STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365752	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foundation Park Care Center	1621 S Byrne Rd Toledo, OH 43614

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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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 0580 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 medical record review, review of an incident report, review of witness statements, staff interview, and review of facility policies, the facility failed to ensure notifications were made to resident representatives and hospice providers following an incident of a resident being lowered to the ground. This affected one (#12) of five residents reviewed for notifications. The facility census was 89.Findings include: Review of Resident #12's medical record revealed an admission date of 12/31/24. Diagnoses included dementia, type II diabetes, displaced fracture of the shaft of the right femur (10/22/25), generalized anxiety disorder, major depressive disorder, anemia, and terminal diagnosis of rectal cancer. Review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero (0) indicating Resident #12 was severely cognitively impaired. Resident #12 was dependent on staff for all activities of daily living including bed mobility and transfer. Resident #12 displayed no behaviors at the time of the review. Resident #12 restarted on hospice care at the time of the review. Review of Resident #12's care plan revised 11/03/25 revealed supports and interventions for alteration in skin integrity, self-care deficit, refusal of care, impaired cognitive function, risk for falls, the resident had a right hip fracture with surgical repair (10/17/25), potential for pain, and had a terminal prognosis. Review of the incident report dated 10/16/25 for Resident #12 revealed at approximately 11:30 A.M. a nurse aide and the wound care team were in Resident #12's room to do wound care. Resident #12 had been placed in a stand-up lift and when Resident #12 was lifted into the lift, he pulled his arm out of the sling and staff members lowered Resident #12 to the floor. Once Resident #12 was lowered down, the resident flung his body to the left side before staff could unstrap Resident #12's legs from the lift. Resident #12 was assisted back into his wheelchair, and no injuries were noted at the time. It was noted Resident #12's physician was notified of the incident but there was no indication Resident #12's spouse or hospice provider were notified of the incident. Review of the witness statements dated 10/16/25 from Resident #12's lowering to the floor incident revealed Registered Nurse (RN) #238 was rounding with the Wound Nurse Practitioner (WNP) and they went to treat Resident #12. With the assistance of Certified Nurse Aide (CNA) #283, Resident #12 was lifted in the stand-up lift using sling and leg straps to support his leg position. CNA #283 reported Resident #12 had been more difficult to care for recently. Resident #12 was assisted to standing and the WNP began the assessment of his wound. Resident #12 had a bowel movement during the assessment and CNA #283 went to the bathroom to get supplies to clean Resident #12. Resident #12 was noted to be restless, resistive, and moving around in the lift. He managed to get his arm out and under the sling, which was out of proper position to support himself. Resident #12 dropped to the side while still having his other arm in the sling. RN #238 and the WNP caught him and attempted to return him to a standing position. Resident #12 resisted, so the sling was unhooked and he was lowered to the floor. Resident #12's leg straps were still connected and before they could be undone Resident #12 threw himself back and to the left. Resident #12 was laying on his left side with this right leg still strapped in the lift. Resident #12 was released from the strap and wound care finished their assessment of his wound. CNA #283 cleaned and re-dressed Resident #12. It was noted Resident #12 had called out for his mother while on the floor but had not called out in pain. There was no indication of pain or injury at the time. Further review revealed no documentation of notifications being made. Review of the witness statement from Licensed Practical Nurse (LPN) #270 revealed she came into Resident #12's room when requested by CNA #283 to assist with transferring Resident #12 back into his chair after he had a behavior and was lowered to the ground. LPN #270 observed Resident #12 laying on the floor anxiously fidgeting when she entered. This was noted to be normal behavior for Resident #12. LPN #270 and CNA #283 assisted Resident #12 back into his chair. It was noted Resident #12 showed no sign of injury or pain while on the floor, during or after transfer. There were no notifications documented as being made to Resident #12's spouse or hospice provider on 10/16/25. Interview on 11/25/25 at 7:04 A.M. with LPN #270 verified she was called to assist Resident #12 on 10/16/25 after he had been lowered to the ground from his lift. LPN #270 explained Resident #12 had gotten his arm out and under the sling which had been supporting him in the lift. Resident #12 had been caught and lowered to the floor while his legs were still secured in the lift. Resident #12 was then transferred to his wheelchair with the assistance of two staff. LPN #270 stated she had not made notifications of the incident to Resident #12's family or hospice provider on 10/16/25. Interview on 11/25/25 at 8:52 A.M. with RN #238 verified she had been in Resident #12's room with the

