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	02/26/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of facility documentation, and review of facility policy, the facility failed to ensure the physician and responsible party were timely notified when a resident was discovered unresponsive on the floor with a laceration to the head. This affected one (#2) of three residents reviewed for timely notification in a facility census of 89. Findings include:Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy, malignant neoplasm of bladder wall, coronary artery disease, major depression with severe psychotic symptoms, anxiety disorder, osteoarthritis, history of transient ischemic attack, and hypertension. Review of the Minimum Data Set assessment dated [DATE] assessed Resident #2 with severe cognitive impairment, no range of motion impairment, independent with ambulation and transfer, and no falls since admission. Review of the nursing care plan dated 10/01/25 was revised to address Resident #2 risk for falls related to cognitive impairment/communication deficits, overestimates or forgets limits/decreased safety, awareness, decreased judgement impulsiveness, incontinence, and prescribed medications which can affect balance. Interventions included: If the resident falls or is found on the floor, assess for injury, notify the medical doctor (MD) and the responsible party if resident has fallen. Review of the facility incident report dated 01/13/26 at 8:00 A.M., and linked nurses' notes documented on 01/13/25 at 2:16 P.M., revealed at 8:00 AM Licensed Practical Nurse (LPN) #200 was informed by a certified nurse aide (CNA) Resident #2 had an unwitnessed fall and was laying on the bathroom floor of his room. LPN #200 went to check the resident and observed the resident laying on the bathroom floor with his head underneath the bathroom sink and feet towards the bathroom door. Resident #2 was diaphoretic, sweaty, and clammy. LPN #200 noticed the resident had hit his head and observed a laceration to the top of the resident's head. Resident #2 was unable to perform range of motion (ROM) due to lack of consciousness. Neurological (neuro) checks were started. Called the Power of Attorney (POA) at 10:45 A.M. to inform of the fall. Faxed the MD regarding the fall at 9:00 A.M., awaiting response. The Director of Nursing (DON) was notified of the resident fall and change in condition at 11:30 A.M. The supervisor called a private ambulance transportation to set-up transportation to the local hospital emergency room for evaluation. Supervisor called the POA to inform of the resident going to the emergency room at 11:45 A.M. The resident left with transportation at 12:11 P.M. At 12:45 P.M. the MD faxed response to send the resident to the emergency room. LPN #200 faxed back to the MD the resident was already gone to hospital. Review of the facility policy titled Notification of Change: Policy and Procedure, reviewed 12/01/25, revealed it is the policy of the facility to notify the resident, physician, and resident representative when there is a change in treatment, accident, significant change in status and/or the decision to transfer or discharge the resident. The facility staff will immediately inform the resident; consult with the (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
	365752	A. Building B. Wing	02/26/2026

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	resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: An incident involving the resident which results in injury and has the potential for requiring physician intervention or a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications. Physician notification will occur when a resident experiences symptoms such as loss of consciousness. On 02/02/26 at 10:40 A.M. interview and record review with the DON verified the physician was not contacted immediately when the resident was found unresponsive. The DON stated they should have been contacted the physician by telephone and not through facsimile, which resulted in a four hour and 45 minute delay in physician response. The DON also verified the resident representative was not notified of the fall until two hours and 45 minutes following the incident.This deficiency represents non-compliance investigated under Master Complaint Number 2718218 and Complaint Number 2717144.

