STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365822	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarfield Manor	461 South Canfield Niles Road 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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365822	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarfield Manor	461 South Canfield Niles Road 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, fall investigation reviews, interviews and facility policy review, the facility failed to ensure falls were thoroughly investigated for Residents #17 and #72. This affected two residents (#17 and #72) of three residents reviewed for falls. The facility census was 70. Findings include:1. Review of the medical record for Resident #17 revealed an admission date of 03/07/25. Diagnoses included history of falling, protein calorie malnutrition, hypertension, high cholesterol, gastroesophageal reflux disease (GERD), glaucoma, delirium, muscle weakness and hearing loss. Review of the fall risk assessment dated [DATE] revealed Resident #17 was at moderate risk for falls. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was severely cognitively impaired. She required supervision for eating, partial to moderate assistance for oral hygiene and showering and was dependent on staff for toileting and dressing. She was frequently incontinent of urine, always incontinent of bowel and was dependent on staff for rolling left to right, sitting to lying, lying to sitting on one side of the bed and sitting to standing or chair to bed transfers. Review of the physician's orders for August 2025 revealed an order for two quarter top positioning bars when up in bed to aid in positioning which began on 03/10/25, an alarm to the bed and wheelchair for safety which began on 05/08/25, a perimeter mattress which began on 05/23/25, and an order for one person assist with bed mobility, transfers and toileting using a front wheeled walker which began on 08/14/25. Review of the nursing note dated 05/22/25 at 5:51 P.M. revealed Licensed Practical Nurse (LPN) #201 was notified by Certified Nurse Aide (CNA) #207 that Resident #17 was out of bed. LPN #201 observed Resident #17 with both legs on the floor and her left arm in between the mattress and the bed railing facing into the mattress. When asked what happened, Resident #17 was unable to respond appropriately and stated, they are calling my mother. Vital signs were obtained, and the resident's blood pressure was 159/98, heart rate 88, pulse ox 94%, temperature 98.2 degrees Fahrenheit (F) and range of motion was within normal limits. The resident denied pain, and no injuries were noted. Resident #17's family, physician and the Director of Nursing (DON) were notified. The call light was noted to be in reach, the bed was in the lowest position, and an intervention of a perimeter mattress and floor mat were put into place. Review of the facility incident report dated 05/22/25 revealed Resident #17 was observed with both legs out of bed, with her left arm wedged in between the mattress and the arm rail. No injuries were noted. The resident was noted to be confused, incontinent with an unsteady gait, impaired memory, recent medication changes and weakness. She was oriented to person only. No predisposing factors were identified. There was no documented evidence of when she had last been toileted. Review of the care plan dated 05/25/25 revealed Resident #17 was at risk for falls due to gait and balance problems, history of falling and glaucoma. Interventions included a bed alarm, ensuring the call light within reach, a chair alarm and two quarter top positioning bars when up in bed to aid in positioning. Review of the nursing note dated 06/13/25 at 2:18 P.M. revealed LPN #202 was outside Resident #17's room when she heard her yelling for help. She went into the room to find the resident holding on to the side rail but still on the bed with her legs hanging out of the bed with blood on the floor and sheets. She called for assistance and CNAs #206 and #208 came into the room and assisted in applying pressure to Resident #17's lower extremity. The resident was assisted back into bed and presented with a large deep laceration into the fatty layers of her upper thigh. An ambulance was already in the facility for another resident; however, it was determined Resident #17's needs were greater, therefore she was taken to the emergency department (ED). Resident #17's daughter was notified; her vital signs were not able to be obtained before ambulance transport. The resident returned from the ED approximately 6:00 P.M. with 15 stitches to the laceration on the inside of her right thigh. Review of the facility incident report dated 06/13/25 revealed Resident #17 was yelling for help and found almost out of bed with blood all over. CNAs #206 and 208 assisted in getting the resident back into bed while LPN #202 attended to and addressed the injury, a deep laceration to inner right thigh. The resident was oriented to person in place, hearing impaired and did not use her call light for assistance. She was immediately sent to the ED. There was no description of the condition of the room, no indication if the bed alarm was in use or activated, no information regarding a perimeter mattress or floor mat and no evidence that the call that was within reach. Witness statements obtained as part of the investigation revealed LPN #202 was outside Resident #17's room when she heard her yell for help. The resident was found halfway out of her bed with the upper half of her body in her bed holding onto the side rail. Blood was noted on the sheets on the floor. Additional staff came to the room and