

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2024
NAME OF PROVIDER OR SUPPLIER  Friendship Village		STREET ADDRESS, CITY, STATE, ZIP CODE  5790 Denlinger Road Dayton, OH 45426	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed to timely assess and treat resident injuries following falls. This affected one (Resident #67) resident of three residents reviewed for falls. The facility census was 76 residents.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including pulmonary hypertension and chronic kidney disease.</p> <p>Review of the care plan for Resident #67 dated 11/01/23 revealed the resident was at risk for falls related to new surroundings, impaired safety awareness, and history of falls. Interventions included the following: anticipate and meet the resident's needs, ensure call light was within reach, keep personal items within reach, monitor for behavior changes, monitor for side effects from medications.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #67 dated 04/13/24 revealed the resident had intact cognition, was dependent with toileting, and required moderate assistance with bathing, dressing, and transfers.</p> <p>Review of the timeline for Resident #67's fall revealed the resident fell on [DATE] at approximately 9:00 P.M. while receiving incontinence care. There was no documentation made in the resident's medical record on 05/03/24 regarding the fall or a post-fall assessment. On 05/04/24 at approximately 8:23 A.M. State tested Nursing Assistant (STNA) #16 notified Registered Nurse (RN) #30 that Resident #67 was unable to transfer related to pain, swelling, and bruising to right lower extremity. The physician was notified, and an x-ray was ordered at approximately 8:40 A.M. on 05/04/24. The x-ray results were finalized at 12:34 P.M. on 05/04/24 with multiple fractures noted to Resident #67's right and left leg. On 05/04/24 at approximately 1:30 P.M. emergency services arrived at the facility and took Resident #67 to the hospital.</p> <p>(continued on next page)</p>		

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note for Resident #67 dated 05/04/24 timed at 8:23 A.M. revealed the resident reported she had fallen on night shift and was unable to transfer related to pain. Resident #67 had swelling and bruising on her right leg and was complaining of severe pain. RN #30 spoke to LPN #26, who worked night shift on 05/03/24. Licensed Practical Nurse (LPN) #26 reported STNA #15 had lowered Resident #67 to the floor. RN #30 notified Resident #67's physician of findings and received an order for x-rays. The x-ray technician arrived at the facility the morning after the fall, and results showed an acute comminuted moderately displaced fracture to the tibia and fibula neck on right lower extremity and an acute mildly displaced fracture of the femur with reactive soft tissue swelling on left lower extremity. Emergency services were called, and Resident #67 was sent to the hospital.</p> <p>Review of the progress note for Resident #67 dated 05/06/24 timed at 4:48 P.M. revealed the note was a late entry for a fall which occurred on 05/03/24 at approximately 9:00 P.M. Resident #67 was being assisted with incontinence care and was standing while facing the chair. Resident #67's legs gave way, and she fell on to her knees and then backwards on the floor. Staff assessed the resident and lifted her into bed. Resident #67 declined to go the hospital against staff recommendation. Resident #67 had increased pain in the morning, and staff received orders for an x-ray and was sent to the emergency room the morning following the fall related to results from x-ray and pain and discomfort.</p> <p>Review of the witness statement per STNA #15 dated 05/06/24 revealed Resident #67 was standing up next to bed while receiving incontinence care when the resident fell to the floor onto her knees. STNA #15 went to get LPN #26 after the fall. STNA #15 reported Resident #67 refused to be moved off of the floor because it was too painful. LPN #26 tried to convince Resident #67 to go to the hospital, but she refused and allowed STNA #15 and LPN #26 to put her back into bed.</p> <p>Review of the witness statement dated 05/06/24 by LPN #26 revealed Resident #67 was lowered to the floor by staff. LPN #26 assessed Resident #67, and she did not want to go to the hospital. Resident #67 was assessed for injuries and did not appear to have any open areas or discoloration noted. Resident #67 was assisted back to bed, and the physician was notified.</p> <p>Review of the x-ray order for Resident #67 dated 05/04/24 revealed a stat (immediate) x-ray was submitted for the resident for right and left knee related to localized swelling and pain.</p> <p>Review of the x-ray results dated 05/04/24 revealed Resident #67 had an acute, comminuted moderately displaced fracture of the right tibia and fibula and a mildly displaced fracture of the left femur.