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	04/30/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of the Legionella plan, policy review and staff interview, the facility failed to ensure the Legionella plan parameters for temperature readings were followed and failed to ensure new interventions were initiated for documented temperatures readings below the control measure. This had the potential to affect all facility residents. The facility census was 49. Findings include: Review of the Legionella plan dated 07/2025 revealed the facility shall check the outflow and return temperatures of the domestic water heaters. The domestic water heaters had control temperatures of 118 degrees Fahrenheit (F) for the county water and 140 degrees F for the city water. Review of the 2026 monthly temperature logs revealed the county water heater temperature readings were below the control measure. For January the temperatures were 110 degrees F and 112 degrees F; February's were 113 degrees F and 115 degrees F; March's were 110 degrees F and 111 degrees F; and April's were 116 degrees F and 118 degrees F. The city water temperature readings below the control measures for January were 111 degrees F and 113 degrees F; February were 109 degrees F and 111 degrees F; March were 110 degrees F and 110 degrees F; and April were 111 degrees F and 112 degrees F. Interview on 04/29/26 at 9:50 A.M. with Maintenance Director #305 confirmed the documentation showed the temperature readings were below the control measures and there was no documentation regarding what the facility did to correct it. Review of facility policy titled Legionella Surveillance dated 10/01/25 revealed hot water shall be stored at a range of 138 to 142 degrees F and circulated at a minimum return temperature of 124 degrees F.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and review of facility policy, the facility failed to ensure the comprehensive care plan was updated for a fall intervention for Resident #45. This affected one resident (#45) of three residents reviewed for falls. The facility census was 49.Findings Include: Review of Resident #45's medical record revealed she was admitted on [DATE] with diagnoses that included but were not limited to hypertension, insomnia and dementia.Review of facility investigation report dated 01/16/26 revealed Resident #45 was found on the floor mat directly beside her bed and a silent bed alarm was implemented as the immediate action taken for fall. Review of Resident #45's progress notes dated 01/20/26, revealed an interdisciplinary team (IDT) note for the fall on 01/16/26 stating a silent alarm was to be applied when Resident #45's was in bed and the plan of care (POC) was reviewed and updated. Review of Resident #45's physicians orders dated revealed an order dated 01/16/26 for a silent alarm to bed every shift. Review of Resident #45's Minimum Data Set (MDS) assessment dated [DATE], revealed she was rarely or never understood. She was alert and unable to make her needs known. She was dependent upon staff with transfers, toileting and personal hygiene.Review of Resident #45's care plans dated 02/23/26 revealed an at risk for falls care plan. Further review of the care plan revealed there was no updated intervention to include the silent bed alarm for the implemented fall intervention on 01/16/26.Interview on 04/30/26 at 12:15 P.M. with Regional Nurse #300 confirmed the comprehensive care plan was not updated to include the fall intervention for a silent bed alarm for Resident #45's fall on 01/16/26. Review of facility policy titled Comprehensive Care Plan dated 08/01/25, revealed the facility is to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Further review revealed the comprehensive care plan will describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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** Based on staff interview, review of the medical record, and review of facility policy, the facility failed to ensure baseline weight measurements were obtained and verified in a timely manner after admission. This affected one resident (#7) of one resident reviewed for nutrition and weight loss. The facility census was 49.Findings include:Review of the medical record for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses that included unspecified dementia and hypertension amongst other diagnoses, with the diagnosis unspecified protein-calorie malnutrition added to the medical record on 01/29/26. Further review of the resident's medical record revealed the resident's cognition could not be assessed using a standardized cognition assessment tool due to the resident being rarely or never understood, though the resident's cognitive skills for daily decision making were noted to be impaired.Review of weight measurements found in Resident #7's medical record revealed an initial weight of 146 pounds (lbs.) documented in the medical record as measured on 12/26/25. Further review of resident weights revealed the next weight measurement was not recorded until two weeks after admission to the facility on [DATE] when Resident #7 was noted to weigh 130 lbs.Interview on 04/30/26 at 10:18 A.M. with Registered Dietitian (RD) #302 revealed the initial weight of 146 lbs. that was documented for 12/26/25 was a weight that they were told by Resident #7's family that was reported to have been measured in an outside facility. Further interview with RD #302 revealed the facility's policy is to measure a new resident's weight upon admission, and then weekly thereafter for the next three weeks unless there are physician orders specifying a different frequency that weights should be measured. Additional interview with RD #302 at this time revealed they were unsure why an initial weight was not obtained for Resident #7 upon admission, and that it would be difficult to tell if or how rapidly the resident was losing weight after arriving to the facility without measuring their weight in a timely manner upon admission.Interview on 04/30/26 at 11:12 A.M. with the facility Administrator revealed they believed there may have been a potential process error that could have resulted in Resident #7 not having a weight recorded upon admission. Further interview with the Administrator at this time revealed the typical process in the facility was that nursing aides measured resident weights, recorded the weight measurements on paper, and then nurses added the measurements into the electronic health record.Interview on 04/30/26 at 11:55 A.M. with RD #302 further verified no weights were obtained for Resident #7 at the facility until 01/30/26. Additional interview at this time with RD #302 revealed the resident was having respiratory complications around the time of admission, thus no initial weight was recorded upon arrival to the facility, but there was no explanation for why weights were not measured for the next two weeks as indicated by facility weight monitoring policy.Review of the facility policy titled Policy for Monitoring Weights-WBCH effective 06/01/24 revealed residents will be weighed on admission if the resident's condition allows for this procedure. Further review of the policy revealed residents will be weighed every week for 3 weeks following admission if the resident's condition allows for this procedure.

