of the care plan dated 08/15/24 revealed Resident #41 had a nutritional problem of underweight basal metabolic rate, significant unplanned weight loss, and inadequate oral intake of food and beverages. Interventions included providing and serving supplements as ordered and monitoring intakes, recording every meal. Review of Medical Nutritional Therapy assessment dated [DATE] revealed Resident #41 was underweight, needs improved oral intake with supervision at meals, had chewing and swallowing problems, and required improvement in meal intake to 75%. Magic cups were consumed three times daily to meet needs. Interview on 11/07/24 at 8:57 A.M. with the DON and ADON #115 revealed intakes, specifically the amount of Ensure and Magic cups consumed, are not available in the electronic medical record. Staff do not document how much residents drink of the supplements; they only record the percentage of food and drink they consume as a whole on the tray. The DON and ADON acknowledged the gap in tracking the resident's full nutritional intake. They confirmed the omission could potentially affect the ability to monitor Resident #41's nutritional progress and needs accurately. Interview on 11/07/24 at 9:06 A.M. with Dietician #111 revealed Resident #41's medical record does not include the specific amount of the supplement he drinks. Dietician #111 stated in order to have an accurate reflection of the resident's nutritional status and ensure appropriate adjustments to the care plan, the intake of supplements should be fully documented. She confirmed this lack of detailed documentation could potentially lead to missed opportunities for intervention or adjustment in the resident's care. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37100 3. Resident #36 was admitted to the facility on [DATE]. Her diagnoses were hypertension, anemia, atherosclerotic heart disease, overactive bladder, acute respiratory failure, osteoporosis, cognitive communication deficit, and cerebral infarction. Review of the MDS assessment dated [DATE] revealed Resident #36 had a severe cognitive impairment. Review of Resident #36's nutritional assessments found her most recent assessment was completed on 06/01/23. There was not another assessment completed until 11/05/24. Review of Resident #36's physician/nutritional orders, dated 10/22/24, revealed an order for Ensure with dinner. There was nothing listed in the order or nutritional notes to indicate how much Ensure was to be given to Resident #36 during dinner. Review of Resident #36's Medication Administration Records (MAR) dated October 2024 to November 2024, revealed no documentation to support how much of the Ensure Resident #35 consumed during each offering. Interview with Dietitian #180 on 11/05/24 at 3:00 P.M., 3:35 P.M. and 11/06/24 at 9:30 A.M. confirmed she did not complete an annual nutritional assessment as required for Resident #36. She confirmed the assessments had been completed on 06/01/23 and 11/05/24. Also, she confirmed there was no documentation to support the amount of nutritional supplement Resident #36 consumed each time it was given; she stated she will simply monitor weights and determine if a new interventions should be put in place. Interview with Registered Nurse (RN) #117 on 11/06/24 at 10:20 A.M. confirmed they do not document the amount of a nutritional supplement consumed by a resident; they simply document if it was provided to the resident or not.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51068 Based on record review and staff interview, the facility failed to follow ordered medication administration parameters, and failed monitor a resident for side effects of anticoagulant use. This affected two (Resident #33 and Resident #25) of six resident reviewed for medications. The facility census was 45. Findings include: 1. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses of pseudomonas, muscle weakness, type II diabetes, anxiety disorder, paroxysmal atrial fibrillation, hypertension, hyperlipidemia, primary osteoarthritis, glaucoma, protein calorie malnutrition, and urinary tract infection (UTI). Review of the Minimum Data Set (MDS) assessment completed 09/27/24 revealed a Brief Interview for Mental Status (BIMS) score of nine indicating the resident had cognitive impairment with no behavioral problems in place. Review of Resident #33's care plan dated 09/09/24 revealed the resident had hypertension and atrial fibrillation and will remain free of complications. Interventions included give anti-hypertensive medications as ordered. Review of Resident #33's physician order dated 09/09/24 revealed Sotalol (antiarrhythmic that can decrease blood pressure) tablet 80 milligrams (mg) by mouth one time daily for hypertension, hold if blood pressure is less than 110/70 or heart rate is less than 60. Review of Resident #33's Medication Administration Record (MAR) from 10/01/24 to 11/07/24 revealed Resident #33 received Sotalol 80 mg on days when the blood pressure (BP) was outside the ordered parameters for administration as follows: 10/02/24 BP 109/60, 10/09/24 BP 98/56, 10/16/24 BP 93/74, 10/21/24 BP 111/65 medication held, 10/30/24 BP not taken, 10/31/24 BP not taken, 11/01/24 BP not taken, 11/02/24 BP not taken, 11/03/24 BP not taken, 11/04/24 BP not taken. Additionally, Resident#33's MAR did not have any documentation of the resident's pulse being taken at the time of the Sotalol administration for any of the doses provided. Interview on 11/06/24 at 9:40 A.M. with the Director of Nursing (DON) revealed the nursing staff will follow the parameters for medication administration prior to administering medications to the residents. The DON confirmed Sotalol was being administered outside of the parameters for Resident #33. 