STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365341	A. Building B. Wing	04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Village	100 Don Desch Drive Coldwater, OH 45828

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, staff interview, review of facility policy, and review of the Ohio Department of Health (ODH) Application Gateway, the facility failed to report an incident of resident-to-resident physical abuse to the state agency. This affected one (#19) of three residents reviewed for abuse. The census was 92. Findings include: 1. Review of Resident #19's medical record revealed an admitted [DATE]. Diagnoses listed included Alzheimer's disease, psychotic disorder, hearing loss, and generalized anxiety disorder. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #19 was rarely understood by staff. Review of progress notes revealed on 03/21/25 at 8:30 P.M. Resident #19 was walking with her walker and came to stop in front of of an empty recliner in the common area. A resident sitting in a nearby chair began yelling at Resident #19. A third resident came into the area and told Resident #19 to move. Resident #19 has confusion, and did not move. The resident sitting in the nearby chair began yelling more. The third resident then used her elbow and struck Resident #19 in the upper right arm, then immediately after doing so, placed both hands onto the resident's arm and pushed. Resident #19 stumbled but did not fall. The nurse was able to reach the residents before it escalated any further. The nurse removed Resident #19 from the area to ensure safety. No evidence of any injury was noted. 2. Review of Resident #23's medical record revealed an admitted [DATE]. Diagnoses listed included dementia, type II diabetes mellitus, atrial fibrillation, and major depressive disorder. Review of a annual MDS dated [DATE] revealed Resident #23 was severely cognitively impaired. (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	Review of progress notes revealed on 03/21/25 at 8:30 P.M. a resident with a walker came to a stop in front of an empty recliner in the common area. A resident sitting in a nearby chair began yelling at the resident. Resident #23 came into the area and told the resident with the walker to move. The resident with the walker has confusion, and did not move. The resident sitting in the nearby chair began yelling more. Resident #23 then used her elbow and struck the resident with the walker in the upper right arm, then immediately after doing so, placed both hands onto the resident with the walker's arm and pushed. The resident with the walker stumbled but did not fall. The nurse was able to reach the residents before it escalated further. The nurse removed the resident with the walker from the area to ensure safety. No evidence of injury was noted on the resident with the walker. This nurse attempted to re-approach Resident #23 to see if they were ok, but the resident in the chair was still telling Resident #23 that she was in trouble, but should have been allowed to defend herself. All further attempts to provide care or follow up for Resident #23 resulted in agitation. The nurse monitored the situation until Resident #23 decided to go to into her room. The nurse asked Resident #23 if they needed assistance with getting ready for bed, and Resident #23 replied, no and don't touch me. Interview with the Administrator on 04/03/25 at 10:30 A.M. confirmed there was a physical altercation between Residents #19 and Resident #23 on 03/21/25. Resident #23 struck Resident #19 in the arm and pushed her. The Administrator confirmed the incident was not reported to ODH. Interview with Certified Nurse Aide (CNA) on 04/03/25 at 11:52 A.M. revealed Resident #19 obtained a bruise on her right upper arm when Resident #23 hit her on 03/12/25. CNA #180 did not witness the incident, but worked the morning after and was informed of what happened. Observation of of Resident #19's right upper arm with Registered Nurse (RN) #60 on 04/03/25 at 1:31 P.M. revealed a pale yellow bruise to the right upper arm. RN #60 stated it was the result of Resident #23 hitting Resident #19. Interview with Regional Director of Clinical Services (RDCS) #150 on 04/07/25 at 8:50 A.M. confirmed the physical altercation on 03/21/25 when Resident #23 struck Resident #19 should have been reported to ODH. RDCS #150 confirmed that Resident #23 striking Resident #19 met the definition of physical abuse per the facility's policy. Review of the ODH's Application Gateway website revealed the facility had not reported the resident-to-resident physical abuse between Resident #19 and Resident #23. Review of the facility policy titled, Abuse, Neglect, Injuries of Unknown Source, and/or Misappropriation of Resident Property Policy, dated 2016 revealed abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The Administrator or his/her designee will notify ODH of all alleged violations involving abuse, neglect, exploitation, mistreatment of a resident, or misappropriation of resident property, and injuries of unknown source as soon as possible, but in no event later than twenty-four (24) hours from the time the incident/allegation was made known to the staff member. This deficiency represent non-compliance investigated under Complaint Number OH00164181.