</p> <p>Interview on 05/30/24 at 1:04 P.M. with Regional Nurse #40 confirmed LPN #26 was terminated for failure to follow protocol on a residents fall according to the facility policy, because the nurse did not assess and treat Resident #67 for injured following the resident's fall on 05/03/24.</p> <p>Interview on 05/31/24 at 9:22 A.M. with x-ray company staff confirmed a stat x-ray was ordered for Resident #67 on 05/04/24 by phone at approximately 8:40 A.M. per RN #30. The x-ray company staff further confirmed stat x-rays should be completed within four to six hours of ordering.</p> <p>Review of the facility policy titled Change in Condition dated March 2018 revealed the staff would assess residents for change in condition and would monitor and document the resident's progress and would notify the attending physician so treatment could be adjusted accordingly.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint Number OH00153637.		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Based on medical record review, observation, resident interview, staff interview, and review of the facility policy, the facility failed to adequately assess and treat resident pain following a fall. This affected one (Resident #67) of three residents reviewed for falls. The facility census was 76.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #67 revealed an admitted [DATE] with diagnoses including pulmonary hypertension and chronic kidney disease.</p> <p>Review of the care plan for Resident #67 dated 11/01/23 revealed the resident had the potential for pain/alteration in comfort related to osteoarthritis, weakness, and history of falls. Interventions included the following: monitor need for scheduled analgesics, evaluate the effectiveness of pain intervention, review for compliance, alleviating of symptoms, dosing schedules and residents satisfaction with results, impact of functional ability and impact on cognition, monitor/document for probable cause of each pain episode, remove/limit causes where possible, monitor/document for side effects of pain medication, monitor/record pain characteristics: quality, severity, anatomical location, onset, duration, aggravating factors, relieving factors, monitor/report to the nurse any signs and symptoms of non-verbal pain, notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain, report to nurse resident complaints of pain or request for pain treatment.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #67 dated 04/13/24 revealed the resident had intact cognition, was dependent with toileting, and required moderate assistance with bathing, dressing, and transfers.</p> <p>Review of the progress note for Resident #67 dated 05/06/24 at 4:48 P.M. revealed the note was a late entry documenting a witnessed fall which occurred on 05/03/24 at approximately 9:00 P.M. Further review of the note revealed it did not include an assessment of the resident's pain level at the time of the fall. Resident #67 complained of pain in the morning and the facility obtained an order for an x-ray which showed multiple fractures, and the resident was transported to the hospital.</p> <p>Review of the x-ray results dated 05/04/24 revealed Resident #67 had an acute, comminuted moderately displaced fracture of the right tibia and fibula and a mildly displaced fracture of the left femur.</p> <p>Review of the physician's orders for Resident #67 revealed an order dated 11/18/23 for Tylenol extra strength 500 milligrams (mg), give two tablets by mouth every six hours a day routinely for pain at 12:00 A.M., 6:00 A.M., 12:00 P.M., and 6:00 P.M.</p> <p>Review of the Medication Administration Record (MAR) for Resident #67 dated May 2024 revealed the resident received Tylenol as ordered on 05/04/24 at 12:00 A.M., 6:00 A.M., and 12:00 P.M. before the resident was sent to the hospital for fractures related to the fall on 05/03/24.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record revealed Resident #67 did not receive pain medication until approximately three hours after the incident occurred nor did the record include an assessment of the resident's pain following the incident until 05/04/24 at 8:23 A.M.</p> <p>Review of the progress note for Resident #67 dated 05/04/24 timed at 8:23 A.M. revealed the resident was complaining of severe pain to her lower extremities and was unable to move due to swelling and bruising to the lower extremities. Review of the record revealed it did not include documentation of facility staff interventions for the resident's pain.</p> <p>Interview on 05/30/24 at 11:47 A.M. with Resident #67 confirmed she was in excruciating pain following her fall which occurred on 05/03/24 at approximately 9:00 P.M. Resident #67 confirmed she received no pain medication following the fall except for her routine Tylenol, and she did not receive a dose of Tylenol until approximately three hours following the fall.</p> <p>Interview on 05/30/24 at 1:51 P.M. with State tested Nursing Assistant (STNA) #16 confirmed Resident #67 did not want to get out of bed in the morning on 05/04/24, and the resident complained of pain and discomfort to the bilateral lower extremities. STNA #16 reported Resident #67 had bruising, dark purple and black in color, and extreme swelling from her knee down to her ankle on her right leg. STNA #16 also stated she was not notified in report by STNA #15 that Resident #67 had fallen on the previous shift.