49039 2. Review of the medical record for Resident #25 revealed an admitted [DATE] with diagnoses of acute kidney failure, dementia, type two diabetes mellitus, protein calorie malnutrition, atrial fibrillation, atrioventricular block and parkinsonism. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment completed 10/09/24 revealed Resident #25 was moderately cognitively impaired, had a diagnosis of atrial fibrillation or other dysrhythmias, and was prescribed an anticoagulant. Review of physician orders dated 09/27/24 revealed an order for Rivaroxaban (anticoagulant) 15 milligrams by mouth in the evening for atrial fibrillation. Additional orders dated 10/28/24 indicated a change to Apixaban (anticoagulant) 2.5 milligrams orally, twice a day, for atrial fibrillation. Review of the care plan dated 10/18/24 revealed that Resident #25 was on anticoagulant therapy for atrial fibrillation. Interventions included daily skin inspection, monitoring for abnormal bleeding or bruising, and documenting any adverse reactions related to anticoagulant therapy. Review of the medical record from 09/27/24 to 11/04/24 revealed no documentation indicating the monitoring of bleeding or bruising was completed due to anticoagulant therapy for Resident #25. Review of physician orders dated 11/05/24 for Resident #25 revealed updated orders to monitor for prolonged signs of bruising or bleeding, including daily checks for bleeding or bruises due to anticoagulant therapy, in accordance with recommended clinical practices for anticoagulant use. Interview on 11/05/24 at 1:33 P.M. with the Administrator confirmed that documentation supporting the monitoring of bleeding or bruising due to anticoagulant therapy was not available in the medical record. Interview on 11/07/24 at 8:59 A.M. with Assistant Director of Nursing #115 confirmed that the medical record did not include evidence supporting the monitoring of increased bruising and/or bleeding for Resident #25. This monitoring is typically part of routine anticoagulant management to prevent undetected complications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review and staff interview, the facility failed to adequately identify and monitor targeted behaviors for residents who use psychotropic medications. This affected one (Resident #15) of five residents reviewed for unnecessary medications. The census was 45. Findings include: Resident #15 was admitted to the facility on [DATE]. Her diagnoses were atrial fibrillation, pain in shoulder, rhabdomyolysis, lymphedema, hypertension., hyperlipidemia, candidiasis, and heart failure. Review of Resident #15's Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. Review of Resident #15's current physician orders found she was prescribed Zoloft (anti-depressant) 25 milligrams (mg) at bedtime for depression. This ordered was started in June 2024. Review of Resident #15's current care plan revealed no care plan to identify the use of Zoloft, nor any interventions or documentation to identify targeted behaviors for the use of an anti-depressant. Review of Resident #15's behavior tracking documents dated 10/07/24 to 11/06/24 revealed the following behaviors were listed on the tracking form: frequent crying, repeated movements, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate, rejection of care, none of the above observed, resident not available, resident refused, and non applicable. There was nothing listed within the behavior tracking document nor other medical documents that identified specific/targeted behaviors for Resident #15's use of Zoloft. Interview with MDS Nurse #113 on 11/05/24 at 3:15 P.M. confirmed there was no care plan for the use of Zoloft. She confirmed there should have been a care plan for this medication. She confirmed there was no care plan or documentation to support targeted behaviors for Resident #15's use of Zoloft. Interview with Director of Nursing (DON) on 11/05/24 at 3:45 P.M. confirmed the facility documented behaviors on a hard copy log for each resident. She confirmed they do not individualize the behavior tracking logs, they have all possible behaviors listed on it. She confirmed there were no identified targeted behaviors listed or being tracked/monitored for Resident #15.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50536 Based on observation, staff interview, and record review, the facility failed to remove, inactivate, or destroy pathogenic organisms on the surface of a multi-use device (glucometer) to the point where it was rendered safe for handling and re-use. This had the potential to affect three residents (#9, #297, #25) receiving glucometer checks on the Skilled Unit. The census was 45. Findings include: Observation on 11/06/24 at 11:46 A.M. of Registered Nurse (RN) #117 completing a finger stick blood glucose stick (FSBS) on Resident #297 revealed prior to going into the resident room, RN #117 swiped the top of the glucometer with a sani wipe, and then entered Resident #297's room, placed the glucometer on the over bed table without placing a barrier on the table, performed the FSBS check, exited the room after performing hand hygiene and then placed the glucometer on top of the medication