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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** Based on review of the medical record, interviews, review of Food and Drug Administration (FDA) guidance, and policy review, the facility failed to ensure residents drug regimen was free from unnecessary drugs when pain medication parameters were not in place. This affected two residents (#12 and #24) out of three residents reviewed for pain. The facility census was 49. Findings include:1. Review of the medical record for Resident #12 revealed an admission date of 04/10/26. Diagnoses included absence of right leg below the knee, encephalopathy, dysphagia, kidney disease, atrial fibrillation, heart failure, hypertension, edema, and Parkinson's disease.Review of physician orders dated 04/10/26 revealed orders for acetaminophen oral tablet 325 milligrams (mg) with instructions to give three tablets every eight hours for pain.Review of physician orders dated 04/10/26 revealed orders for acetaminophen oral tablet 325 mg with instructions to give one tablet every six hours as needed for mild pain.Review of the plan of care dated 04/11/26 revealed the resident had acute and chronic pain with interventions to educate the resident about phantom pain and evaluate the effectiveness of pain medications.Review of physician orders dated 04/13/26 revealed orders for oxycodone 10 mg with instructions to give one tablet every eight hours for pain.Review of physician orders dated 04/13/26 revealed orders for oxycodone 10 mg with instructions to give one tablet every four hours as needed for severe pain.Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 15 indicating intact cognition. The MDS assessment also stated Resident #12 had received opioid medications.Review of the Medication Administration Review (MAR) dated 04/2026 revealed oxycodone was given for pain levels of two out of 10, four times; pain levels of three, four, and five out of 10, six times; pain level of six out of 10, 10 times; pain level of seven out of 10, 10 times; and a pain level of eight out of 10, nine times. Acetaminophen was administered for a pain level of eight out of 10. Further review of the MAR found no evidence of parameters of when staff should administer the oxycodone verses the acetaminophen and also did not include any language about maximum daily doses. The full ordered amount of acetaminophen would be a dose of 4,225 mg daily. Interview on 04/20/26 at 11:20 A.M. with Registered Nurse #206 revealed resident pain would be considered mild/moderate for pain levels one to five out of 10 and moderate/severe for five to 10 out of 10. She confirmed, per basic nursing judgement, acetaminophen should not be administered more than 3,000 mg each day. Interview on 04/20/26 at 11:40 A.M. with Regional Nurse #300 confirmed the orders for Resident #12 were not clear, gave no parameters or instructions and confirmed staff gave acetaminophen for higher pain levels (eight out of 10) and oxycodone for lower levels of pain (two, three and four out of 10). Regional Nurse #300 confirmed there was no guidance or instructions provided to nursing staff regarding pain scales for Resident #12 and also confirmed it should be clear about the maximum amount of acetaminophen which should be given. She confirmed 4,000 mg was high and acute liver failure could occur if she was administered over 4,000 mg. Interview on 04/29/26 at 4:23 P.M. with Nurse Practitioner #301 revealed she did not like following parameters for pain medication and putting instructions in the orders, as she wanted the nursing staff to be able to use nursing judgement and for residents to be able to request whatever pain medication they wanted as long as it had been ordered. She was unable to provide a number parameter related pain but stated Tylenol/acetaminophen would be given for lower level of pain (mild or moderate) and a narcotic like oxycodone or tramadol would be for more severe pain. She acknowledged numbers such as a two and three [out of 10] would be more mild pain and an eight to 10 out of 10 would be more severe. She also verified a resident should not go over 3,000 mg of acetaminophen. Resident #12 was brought up specifically and NP #301 verified Resident #12 could go up to 4,000 mg but definitely not over that amount. After confirming Resident #12 had orders for acetaminophen that could put her over 4,000 mg per day, NP #301 stated only by about 1/2 a pill. Review of FDA Guidance titled Acetaminophen - What you should know about using acetaminophen safely current as of 08/14/25, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the maximum total amount of acetaminophen taken in 24 hours should not be more than 4,000 mg for adults. It also noted that taking too much acetaminophen can cause liver failure and death. 