

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Briarwood Village		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  365341	Facility ID:  365341  If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, medical record review, staff interview, review of facility investigation, physician interview, review of bed user service manual, and policy review, the facility failed to ensure Resident #01 was provided adequate supervision during the provision of activities of daily living. Resident #01 was cognitively impaired, and dependent on staff for transfer and bed mobility with bilateral lower extremity contractures. This resulted in Immediate Jeopardy, actual harm and death beginning on [DATE] at 10:11 A.M. when two Certified Nurse Aides (CNA) directed attention away from Resident #01, who was lying in bed on her left side with the bed elevated. Resident #01 rolled from the elevated bed and fell to the floor, sustaining a laceration to the scalp requiring six staples, acute odontoid process fracture (second cervical vertebra [C2] in the neck) and closed displaced fracture of first cervical vertebra (C1 in the neck). On [DATE] Resident #01 expired as a result of the injuries sustained at the time of the fall from bed. This affected one (Resident #01) of three residents reviewed for accidents and supervision. On [DATE] at 3:00 P.M., the Administrator, Director of Nursing (DON), Executive Director (ED) #34, and Clinical Corporate Support Registered Nurse (CCSRN) #55 were notified Immediate Jeopardy began on [DATE] at 10:11 A.M. when CNAs #61 and #89 directed attention away from Resident #01, allowing the resident to be unsupervised in an elevated bed. Resident #01 was dependent on staff to roll side to side in bed, and for bed mobility, and transfers. Resident #01 had bilateral lower extremity contractures, and her legs were fixed in the flexed position (pulled up toward the torso). CNA #61 left the left side of the bed to obtain a lift sling located approximately three feet from the foot of the bed and CNA #89 left the right side of the bedside and proceeded to the left side of the bed to remove a trash bag from a trash can, directing attention away from the resident. CNAs #61 and #89 heard a scream and turned around to see Resident #01 rolling off the bed. CNA #89 ran and attempted to catch Resident #01 however, CNA #89 was unable to reach Resident #01 before she hit the floor. Resident #01 was subsequently transported to the hospital and was treated for six staples to the laceration to the head and discovered with two cervical (neck) fractures which required surgical intervention. Resident #01 and responsible party declined further treatment, and Resident #01 returned to the facility for palliative care. Resident #01 expired on [DATE] due to her injuries. Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective action: On [DATE], at 10:40 A.M., Registered Nurse (RN) #83 assessed Resident #01 and contacted emergency medical services. Resident #01 was transported to the hospital for evaluation. Resident #01 returned to the facility from the hospital on the same day ([DATE]) at 4:50 P.M. and the plan of care was revised to include floor mats to side of bed as the resident reported that she tried to get out of bed when she fell and hit the floor. On [DATE], Resident #01 expired in the facility. On [DATE], the DON began educating all nursing staff on the facility policies regarding fall prevention, including the Fall Reduction Policy, care of residents at bed side, completion of fall documentation and assessments post fall. All 46 licensed nurses and CNAs were educated by [DATE]. On [DATE], the SDC #95, Physical Therapy Assistant (PTA) #109 and CNA #106 completed competencies for all 46 licensed nurses and CNAs nursing staff regarding bed mobility, turning and repositioning and safely caring for residents in bed. On [DATE], the DON, Regional Nurse #103, Staff Development Coordinator (SDC) #95 and Case Manager #97 audited all residents who had falls within the past 30 days to ensure appropriate investigation and fall interventions in place in room and on care plan. On [DATE], SDC #95 and DON reeducated all 46 licensed nurses and CNAs to ensure adequate supervision in accordance with the resident's plan of care is provided during the provision of resident activities of daily living (ADL). Staff not educated by [DATE] will not be permitted to work until education completed. On [DATE], Regional Nurse #103, DON and Minimum Data Set (MDS) Nurse #114 completed care plan audits on all 43 residents who were totally staff dependent for all ADL care while in bed to ensure all fall risk assessments were up to date and to ensure care plans accurately reflect assessment and fall risk interventions. On [DATE], an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was conducted with Interdisciplinary Team (IDT) which included ED #34, Administrator, Human Resources Manager #115, MDS Nurse #114, Restorative Nurse #117, DON, and Medical Director #130 to discuss the incident and follow-up interventions in response to corrective actions that the facility needed to complete to keep their residents safe in the future. On [DATE], Regional Director of Operations #135 and Regional Nurse #103 educated ED #34, Administrator and DON on the need to ensure that investigations of falls are thorough. Beginning [DATE] the DON or designee will conduct</p>		