</p> <p>Interview on 05/30/24 at 1:59 P.M. with Resident #66, Resident #67's roommate, confirmed after Resident #67 fell on [DATE] at approximately 9:00 P.M. the resident was crying and screaming out all night in pain.</p> <p>Interview on 05/30/24 at 2:22 P.M. with the Director of Nursing (DON) confirmed Resident #67 had a fall on 05/03/24 at approximately 9:00 P.M. The DON confirmed Resident #67's medical record did not include an assessment of the resident's pain following the fall and the resident did not receive pain medication until three hours after the fall. The DON confirmed the facility staff documented the resident was in excruciating pain on 05/04/23 at 8:23 A.M. but the staff did not obtain orders for additional pain medication nor did the staff document the implementation of nonpharmacological measures for pain.</p> <p>Review of the facility policy titled Administering Pain Medications dated October 2022 revealed the pain management program was based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Acute pain should be assessed every 30 to 60 minutes after onset and reassessed as indicated until relief was obtained. Facility staff should also evaluate and document the effectiveness of nonpharmacological interventions for pain management.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00153637.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43062</p> <p>Based on observation, staff interview, review of the facility policy, and review of Material Safety Data Sheets (MSDS), the facility failed to store, prepare, and distribute food in a sanitary manner. This had the potential to affect 75 residents residing at the facility. The facility identified one (Resident #50) who did not receive food from the facility kitchen. The facility census was 76.</p> <p>Findings include:</p> <p>Initial tour of the facility kitchen on [DATE] at 8:57 A.M. with Dietary Director (DD) #301 revealed there was a large hole in the floor with a missing floor tile at the end of the tray line counter. There was rust and metal flaking off the end of the tray line counter that was used for food preparation. The tray line counter also had food debris and splatter running down the side. The trash cans located in the kitchen had food splatter running down the sides and did not have lids on them. There was black dirt, black smudge, and food debris all along the walls and under the appliances. There were grease stains on the front of the oven. There was a large container of oven and grill cleaner chemical cleaner sitting on a lower table near the oven in the food preparation area. There was a tall metal cart which contained nine loaves of expired bread and half a pack of expired hamburger buns with a use by date of [DATE].</p> <p>Interview on [DATE] at 8:57 A.M. and during the tour with DD #301 confirmed the hole in the floor, the rust and metal flaking on the counter, the dirt and debris on the tray line counter and trash cans, the absence of lids for the trash cans, the presence of general dirt and debris on the walls and the under appliances, the presence of hazardous cleaning chemicals in the food preparation area and the expired bread and hamburger buns.</p> <p>Observation of the walk-in refrigerator on [DATE] at 9:10 A.M. with DD #301 revealed the refrigerator contained the following items: a sliced tomato, wrapped in plastic and undated, a large plastic bag of cheese which was open and undated, nine individual dessert cups of pudding which were unlabeled and undated, a large metal container of mashed potatoes which was unlabeled and undated, an undated unlabeled and opened package of sliced turkey, a large metal container of unlabeled and undated mechanical soft chicken, a large opened plastic bag of coleslaw undated, a large opened plastic bag of lettuce undated, a large metal pan of tomato sauce undated, two large metal containers of greens beans undated.</p> <p>Interview on [DATE] at 9:10 A.M. and during the tour with DD #301 confirmed the identity of all unlabeled foods observed. DD #301 confirmed all the observations of opened and undated food and confirmed all stored foods should be labeled and should be dated when opened.</p> <p>Observation on [DATE] at 11:24 A.M. with Maintenance Supervisor (MS) #300 revealed the facility garbage disposal was broken. MS #300 approached the sink in the facility kitchen and used flashlight to illuminate the inside of the garbage disposal which revealed rotten food debris and brown looking sludge. The sludge from the broken disposal was leaking onto the floor below. There were numerous gnats flying around the garbage disposal. There was a yellow tag on the garbage disposal dated [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 11:24 A.M. with MS #300 confirmed the garbage disposal had not been working for several months and he could not get payment approved for repair. MS #300 confirmed the rotten food debris in the disposal, the sludge leaking onto the floor below, and the presence of gnats flying around the garbage disposal.