STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365538	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friends Extended Care Center	150 East Herman Street Yellow Springs, OH 45387

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 record review, staff interview, and procedure review, the facility failed to maintain documentation of all routine activities related to maintenance, testing, and treatment of water systems. This had the potential to affect all 49 residents residing in the facility. The facility census was 49. Findings include: Review of the facility Legionella documentation revealed no documentation to support maintenance flushed the faucets of the unoccupied rooms weekly or if unoccupied for more than three days. Review of the facility document titled Monitoring Waterborne Organisms: Legionnaire's Disease, stated the departments would complete records of all routine and special activities related to maintenance, testing, and treatment of involved water systems. Review of Water Control Measures for Legionnaire's Disease stated the following would be completed: 1) Legionella testing on the water system would be done on an Annual basis 2) all ice machines would be tested on an Annual basis 3) any rooms that are unoccupied for more than 3 days would have all fixers flushed (hot and cold for 15 minutes) 4) whirlpool tub would be flushed (hot and cold) for 15 minutes every Wednesday 5) annually all shower hoses and faucet aerated outlet would be cleansed or replaced throughout the facility. Interview on 02/19/26 at 11:55 A.M. with Director of Building Services (DOBS) #124 stated the maintenance staff go to unoccupied rooms weekly and run water from faucets as part of the Legionnaire procedures. DOBS #124 stated the facility did not have documentation to show which rooms the maintenance staff had flushed the faucets weekly. BOBS #124 also confirmed the procedures called for unoccupied rooms to have all fixers flushed every three days and the facility had only done weekly.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation and staff interviews, the facility failed to maintain essential kitchen equipment in safe, working condition. This had the potential to affect all 49 residents residing in the facility. The census was 49. Findings include: An observation in the kitchen on 02/18/26 at 10:00 A.M. revealed the Dietary [NAME] (DC) #121 calling out the stove was on fire. Flames could be seen coming from under the lower left burner on the gas stove. Four of the six burners were on with lunch prep taking place. The Director of Environmental Services (DES) #122 heard DC #121 calling out, approached the stove and put the fire out using a fire extinguisher. During an interview on 02/18/26 at 10:14 A.M. with DC #121 stated she reported the fire was due to grease and other debris which had accumulated under the burners. DC #121 stated, look under there you can see how dirty it is. DC #121 reported the middle burners had caught fire about a week ago for Director of Dietary (DOD) #125. DC #121 stated she thought it was recommended the stove should be cleaned at that time, but she was not sure if that occurred. DC #121 mentioned since the middle burners had caught fire for DOD #125, she had not used those burners, which was why she was using the burners on the left and right. DC #121 stated now that the left burners had also caught fire, she did not feel safe using the stove and would need to provide an alternative meal for lunch that did not require being cooked on the stove. An observation on 02/19/26 at 11:50 A.M. revealed DES #122 using a drill and a scraper to remove debris from the left burner cover. DES #122 reported they had fully disassembled the stove and cleaned each part. During an interview on 02/19/26 at 11:56 A.M. with DOD #125 she stated there was no policy for cleaning the stove nor a log to document when it was cleaned. DOD #125 reported every weekend either herself or the assistant wiped down the burner covers and placed the under tray in the 3-sink sanitizer to wash but they never took the covers off to clean under the burners where the fire had originated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and policy review, the facility failed to assess and document wound descriptions including measurements. This affected one (#06) out of two residents reviewed for pressure ulcers/injuries. The facility census was 49. Findings include: Review of the medical record for Resident #06 revealed an admission date of 01/16/26 with diagnoses of non-stemi elevation (nstemi) myocardial infarction, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, acute respiratory failure with hypoxia, cellulitis of buttock, and essential (primary) hypertension. Review of the Discharge Return Anticipated Minimum Data Set (MDS) dated [DATE] revealed resident was cognitively intact, resident was independent with eating, oral hygiene, and personal hygiene. Resident #06 required partial assistance with toileting hygiene, bathing, bed mobility, and ambulation. Further review revealed Resident #06 did not have a pressure ulcer or injury. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed resident had a stage three pressure ulcer. Review of the Skin Observation Tool dated 01/16/26 revealed resident had cellulitis to his right buttocks. Further review revealed there was no measurements documented. Review of the Continuity of Care Document from Medical Center #01 dated 01/16/26 revealed Resident #06 had sepsis secondary to cellulitis involving the buttocks with no evidence of abscess. Review of the Skilled Daily Note dated 01/16/26 at 10:19 P.M. revealed Resident #06 had cellulitis to buttocks. No measurements documented. Review of the Weekly Skin assessment dated [DATE] revealed only pre-existing wounds found. No measurements documented. Review of the Nursing Note dated 01/20/26 at 7:50 P.M. revealed no documentation of wound present. Review of the Skilled Daily Notes dated 01/26/26 at 4:57 P.M. revealed to continue with current treatment to sacral wound, wound is stable at this time. No measurements documented. Further revealed also revealed resident had a dressing to the right wrist with no measurements documented. Resident had multiple bruises to the right upper arm with no measurements documented. Residents had two bruises on the left forearm with no measurements documented. Review of the Nursing admission Form dated 01/27/26 revealed resident had cellulitis to the right buttocks. No measurements documented. Resident #06 had a surgical opening to the right wrist, well approximated. No measurements documented. Review of the Skin Note dated 01/28/26 at 1:17 A.M. revealed treatment to area on coccyx done per order, small open area remains. No measurements documented. Review of the care plan dated 02/02/26 revealed resident has a pressure ulcer with intervention of weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Review of the Skin Note dated 02/02/26 at 2:59 P.M. revealed area to resident's buttocks has an open area with wound bed 100% granulation tissue measuring 1.5 cm x1.0 cm x 0.3cm. Review of the Wound Nurse Practitioner's noted dated 02/05/26 revealed Resident #06 with a stage three pressure wound to the pelvis buttocks right measuring 1 X 1.5 X 0.3=0.45 cm3 with 90% granulation tissue. Further review revealed a stage three pressure wound to the pelvis coccyx measuring 0.5 X 0.5 X 0.1=0.03 cm with 30% granulation tissue. Review of the Skin Note dated 02/08/26 at 6:00 A.M. revealed treatment done on cellulitis to buttocks. Open area remains. Wound bed pink with no drainage or odor noted. No measurements documented. Review of the Wound Nurse Practitioner's note dated 02/13/26 revealed Resident #06 with a stage three pressure wound to the pelvis buttocks right measuring 1.5 X 0.5 X 0.3=0.22 cm3. Further review revealed a stage three pressure wound to the pelvis coccyx measuring 0.5 X 0.5 X 0.1=0.03 cm3 Review of the Skin Note dated 02/15/26 at 5:58 P.M. revealed there was no skin issues noted. Interview on 02/18/26 at 2:24 P.M. with Director of Admission/Licensed Practical Nurse (LPN) #123 confirmed there was no wound measurements documented on Resident #06 on 01/16/26 for the wound to the buttocks. Interview also confirmed Resident #06 admitted to the facility on [DATE] with an open wound to the buttocks. Interview also confirmed there was no wound measurements documented on the cellulitis wound to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the buttocks until 02/02/26 on a skin note. Interview also confirmed there was no other measurements documented on the wound by the facility staff. Interview also confirmed Resident #06 was not seen by the wound Nurse Practitioner (NP) until 02/05/26 at which time the resident was diagnosed with one stage three pressure ulcer to the right buttocks and one stage three pressure ulcer o the coccyx with measurements documented on the wound NP notes. Observation on 02/18/26 at 3:05 P.M. with Registered Nurse (RN) #131 of wound care to Resident #06 buttocks and coccyx area. RN #131 measured the coccyx wound as approximately 0.5 cm x 0.5 cm x 0.1 deep, with pink granulation tissue present. The right buttocks wound was open measuring approximately 1.5 cm x 1.0 cm x 0.2 cm with pink granulation tissue present. Review of the Wound Care policy, dated 2001 revealed the facility will provide care to promote wound healing. Review also revealed the facility will document the wound type, date, time, wound bed color, size, and drainage.