cart without the use of a barrier. RN #117 then documented the FSBS in the electronic health record and placed the glucometer in the top drawer of the medication cart without cleansing or sanitizing the glucometer. Interview with RN #117 after she placed the glucometer in the medication cart confirmed there was one glucometer used for the three residents on the skilled unit who required FSBS checks. RN #117 verified she had completed the FSBS procedure. When asked if she sanitized the glucometer prior to placing it back in the medication cart she verified she had not. Observation of the sani-wipe container with the RN at this time also confirmed the manufacturer's direction for dry time on the sani-wipe used to swipe the top of the glucometer prior to the procedure required a two-minute dry time. The nurse confirmed the glucometer was just swiped and did not have the two minute dry time as recommended by the manufacture. Review of the facility's policy titled Glucometer Policy and Procedure, undated, on 11/06/24 at 2:12 P.M. revealed that the policy of the facility is to prevent the spread of bloodborne pathogens. The policy listed recommendations (guidance) for cleaning and decontamination of glucometers that may be contaminated with blood and body fluids. The recommendations included to clean and disinfect glucometers if they must be reused between patients, disinfect the exterior surfaces of the glucometer after each use (even if there is no visible blood or soil) following the manufacturer's directions.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49039 Based on record review and interview the facility failed to follow guidance within their antibiotic stewardship program to ensure antibiotics were ordered appropriately. This affected two (Resident #33 and #101) out of three reviewed for appropriate antibiotic usage. The facility census was 45. Findings include: 1. Review of the medical record for Resident #101 revealed an admitted [DATE] with diagnoses of spinal stenosis, Crohn's disease, anxiety, urinary tract infection, osteoporosis and anemia. Review of Minimum Data Set (MDS) 3.0 assessment completed 09/13/24 revealed Resident #101 was cognitively intact, required substantial to maximal assistance with toileting, and was occasionally incontinent of urine. Review of hospital records dated 09/06/24 revealed Resident #101 was admitted for elective decompression and fusion of the L3-L5 vertebrae. Complications during the hospital stay included acute-on-chronic anemia and a urinary tract infection (UTI) (possibly present on admission). It was noted the UTI was suspected to have developed during the hospital stay, although it was unclear whether symptoms of dysuria or increased urinary frequency were present at admission. No culture and sensitivity testing was performed. Review of admission vitals from 09/06/24 revealed no concerns for fever or increased temperature. The hospital record showed Resident #101 received the first dose of Macrobid (antibiotic) on 09/06/24 at 9:16 A.M. Review of the Medication Administration Record (MAR) for September 2024 showed Resident #101 received Macrobid 100 mg capsules, administered by mouth two times a day for infection. The second dose was given on 09/06/24 at 9:00 P.M., with a discontinue dated of 09/08/24 at 9:00 A.M. Review of the Temperature Summary from admission to 09/19/24 revealed no abnormal temperatures. Review of the infection control log dated 09/06/24 to 09/30/24 revealed Resident #101 had a community-acquired urinary tract infection (UTI) with an onset date of 09/06/24, acquired during hospitalization . The prescribed antibiotic therapy was Macrobid 100 mg, two times a day for two days, as ordered by the hospital. Review of the Revised McGeer Criteria for Infection Surveillance Checklist dated 09/06/24 for Resident #101 revealed the infection checklist had not been completed and had not noted appropriate antibiotic usage according to McGeer criteria for urinary tract infections. McGeer criteria for prescribing antibiotics require the presence of either: -Marked acute dysuria or pain, swelling, or tenderness, and fever with at least one of the following symptoms: suprapubic pain, gross hematuria, increased incontinence, increased urgency, or frequency; OR if there is no fever or leukocytosis, then at least two of the above symptoms must be present. -Additionally, a urine sample must show greater than or equal to 10,000 CFU/mL (colony-forming units per milliliter) or no more than two species of organisms. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #101 medical revealed she did not meet these criteria. No symptoms such as fever, suprapubic pain, or increased incontinence were documented, and a urine culture was not obtained to support the diagnosis. Therefore, the decision to prescribe antibiotics was not fully aligned with the McGeer criteria for UTI management. Interview on 11/07/24 at 8:44 A.M. with Assistant Director of Nursing (ADON) #115 confirmed Resident #101 did not meet the McGeer criteria for antibiotic usage. ADON #115 explained that, despite not meeting the criteria, there are constant difficulties in obtaining lab results from the hospital once residents admit to the facility. She confirmed that she did not have the necessary lab results for Resident #101 to confirm whether the antibiotic usage was appropriate nor documentation supporting these records were requested. Furthermore, the medical record did not indicate physical signs or resident complaints consistent with a urinary tract infection, such as dysuria, fever, or increased urinary frequency. ADON #115 stated that she did not see the need to discontinue the antibiotics ordered by the hospital, given that the UTI diagnosis was made during hospitalization and antibiotic treatment had already been initiated. 