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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)

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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 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 medical record review, review of an incident report, review of written statements, staff interview, and review of a facility policy, the facility failed to thoroughly assess residents following an incident where the resident was lowered to the ground. This affected one (#12) of three residents reviewed for transfers. The facility census was 89.Findings include:Review of Resident #12's medical record revealed an admission date of 12/31/24. Diagnoses included dementia, type II diabetes, displaced fracture of the shaft of the right femur (10/22/25), generalized anxiety disorder, major depressive disorder, anemia, and terminal diagnosis of rectal cancer. Review of Resident #12's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of zero (0) indicating Resident #12 was severely cognitively impaired. Resident #12 was dependent on staff for all activities of daily living including bed mobility and transfer. Resident #12 displayed no behaviors at the time of the review. Resident #12 restarted on hospice care at the time of the review. Review of Resident #12's care plan revised 11/03/25 revealed supports and interventions for alteration in skin integrity, self-care deficit, refusal of care, impaired cognitive function, risk for falls, the resident had a right hip fracture with surgical repair (10/17/25), potential for pain, and had a terminal prognosis. Review of the incident report dated 10/16/25 for Resident #12 revealed at approximately 11:30 A.M. a nurse aide and the wound care team were in Resident #12's room to do wound care. Resident #12 had been placed in a stand-up lift and when Resident #12 was lifted into the lift, he pulled his arm out of the sling and staff members lowered Resident #12 to the floor. Once Resident #12 was lowered down, the resident flung his body to the left side before staff could unstrap Resident #12's legs from the lift. Resident #12 was assisted back into his wheelchair, and no injuries were noted at the time. The incident report did not indicate how Resident #12 was assessed for injuries. Review of the witness statements dated 10/16/25 from Resident #12's lowering to the floor incident revealed Registered Nurse (RN) #238 was rounding with the Wound Nurse Practitioner (WNP) and they went to treat Resident #12. With the assistance of Certified Nurse Aide (CNA) #283, Resident #12 was lifted in the stand-up lift using sling and leg straps to support his leg position. CNA #283 reported Resident #12 had been more difficult to care for recently. Resident #12 was assisted to standing and the WNP began the assessment of his wound. Resident #12 had a bowel movement during the assessment and CNA #283 went to the bathroom to get supplies to clean Resident #12. Resident #12 was noted to be restless, resistive, and moving around in the lift. He managed to get his arm out and under the sling, which was out of proper position to support himself. Resident #12 dropped to the side while still having his other arm in the sling. RN #238 and the WNP caught him and attempted to return him to a standing position. Resident #12 resisted, so the sling was unhooked and he was lowered to the floor. Resident #12's leg straps were still connected and before they could be undone Resident #12 threw himself back and to the left. Resident #12 was laying on his left side with this right leg still strapped in the lift. Resident #12 was released from the strap and wound care finished their assessment of his wound. CNA #283 cleaned and re-dressed Resident #12. It was noted Resident #12 had called out for his mother while on the floor but had not called out in pain. There was no indication of pain or injury at the time. Further review revealed there was no documentation of how Resident #12 had been assessed for injury. Review of the witness statement from Licensed Practical Nurse (LPN) #270 revealed she came into Resident #12's room when requested by CNA #283 to assist with transferring Resident #12 back into his chair after he had a behavior and was lowered to the ground. LPN #270 observed Resident #12 laying on the floor anxiously fidgeting when she entered. This was noted to be normal behavior for Resident #12. LPN #270 and CNA #283 assisted Resident #12 back into his chair. It was noted Resident #12 showed no sign of injury or pain while on the floor, during or after transfer. However, it was noted on 10/17/25 when LPN #270 went back to Resident #12's room to pass medications Resident #12's hospice aide was in the room and reported there was something wrong with Resident #12's leg. LPN #270 assessed Resident #12 and found his right leg was rotated inward. A stat x-ray was completed and revealed the resident had a right femur fracture with severe dislocation and Resident #12 was sent to the hospital for further treatment. Interview on 11/25/25 at 7:04 A. M. with LPN #270 verified she was called to assist Resident #12 on 10/16/25 after he had been lowered to the ground from his lift. LPN #270 explained Resident #12 had gotten his arm out and under the sling which had been supporting him in the lift. Resident #12 had been caught and lowered to the floor while his legs were still secured in the lift. It was thought Resident #12's leg was broken when he threw himself to the side