2. Review of the medical record for Resident #24 revealed an admission date of 05/22/25. Diagnoses included atrial fibrillation, heart failure, hypertension, edema, and Parkinson's disease. Review of physician orders dated 05/21/25 revealed orders for tramadol 50 mg with instructions to give every eight hours as needed for pain.Review of physician orders dated 06/09/25 revealed orders for Tylenol 325 mg with instructions to give every eight hours as needed for severe pain and administer with tramadol for severe pain. Review of the plan of care dated 06/11/25 revealed the resident had pain related to Parkinson's and took opioid medication with interventions to anticipate resident needs for pain relief, evaluate the effectiveness of pain medications, and to monitor requests for pain medications. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 14 indicating intact cognition. The MDS assessment also stated Resident #24 had received opioid medications.Review of the Medication Administration Review (MAR) dated 03/2026 revealed tramadol was given for pain levels of two out of 10, two times; pain level of three out of 10, four times; pain level of four out of 10, two times; pain level of five out of 10, two times; pain level of six out of 10, four times; pain level of seven out of 10, two times; and pain levels of eight out of 10 and 10 out of 10, two times. Tylenol was administered for a pain level of two and three out of 10 and was administered one of two times along with the tramadol. Review of the MAR revealed no evidence of parameters for when pain medication should be administered and which as needed pain medication to administer. Review of the Medication Administration Review (MAR) dated 04/2026 revealed tramadol was given for pain levels of three, four, and five out of 10, three times and a pain level of six out of 10, three times. Tylenol was not administered during this month. Review of the MAR revealed no evidence of parameters for when pain medication should be administered and which as needed pain medication to administer. Interview on 04/20/26 at 11:20 A.M. with Registered Nurse #206 revealed resident pain would be considered mild/moderate for pain levels one to five out of 10 and moderate/severe for five to 10 out of 10.Interview on 04/20/26 at 11:40 A.M. with Regional Nurse #300 confirmed the orders for Resident #24 were not clear whether staff should only administer Tylenol or administer the Tylenol along with the ordered tramadol. Interview on 04/29/26 at 4:23 P.M. with Nurse Practitioner #301 revealed she did not like following parameters for pain medication and putting instructions in the orders, as she wanted the nursing staff to be able to use nursing judgement and for residents to be able to request whatever pain medication they wanted as long as it had been ordered. She was unable to provide a number parameter related pain but stated Tylenol/acetaminophen would be given for lower level of pain (mild or moderate) and a narcotic like oxycodone or tramadol would be for more severe pain. She acknowledged numbers such as a two and three [out of 10] would be more mild pain and an eight to 10 out of 10 would be more severe. NP #301 verified the order for Resident #24 was confusing and stated she would expect staff to be giving the Tylenol for lower levels of pain and tramadol for the higher levels of pain. She confirmed the order was not clearly written. Review of facility policy titled Pain Management dated 08/15/25 revealed the facility shall ensure pain management was provided to residents who required such services. The facilities pharmacological interventions shall follow a systemic approach for selecting medications and doses to treat pain. The interdisciplinary team was responsible for developing a pain management regimen specific to each resident. The following principles shall be utilized for prescribing analgesics including consider evidence based practice tools, consider scheduled medications in place of as needed medications for breakthrough pain, utilize the most effective and least invasive route for administration, use lower doses of medication initially and titrate slowly upward, and opioid treatments shall be prescribed and dosed in accordance with professional standards to optimize effects and minimize adverse reactions.