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36303 Based on medical record review, staff interview, local health department staff interview, and review of facility policy, the facility failed to report norovirus cases and multiple resident's gastrointestinal (GI) symptoms (nausea/vomiting/diarrhea) to the local health department. This had the potential to affect all 92 residents of the facility. The census was 92. Findings include: 1. Review of Resident #4's medical record revealed an admitted [DATE]. Diagnoses listed included chronic kidney disease, obstructive sleep apnea, hypothyroidism, and morbid obesity. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact. Review of progress notes revealed Resident #4 was not feeling well and was sent to the emergency room (ER) for evaluation on 02/25/25. Resident #4 returned to the facility on [DATE]. Review of hospital documentation revealed Resident #4 tested positive for norovirus on 02/25/25. 2. Review of Resident #107's medical record revealed an admitted [DATE]. Diagnoses listed included chronic kidney disease, obstructive sleep apnea, hypothyroidism, and morbid obesity. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact. Review of progress notes revealed Resident #107 was sent to the ER for shortness of breath, abdominal pain, and difficulty urinating on 02/21/25. Resident #107 returned to the facility on [DATE]. Review of hospital documentation revealed Resident #4 tested positive for norovirus on 02/22/25. Review of facility timeline documentation revealed Resident #107 returned to the facility from the hospital on 02/23/25 and was positive for norovirus. Resident #4 was sent to the hospital on 02/25/25 and tested positive for norovirus on admission to the hospital. Between 02/23/25 and 03/05/25 16 residents (#30, #50, #61, #63, #64, #68, #83, #108, #77, #82, #84, #87, #97, #112, #120, and #121) throughout the facility experienced GI symptoms. Residents (#30, #68, #77, #84, #87) were tested and were negative for norovirus. The remaining residents with GI symptoms were put in contact isolation, but not tested . On 03/05/25 residents in the memory care unit started with GI symptoms and the entire unit was put on contact isolation. 16 residents (#13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, and #28) resided in the memory care unit. Interview with Licensed Practical Nurse (LPN) #50 on 04/03/25 at 10:44 A.M. revealed Resident #107 tested positive for norovirus when sent to the hospital. LPN #50 reported two staff members were tested at a local hospital and were positive for norovirus. All staff had been educated on how to prevent the spread of norovirus. LPN #50 stated the local health department had not been made aware of the norovirus cases. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Administrator on 04/03/25 at 1:50 P.M. confirmed two residents (#4 and #107) and two CNAs (#100 and #110) tested positive for norovirus at a local hospital. The Administrator confirmed multiple residents throughout the facility had GI symptoms. The Administrator confirmed the local health department was not called. Review of facility provided documentation revealed CNA #100 and CNA #110 were off work form 02/28/25 through 03/04/25. Test results for norovirus were not provided. Phone interview with Local Health Department Registered Nurse (LHDRN) #200 on 04/03/25 at 2:23 P.M. confirmed the local health department had not been contacted regarding residents and staff testing positive for norovirus and multiple residents with GI symptoms throughout the facility. Phone interview with LHDRN #210 on 04/07/25 at 10:53 A.M. confirmed the local health department had not been contacted regarding residents and staff testing positive for norovirus and multiple residents with GI symptoms throughout the facility. LHDRN #210 confirmed the facility should have called and reported. Interview with Regional Director of Clinical Services (RDCS) #150 on 04/07/25 at 8:50 A.M. confirmed norovirus cases and GI symptoms throughout the facility should have been reported to the local health department. Review of the facility policy titled, Reportable Diseases Ohio, dated revised April 2022 revealed it is the purpose of the facility to report diseases declared to be dangerous to the public health. It is the policy of the facility that all infectious, contagious or communicable diseases be reported in accordance with Ohio rules. The following diseases are classified as Class C and shall be reported by the facility to the local health department by the end of the next business day. This applies to an outbreak, unusual incidence, or epidemic of other infectious diseases from the following sources: (1) Community (2) Foodborne (3) Healthcare-associated (4) Institutional (5) Waterborne; and (6) Zoonotic; (7) If the outbreak, unusual incidence, or epidemic, including but not limited to, histoplasmosis, pediculosis, scabies, and staphylococcal infections, has an unexpected pattern of cases, suspected cases, deaths, or increase incidence of disease that is of a major public health This deficiency represent non-compliance investigated under Complaint Number OH00164181.