STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365937	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohman Family Living at Briar	15950 Pierce St Middlefield, OH 44062

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. (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
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F 0609 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 review, interview and review of facility policy, the facility did not ensure an allegation of verbal abuse was reported as required. This affected one resident (#68) of three residents reviewed for abuse. The facility census was 89.Findings included: Review of medical record for Resident # 68 revealed an admission date of 08/03/23 with diagnoses of schizoaffective disorder, malnutrition, epilepsy, and dementia.Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #68 had severely impaired cognition and required staff assistance for all activities of daily living (ADLs).Review of the care plan for Resident #68, dated 06/09/25, revealed Resident #68 had impaired cognition related to dementia, schizoaffective disorder, mood problems related to dementia and intellectual disability. Interventions included to reorient as needed, keep explanations simple and use yes or no questions and if resident resists care, assure safety, back off and reapproach later. Review of the 08/20/25 psychiatric evaluation revealed Resident #68 was alert but disoriented to person, place, time and situation. Memory was poor, impaired attention and concentration; insight, judgement and impulse control poor. Resident #68 reported no concerns during the evaluation. Review of the facility investigation, date initiated 09/06/25, revealed on 09/06/25 Licensed Practical Nurse (LPN) #282 and LPN #321 wrote a witness statement indicating Resident #68 told them an aide asked Resident #68 why am I still breathing. Review of an unsigned statement dated 09/08/25 revealed Resident #68 was interviewed and indicated an aide with curly brown hair and glasses asked her why is she still breathing. The aide was working in the facility at that time and when the writer pointed out the aide to Resident #68, Resident #68 said that it was her, however, that aide was not working in the facility at the time the incident was said to have occurred. When Resident #68 was asked about Certified Nursing Assistant (CNA) #240, Resident #68 stated she's good. Review of a statement written by Unit Manager (UM) #290 revealed an interview with CNA #240 who denied she had ever made any such statement to Resident #68. Other resident interviews included in the facility investigation revealed no findings related to abuse allegations. An interview on 09/11/25 at 9:25 A.M. with Licensed Practical Nurse (LPN) #321 revealed she was not a witness to the verbal abuse allegation and stated she saw Resident #68 in the morning following the alleged incident. LPN #321 stated Resident #68 wanted help to call her sister and let her know what had occurred during the night. LPN #321 assisted Resident #68 with the phone call and overheard Resident #68 stating the aide wanted her to stop breathing, and wanted her dead. LPN #321 stated no other residents came to her with any complaints of disrespect or verbal abuse. LPN #321 stated she reported the incident to the Unit Manager #290 in the morning.An interview on 09/11/25 at 11:02 AM with LPN #282 revealed during the morning following his shift on 09/06/25, CNA #201 reported to him that another CNA (CNA #240) had been verbally mean to Resident #68, however; CNA #201 did not witness it. LPN #282 stated he had worked at the time the incident allegedly occurred, and it was not brought to his attention at that time. LPN #282 stated he was unaware of any complaints of verbal abuse or complaints from residents aside from the allegation made by Resident #68. An interview on 09/11/25 at 11:48 A.M. with CNA #201 revealed that Resident #68 told her that CNA #240 said to Resident #68 to stop breathing. She stated she did not witness it, but CNA #240 could come across with a tone in her voice, aggressive and needed to have more patience with the residents. CNA #201 verified she reported the incident to the nurse. An interview on 09/11/25 at 3:00 P.M. with Unit Manager (UM) #290 revealed she spoke with LPN #282 and Resident #68 regarding the allegation. UM #290 stated Resident #68 could not identify the aide in question. UM #290 also interviewed the other residents on the floor which denied any inappropriate comments or verbal abuse. UM #290 verified Resident #68 had made an allegation of verbal abuse from an aide, identified by staff as CNA #240, and it had been investigated. An interview on 09/11/25 at 3:44 P.M. with the Director of Nursing (D.O.N.) revealed she spoke with Resident #68 about the incident but Resident #68 could not identify the aide. The DON stated she also spoke with the other residents and could not validate the alleged comments. The DON confirmed she did not report the allegation to Ohio Department of Health (ODH) and did not submit a Self- Reported Incident Form (SRI). The DON verified all allegations of abuse are required to be reported to the state agency. The DON verified an investigation had been done to determine if abuse had occurred. Review of the ODH Certification and Licensure System (CALS) on 09/11/25 confirmed no SRI was completed regarding the allegation of verbal abuse from staff to Resident #68. Review of facility policy titled, Abuse, Neglect, Exploitation & Misappropriation of Resident Property, dated 2022, revealed the policy was to investigate all