51068 2. Review of the medical record for Resident #33 revealed an admitted [DATE] with diagnoses of pseudomonas, muscle weakness, type II diabetes, anxiety disorder, paroxysmal atrial fibrillation, hypertension, hyperlipidemia, primary osteoarthritis, glaucoma, protein calorie malnutrition, and urinary tract infection (UTI). Review of end of protective payment stay (PPS) part A stay Minimum Data Set (MDS) Assessment completed 9/27/24 revealed a brief interview for mental status (BIMS) score of 09 indicating the resident had cognitive impairment with no behavioral problems in place. Review of progress note on 10/17/24 revealed Resident #33 started experiencing hallucinations and his son stated, that is his behavior when UTI is started. An order for stat urine was obtained. Urine was collected per straight catheterization. Review of the physician orders on 10/17/24 revealed orders to obtain a urine analysis. Review of progress note on 10/18/24 the urine sample was sent to the lab for analysis and culture. MD was notified and ordered to start Keflex three times daily, two days prior to receiving the urine culture results. Review of the infection log confirmed Resident #33 had an identified organism of pseudomonas aeruginosa with date of onset on 10/18/24. Review of physician orders start date 10/18/24 and end date 10/21/24 revealed Keflex oral capsule 500 milligram by mouth three times daily. Review of the lab results for the urine culture was collected by American health associates was collected on 10/18/24 and reported on 10/21/24. Review of progress note on 10/21/24 the physician was notified of the urine analysis lab results. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders revealed the resident was ordered to have Cipro oral tablet 250 milligrams by mouth three times daily, with a start date 10/21/23 and discontinued date 10/23/24. Review of physicians note on 10/23/24 revealed due to the urine culture results the physician changed the antibiotic from Cipro to Cefepime due to the urine culture results. Review of physician orders revealed Cefepime Hydrochlorothiazide (HCl) injection solution reconstituted one gram injected intramuscularly every 12 hours, with a start date 10/24/24 and completed date 10/29/24. Review of the progress note on 10/30/24 revealed Resident #33's son was concerned about the resident's confusion and the doctor advised three more days on Cefepime and placed the order. Review of the physician orders revealed Cefepime Hydrochlorothiazide (HCl) injection solution reconstituted one gram injected intramuscularly every 12 hours, with a start date of 10/31/24 and completed date 11/01/24. Review of the physician orders on 11/01/24 revealed orders to obtain a urine analysis stat. Review of progress note on 11/01/24 revealed clean catch urine is ready for stat pickup. Review of progress note on 11/04/24 revealed the stat order had not been received. Review of the Medication Administration Record (MAR) revealed the first dose of Keflex began on 10/18/24 and ended on 10/21/24. Additionally, revealed the first does of Cipro began 10/21/24 and ended on 10/23/24, and the first dose of Cefepime began 10/24/24 and ended on 10/28/24. The second order of Cefepime began 10/31/24 and ended 11/02/24. Review of the care plan dated 09/09/24 for Resident #33 revealed the resident's risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of UTI with interventions including monitoring/document for signs and symptoms of UTI. Review of the medical record revealed no evidence of a urine culture to support a diagnosis of a UTI prior to the start of Keflex or the extension of Cefepime. Interview on 11/06/24 at 9:22 A.M. with LPN #129, confirmed when a UTI is suspected after a resident has signs and symptoms of a UTI they will notify the doctor to let them know what symptoms they are seeing. The physician will order a urine analysis and await the results and notify the responsible party of the order. Once the order is received, the physician will prescribe an antibiotic based on the results of the culture and notify the responsible party of the medication. Interview on 11/06/24 at 9:30 A.M. with director of nursing (DON), confirmed the process for UTI's is to wait for a urine analysis result prior to administering any medications directed towards a UTI. DON confirmed the physician was waiting for the results from the urine culture and the physician started Resident #33 on Keflex. DON stated once the culture came back it appeared to be something different, so they switched him to Cipro. DON stated they switched him to Cefepime because Cipro was causing more confusion. The urine analysis stat request was sent on 11/1/24. DON reported they contacted the lab on 11/04/24 but the culture was still not available. (continued on next page)

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	11/07/2024

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the revised McGeer criteria for infection surveillance checklist revealed that a UTI without indwelling catheter requires both signs and symptoms and microbiologic criteria prior to administering antibiotics.