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	02/26/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of facility incident report, review of hospital documentation, and review of facility policy, the facility failed to provide appropriate treatment and neurological assessments following the discovery of a resident on the floor unresponsive with a laceration to the head. This affected one (#2) of three residents reviewed for timely care and treatment. The facility census was 89. Findings include: Review of the medical record revealed Resident #2 admitted to the facility on [DATE]. Diagnoses included dementia, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy, malignant neoplasm of bladder wall, coronary artery disease, major depression with severe psychotic symptoms, anxiety disorder, osteoarthritis, history of transient ischemic attack, and hypertension. Review of the Minimum Data Set assessment dated [DATE] assessed Resident #2 with severe cognitive impairment, no range of motion impairment, independent with ambulation and transfer, and no falls sinceadmission. Onn 11/24/25 Resident #2 was assessed with intermittent confusion, no falls in the past three months, independent with ambulation, and balance normal. Review of the nursing care plan dated 10/01/25 was revised to address Resident #2 risk for falls related to cognitive impairment/communication deficits, overestimates or forgets limits/decreased safety, awareness, decreased judgement impulsiveness, incontinence, and prescribed medications which can affect balance. Interventions included: If the resident falls or is found on the floor, assess for injury; Review the information of the fall and attempt to determine the cause of the fall; Complete neurological (neuro) checks for post fall head injury or unwitnessed fall, and notify MD of any abnormalities identified. Review of the facility incident report dated 01/13/26 at 8:00 A.M., and linked nurses' notes documented on 01/13/25 at 2:16 P.M., revealed at 8:00 AM Licensed Practical Nurse (LPN) #200 was informed by a certified nurse aide (CNA) Resident #2 had an unwitnessed fall and was laying on the bathroom floor of his room. LPN #200 went to check the resident and observed the resident laying on the bathroom floor with his head underneath the bathroom sink and feet towards the bathroom door. Resident #2 was diaphoretic, sweaty, and clammy. LPN #200 noticed the resident had hit his head and observed a laceration to the top of the resident's head. Resident #2 was unable to perform range of motion (ROM) due to lack of consciousness. Neurological (neuro) checks were started. Called the Power of Attorney (POA) at 10:45 A.M. to inform of the fall. Faxed the MD regarding the fall at 9:00 A.M., awaiting response. The Director of Nursing (DON) was notified of the resident fall and change in condition at 11:30 A.M. The supervisor called a private ambulance transportation to set-up transportation to the local hospital emergency room for evaluation. Supervisor called the POA to inform of the resident going to the emergency room at 11:45 A.M. The resident left with transportation at 12:11 P.M. At 12:45 P.M. the MD faxed response to send the resident to the emergency room. LPN #200 faxed back to the MD the resident was already gone to hospital. Review of the neurological observation form, dated 01/13/26 at 8:00 A.M., documented vital signs at 8:15 A.M., 8:30 A.M., 8:45 A.M., 9:00 A.M., 9:30 A.M., 10:00 A.M. The form listed areas to document the pupillary response for the right and left eye and hand grasps for the right and left hand. No pupillary response or hand grasps were assessed on any of these times. The medical record contained no additional assessment or further documentation was recorded.Review of the progress notes dated 01/13/26 at 7:17 P.M. noted Registered Nurse (RN) #502 contacted the local hospital to inquire about Resident #2. The emergency room nurse reported the resident would not be returning to the facility and will instead be discharged to Hospice due to significantly large intracranial hemorrhage that cannot be operated on. Review of the hospital computed tomography (CT) scan results dated 01/13/26 revealed substantial intraventricular (continued on next page)

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	02/26/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hemorrhage as well as hemorrhage into the cerebellum with mass effect. Given the location of hemorrhage suspect this is likely a spontaneous hemorrhage, not traumatic. Unfortunately, this is a catastrophic hemorrhage and prognosis is grave. No intervention is likely to be of any benefit. Patient will die as a result of this. Patient is a Do Not Resuscitate (DNR) comfort care, initiate comfort care protocol at this time. Recommend palliative care/hospice consultation. Discussed with trauma team. As above, prognosis grave and no intervention likely to be of benefit. Interview on 02/25/26 at 10:45 A.M. CNA #300 stated CNA #303 found Resident #2 on the floor of his bathroom unresponsive at approximately 8:00 A.M. on 01/13/26. CNA #300 was called to the room, and observed the resident was on the floor, unconscious and non-responsive. Unit Manager LPN #201, LPN #200, CNA #300, and CNA #303 proceeded to lift the resident from the floor and placed him to his bed. Emergency medical services (EMS) was not observed to be contacted. The resident remained unresponsive. Interview on 02/02/26 at 10:40 A.M. the DON stated the resident never regained consciousness. The DON verified the post fall neurological assessment only contained vital signs and did not document the resident's pupillary response or hand grasps. In addition, facility staff failed to contact EMS when the resident was discovered on the floor unresponsive with an observed head injury, instead moving him back into the bed. This deficiency represents non-compliance investigated under Complaint Number 2717144.

