

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Briarfield at Ashley Circle		STREET ADDRESS, CITY, STATE, ZIP CODE 5291 Ashley Circle Youngstown, OH 44515	
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 observation, record review and interview, the facility failed to ensure transmission-based precautions (TBP) were clearly identified for Resident #82 and failed to maintain appropriate infection surveillance. This affected one resident (#82) of three reviewed for infection control. The facility identified Resident #82 as the only resident on TBP. This had the potential to affect all 65 residents in the facility. Findings include: Review of the medical record for Resident #82 revealed an admission date of 09/15/25. Diagnoses included osteomyelitis (an infection of the bone that can cause inflammation, pain, and damage), diabetes, cellulitis, and spinal stenosis. Review of the medical record revealed the Minimum Data Set (MDS) assessment and care plan were not yet due to be completed. Review of the physician's orders for September 2025 revealed an order for contact precautions, which began on 09/16/25. Observation on 09/22/25 at 9:32 A.M. revealed a bag containing personal protective equipment (PPE) hanging on the outside of Resident #82's door. Interview on 09/22/25 at 10:03 A.M. with Registered Nurse (RN) #541 revealed Resident #82 had open wounds which required the use of enhanced barrier precautions (EBP) during treatment. She confirmed the facility did not identify when TBP were in place for a resident by placing any signage on the door. The facility expected staff to review the residents' orders. She had no knowledge of Resident #82 being on contact precautions. Review of the facilities infection control logs revealed no documented evidence of an infection surveillance system. Interview 09/24/25 at 9:55 A.M. with the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #600 revealed the facility did not have a surveillance system in place to track infections. Interview on 09/24/25 at 10:57 A.M. with the DON and LPN #600 confirmed that any resident on TBP should have signage on their door indicating what type of precautions they were on. They were aware Resident #82 was on contact precautions and should have had signage indicating such. Review of the facility policy titled Infection Prevention and Control Program, dated 06/01/27, revealed the facility would develop surveillance and control measures to protect residents and personnel from healthcare associated infections and perform surveillance to monitor and investigate the cause of infection and manner of spread in order to prevent infections in the facility. Review of the facility policy titled Isolation Precautions, dated 01/01/21, revealed the facility would notify residents, family and staff of the need for TBP, explain the relevant procedures and obtain appropriate signage for TBP and post them outside the residents' door frame.		

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
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Briarfield at Ashley Circle		STREET ADDRESS, CITY, STATE, ZIP CODE 5291 Ashley Circle Youngstown, OH 44515	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure there was consistent communication between the facility and the dialysis center regarding Resident #4's hemodialysis treatments. This affected one resident (#4) of three residents reviewed for dialysis. This had the potential to affect residents (#4, #21 and #41) identified by the facility who received dialysis. The facility census was 65. Findings include: Review of the medical record for Resident #4 revealed in admission date of 02/16/12. Diagnoses included end stage renal disease, schizophrenia, hypertension, depression, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact. She required setup help for eating, oral and personal hygiene, dressing, toileting, and showering. Review of the physician's orders for September 2025 revealed an order for hemodialysis on Mondays, Wednesdays and Fridays. Resident #4's thrill and bruit was expected to be checked every shift. Review of the care plan dated 09/05/25 revealed Resident #4's health status was compromised due to hemodialysis. Interventions included encouraging compliance with the recommended diet, consulting with the dialysis dietitian as needed, monitoring mental status after each dialysis treatment, monitoring for signs and symptoms of infection and monitoring labs and weights. The care plan also revealed Resident #4 demonstrated disregard for others by refusing to return her dialysis communication sheets to the facility after each dialysis session. Interventions included discussing the behavior with the resident, drawing on her strengths, and making limitations clear. Review of the dialysis communications sheets for August 2025 revealed pre and post dialysis assessments for Resident #4 were completed on 08/01/25, 08/04/25, 08/13/25, 08/18/25 and 08/25/25. Interview on 09/24/25 at 11:28 A.M. with the Director of Nursing (DON) confirmed the facility had a very difficult time obtaining communication