</p> <p>Interview on [DATE] at 11:25 A.M. with DD #301 confirmed the yellow tag hanging from the garbage disposal was dated [DATE] and indicated the disposal had been taken out of service at that time. DD #301 further confirmed the yellow tag was hung to prevent staff from using broken equipment.</p> <p>Review of the facility policy titled Sanitization dated [DATE] revealed the facility food service area should be maintained in a clean and sanitary manner. The facility kitchen areas should be kept clean and free of litter, rubbish, and insects. Further review of the policy confirmed the kitchen surfaces not in contact with food should be cleaned on a regular schedule to prevent the accumulation of grime.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00153570.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412</b></p> <p>Based on record review, observation, staff interview, and review of the facility policy, the facility failed to provide adequate incontinence care in a sanitary manner. This affected one (Resident #13) of three residents reviewed for incontinence care. The facility census was 76.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #13 revealed an admitted [DATE] with diagnoses including cerebral palsy, heart failure, schizoaffective disorder, and type two diabetes mellitus.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #13 dated 04/17/24 the resident had intact cognition was dependent on staff with toileting and was always incontinent of bowel and bladder.</p> <p>Review of the physician's order for Resident #13 revealed an order dated 05/03/24 for staff to apply zinc oxide topical ointment to the peri-area and buttocks after each incontinent episode.</p> <p>Observation of incontinence care on 05/28/24 at 1:09 P.M. for Resident #13 per State tested Nursing Assistants (STNAs) #10 and #11 revealed the resident's incontinence brief was heavily saturated with urine. The STNAs removed Resident #13's soiled brief, and STNA #11 cleansed the front of the resident's peri area with a washcloth and then immediately used the same soiled washcloth to cleanse the resident's buttocks. STNA #11 then applied zinc oxide and a clean incontinence brief.</p> <p>Interview on 05/28/24 at 1:35 P.M. with STNA #11 confirmed she used the same washcloth to clean Resident #13's front peri area and then immediately cleansed the resident's buttocks using the same soiled washcloth before applying zinc oxide and a clean incontinence brief.</p> <p>Interview on 05/28/24 at 1:49 P.M. with the Director of Nursing (DON) confirmed staff should not use the same washcloth for cleaning a resident front to back during incontinence care.</p> <p>Review of the facility policy titled Supporting Activities of Daily Living dated March 2018 revealed residents would be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00153552.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>43062</p> <p>Based on observation, staff interview, and review of the facility policy the facility failed to maintain mechanical equipment in a safe operating condition. This had the potential to affect all residents residing in the facility. The facility census was 76.</p> <p>Findings include:</p> <p>Observation of the laundry room on 05/28/24 at 8:47 A.M. with the Maintenance Supervisor (MS) # 300 revealed the facility had three dryers in use for resident laundry. All three dryers had a thick layer of lint on the vents.</p> <p>Interview on 05/28/24 at 8:47 A.M. with MS #300 confirmed the lint on all three dryer vents was very thick and it appeared they had not been cleaned for several loads or possibly even several days of use. MS #300 confirmed the vents should be cleared of lint after each load of laundry. MS #300 confirmed the facility should have a lint cleaning log in the laundry with signatures of staff to verify cleaning of the vents after each load, but the facility did not have a record of the dryer vent cleaning.</p> <p>Interview on 05/28/24 at 8:49 A.M. with Laundry Worker (LW) #302 confirmed he had completed several loads of laundry since the beginning of the shift, and he had not cleaned the dryer vents since 05/27/24.</p> <p>Interview on 06/03/24 at 8:16 A.M. with the Administrator confirmed the staff should clean the lint from the dryers after each load as an environmental safety measure and should sign off completion of the task.</p> <p>Review of the facility job description titled Laundry Worker undated revealed the laundry worker was to establish safety precautions when performing tasks and when using equipment.</p> <p>Review of the facility policy titled Homelike Environment dated February 2021 revealed residents should be provided with a safe, clean, comfortable, and homelike environment.</p> <p>This deficiency represents noncompliance investigated under Complaint Number OH00153570.</p>		