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	02/26/2026

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 0686 Level of Harm - 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 medical record review, staff interview, and review of facility policy, the facility failed to ensure interventions were implemented to prevent a pressure ulcer from increasing in size and stage. This resulted in actual harm beginning on 12/22/25 when one resident (#01), who was identified at low risk for pressure ulcer development, was discovered with a Stage II pressure ulcer which increased in size and depth and was assessed as an unstageable pressure ulcer with malodorous necrotic tissue 19 days after being discovered. The facility failed to provide any reassessment of the resident's condition and for a possible source of the pressure ulcer and no nutritional assessments had been completed from the time when the pressure ulcer was initially identified. This affected one (#01) of three residents reviewed for pressure ulcer prevention and wound healing. The facility census was 89. Findings include: Review of the medical record revealed Resident #01 admitted to the facility on [DATE]. Diagnoses included hypertension, edema, autonomic neuropathy disease, Vitamin D deficiency, dementia, persistent mood disorder, major depression, Alzheimer's disease, and bacterial pneumonia. Review of the Minimum Data Set assessment dated [DATE] assessed Resident #01 with severely impaired cognition, rejection of care one to three days during the assessment, dependent on staff for the completion of activities of daily living. The resident required substantial to maximal assistance with rolling left to right on bed, supervision and/or touching assistance with standing or chair to bed transfer, and was independent with ambulation. The resident was always incontinent of bowel and bladder and developed an in-house acquired unstageable pressure ulcer. Review of the nursing care plan dated 08/07/25 addressed Resident #01 was at risk for pressure ulcer development related to cognitive impairment/communication deficits/decreased sensory perception, incontinence, mobility/balance deficits, weak gait, prescribed medications which can influence sensory perception to pressure, and sits frequently during the day/ decreased activity levels. Interventions included to monitor/document/report as needed (PRN) any changes in skin status such as appearance, color, wound healing, signs/symptoms of infection, wound size (length X width X depth), and stage. Inform the nurse / physician / wound specialist consultant/resident's responsible party of any new areas of skin breakdown. Dietitian to assess nutritional needs to support skin health/wound healing. Wound Specialist Center to manage wound healing which includes providing treatment orders and monitoring the wound healing process/ measurements. Nurse to complete Skin Assessment due weekly on shower day. Apply House Barrier Cream topically to buttocks/coccyx after each incontinent episode and as needed. Review of the physician order dated 08/13/25 instructed nursing staff to conduct skin assessments on scheduled shower days twice weekly on Wednesday and Saturday. Review of the nutritional assessment dated [DATE] evaluated Resident #01 as having a potential nutritional problem related to cognitive impairment/decreased hunger perception, terminal condition of dementia, and diet restrictions related to mechanically altered diet. The resident was receiving regular, mechanically altered diet with fair to sufficient intakes per nursing and was at risk for malnutrition. No additional nutritional interventions were documented in the medical record. Review of the skin assessment dated [DATE] revealed Resident #01 was assessed at low risk for developing a pressure ulcer. Review of the shower/skin assessment dated [DATE] at 8:25 P.M. identified no area of skin breakdown with skin intact. Review of progress notes dated 12/04/25 at 7:09 A.M. revealed at 5:15 A.M. the certified nurse aide (CNA) notified nurse Registered Nurse (RN) #500 Resident #01 had an open area to the coccyx. RN #500 assessed the area, barrier cream was applied, the on coming supervisor was notified, and the wound care nurse to assess today. Review of the Wound/Skin Care Management Documentation Form dated 12/04/25 identified a coccyx wound identified as a Stage II pressure ulcer (continued on next page)