sheets for Resident #4 from the dialysis center. She confirmed while Resident #4 was capable of returning the forms herself, she was not expected to do so, and the facility did attempt to follow up with the dialysis center on forms that had not yet been returned. She further explained she talked with both Resident #4 as well as the dialysis center on multiple occasions and explained the importance of the communication forms and making sure these forms were returned upon the residents' returned to the facility from dialysis but had not yet been successful in implementing a system to ensure effective communication and exchange of information. She confirmed she had no other evidence pre and post dialysis assessments had been completed. Review of the undated facility policy titled Pre Dialysis Patient Care revealed the facility would ensure ingoing assessment of the residents' condition and monitor for complications before and after dialysis treatments. Review of the facility policy titled Post Dialysis Care Policy dated June 2021 revealed a post dialysis assessment would be completed when a resident returned to the facility from dialysis and include monitoring the access site, assessing for pain, altered mental status and elevated temperature and assessing the bruit and thrill.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Briarfield at Ashley Circle		STREET ADDRESS, CITY, STATE, ZIP CODE 5291 Ashley Circle Youngstown, OH 44515	
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 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 record review, interview and facility policy review, the facility failed to ensure non-pharmacological interventions for pain were attempted prior to the administration of opioid pain medication. This affected one resident (#4) of five residents reviewed for unnecessary medications. The facility census was 65. Findings include: Review of the medical record for Resident #4 revealed in admission date of 02/16/12. Diagnoses included end stage renal disease, schizophrenia, hypertension, depression, and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was cognitively intact. She required setup help for eating, oral and personal hygiene, dressing, toileting, and showering. Review of the physician's orders for September 2025 revealed an order for Percocet (an opioid pain medication) every eight hours as needed (prn) for pain which began on 08/15/25. Review of the Medication Administration Record (MAR) for August 2025 revealed Resident #4 was given Percocet once on 08/18/25 for a pain level of four on a zero to ten scale with ten being the worst, once on 08/20/25 for a pain level of six, once on 08/21/25 for a pain level of seven, once on 08/22/25 for a pain level of five, once on 08/25/25 for a pain level of five, once on 08/26/25 for a pain level of five, once on 08/27/25 for a pain level of four, and once on 08/30/25 for a pain level of five. There was no documented evidence that nonpharmacological interventions were attempted prior to administering the opioid pain medication. Review of the MAR for September 2025 revealed Resident #4 was given Percocet once on 09/03/25 for a pain level of four, once on 09/03/25 for a pain level of four, once on 09/04/25 for a pain level of four, once on 09/05/25 for a pain level of five, once on 09/06/25 for a pain level of seven, once on 09/09/25 for a pain level of five, once on 09/10/25 for a pain level of eight, once on 09/11/25 for a pain level of five, once on 09/12/25 for a pain level of five, once on 09/16/25 for a pain level of four, once on 09/19/25 for a pain level of eight, once on 09/20/25 for a pain level of five, once on 09/23/25 for a pain level of seven, once on 09/23/25 for a pain level of five, and once on 09/24/25 for a pain level of six. There was no documented evidence that nonpharmacological interventions were attempted prior to administering the opioid pain medication. Observation on 09/23/25 at 1:29 P.M. with Resident #4 revealed she was sitting in a wheelchair in her room, watching television. Interview at the time of the observation revealed no concerns regarding pain management. Observation on 09/24/25 at 6:56 A.M. revealed Resident #4 was sleeping in bed with no overt signs of pain evident. Observation on 09/25/25 at 8:42 A.M. revealed Resident #4 was sitting on the side of her bed eating breakfast. She was in good spirits and reported no concerns regarding pain at the time. Interview on 09/24/2025 at 1:30 P.M. with Licensed Practical Nurse (LPN) #510 revealed residents often just asked for their pain medication and were not offered nonpharmacological interventions. She revealed there were times she would offer an alternative to medication, but she could provide no evidence that those efforts had ever been documented. Review of the undated facility policy titled Pain Management revealed the facility would maintain optimal comfort and a pain free existence including assessing for pain, implementing interventions, monitoring after administration of medication and documenting all efforts in the residents' medical record.		