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	02/26/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	measuring 1 centimeter (cm) long by 1.5 cm wide by 0.1 cm deep, draining a scant amount of serosanguinous (blood tinge) drainage, with 100% epithelial tissue. No additional interventions including nutritional support/evaluation was contained in the medical record. There was no evidence a reassessment of the resident's condition and possible source of the pressure ulcer was conducted. On 12/05/25 a nursing plan of care was developed to address Resident #01's current coccyx skin alteration. Interventions on 12/05/25 included: apply triad paste, may use chamosyn with honey apply two times a day for open/redness and as needed for after showering or episodes of incontinence. Review of Wound/Skin Care Management Documentation Form dated 12/11/25 identified the coccyx wound to be a Stage II pressure ulcer measuring 1.5 cm long by 1.5 cm wide by 0.1 cm deep, draining a scant amount of serosanguinous drainage, with 50% granulation tissue and 50% epithelial tissue. No additional interventions including nutritional support/evaluation was contained in the medical record. There was no evidence a reassessment of the resident's condition and possible source of the pressure ulcer was conducted. Review of Wound/Skin Care Management Documentation Form dated 12/18/25 identified the coccyx wound to be a Stage II pressure ulcer measuring 2.0 cm long by x 1.5 cm wide by 0.1 cm deep, draining a scant amount of serosanguinous drainage, with 60% granulation tissue and 40% slough tissue. There was no evidence of a reassessment of the resident's condition due to the increasing size of the pressure ulcer. No additional interventions including nutritional support/evaluation was contained in the medical record. Review of the Wound/Skin Care Management Documentation Form dated 12/22/25 identified the coccyx wound to be a an unstageable pressure ulcer measuring 3.0 cm long by 4.0 cm wide by 2.0 cm deep with a foul odor and moderate amount of necrotic tissue. The treatment order was revised to include cleansing the open area with normal saline, pat dry, pack with wound cleansing moistened gauze and cover with foam dressing. There was no evidence any interventions to include a reassessment of the resident's condition to identify a possible source of the pressure ulcer, mechanical pressure relief devices, off-loading strategies, or nutritional support/evaluation were completed. Review of the record revealed on 12/23/25 the Wound Specialist Certified Nurse Practitioner evaluated the pressure ulcer. The documentation revealed nursing reported the coccyx pressure ulcer had worsened since yesterday. The note stated Resident #01 ambulates with a walker throughout the facility or sits in a chair all day. Nursing reports resident will put herself back into bed. Nursing reports due to her size she does not have good bed mobility. She has a fair appetite and incontinent of bowel and bladder. Muscluloskeletal and neurological assessment identified generalized muscle weakness with poor bed mobility. The skin area was described as an unstageable wound with 100% malodorous necrotic tissue measuring 3 cm by 4 cm by 2 cm with moderate serosanguinous drainage. Unable to stage due to inability to see wound bed and all tissue is necrotic. Suspect chronic incontinence, pressure from sitting and poor bed mobility has caused unstageable pressure ulcer. Plan orders included an air pressure mattress, reposition every two to three hours as tolerated, skin assessments and ongoing risk assessments by nursing per policy. Monitor wound for signs and symptoms of infection, frequent incontinence checks, monitor nutrition and optimize protein intake. Will debride to remove biofilm weekly to aide in wound healing and decrease bioburden. Treatment order to cleanse with normal saline and pat dry. Pack wound loosely with 1/4 strength Dakins moistened gauze packing to wound bed and fill any dead space with fluff gauze. Cover with foam dressing and change twice daily and PRN. Further review of the medical record lacked documentation indicating the recommendations were promptly implemented as ordered. On 12/23/25 the plan of care was updated to include the Wound Specialist Center is managing the healing process and completing wound measurements. Interventions included to notify them of significant wound changes. Further review of the medical record revealed no additional interventions (continued on next page)

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	02/26/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	to address mechanical off-loading interventions, or nutritional evaluation with support were documented. Review of the progress notes on 12/26/25 at 2:52 P.M. revealed Resident #01 was sent to emergency room per physician order and admitted to local hospital at 10:00 P.M. for diagnosis of pneumonia. Resident #01 did not return to the facility. Review of facility policy titled Skin Care Prevention and Pressure Management Policy, revised 10/2019, revealed any new pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers. Based upon the assessment and resident's clinical condition, choices and identified needs, basic or routine care may include but not limited to interventions to redistribute pressure, minimize exposure to moisture and keep skin clean, especially fecal contamination. Provide appropriate non-irritating surfaces and maintain or improve nutrition and hydration status where feasible. The resident should be monitored for condition changes that might increase the risk for breakdown and the defined interventions should be implemented and monitored for effectiveness. Interview on 02/26/26 at 7:34 A.M. RN #501, the Infection Preventionist/Staff Development/Wound Care nurse, verified the pressure ulcer went from a Stage II pressure ulcer on 12/04/25 to an unstageable pressure ulcer on 12/23/25. RN #501 verified no documentation was present to indicate the facility attempted to determine the origin of the pressure ulcer and nutritional interventions had been implemented to address Resident #01's skin breakdown as identified interventions on the care plan and per facility policy. This deficiency represents non-compliance investigated under Master Complaint Number 2718218 and Complaint Number 2717144.