STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365907	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Care Ctr Sylvania	4111 Holland Sylvania Rd Toledo, OH 43623

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on record review, staff interview, and policy review, the facility failed to ensure residents were prepared a safe and orderly discharge. This affected Residents #8 and #9 reviewed for discharge. The facility census was 76. Findings included: 1. Review of Former Resident (FR) #8's medical record revealed an admitted [DATE] and was discharged to home on 12/30/24. Diagnoses included left femur fracture, atrial fibrillation, and dementia. Review of FR #8's discharge Minimum Data Set (MDS) dated [DATE] revealed her cognition was intact. The resident required moderate assistance with toileting, shower/bathing, lower body dressing, chair to bed transfers, toilet transfer, and walking up to 50 feet. Review of FR #8's care plan revealed she required assistance with discharge planning for a home goal and to arrange outside services and equipment needs prior to discharge. Review of FR #8's Notice of Medicare Non-Coverage (NOMNC) revealed an end of service date of 12/29/24. The resident denied an appeal and chose to discharge to home. The form was signed on 12/27/24. Review of FR #8's medical record revealed a physician's note dated 12/29/24 to discharge home with home healthcare for skilled nursing, occupational therapy, physical therapy, and speech therapy. Review of FR #8's Social Service note dated 12/27/24 revealed Social Service Designee (SSD) #100 met with the resident and her daughter to discuss the discharge. The daughter informed SSD #100 that she would pick up FR #8 on 12/30/24 at 12:00 P.M. and SSD #100 was also informed the resident would need Home Health Care (HCC) and informed the SSD which companies they chose. Review of FR #8's assessment note dated 12/30/24 revealed the resident was discharged to home. Review of FR #8 Social Service note dated 12/31/24 revealed a HHC referral was sent to the HHC Company. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with HHC Employee #400 on 01/17/25 at 10:09 A.M. revealed the company received an email from SDD #100 on 12/31/24 requesting home care for FR #8. Due to the holiday the resident was failed to be contacted until 01/03/25. HHC Employee revealed the company required long term care facilities to complete referrals earlier to ensure medical durable equipment and care were scheduled for the day of discharge. Interview with SSD #100 on 01/17/25 at 9:05 A.M. revealed the referral to the HHC for FR #8 was sent on 12/31/24 but she didn't recall receiving a confirmation. 2. Review of FR #9's medical record revealed an admitted [DATE]. The resident was discharged to home on 11/25/24. Diagnoses included breast cancer and chronic kidney disease. Review of Resident #9's discharge MDS dated [DATE] revealed the resident had an intact cognition. The resident required moderate assistance for showers/bathing and supervision for walking and toileting. Review of Resident #9's NOMNC revealed the resident was notified on 11/22/24 that the long-term care coverage would end on 11/24/24. The resident chose not to appeal. Review of FR #9's Social Service note dated 11/22/24 revealed FR #9's son agreed to a discharge day of 11/25/24 and the SSD informed the family she would send information to their HHC company of choice. Review of FR #9's medical record revealed she discharged to home on 11/25/24. Review of FR #9's Social Service note dated 11/27/24 revealed the SSD placed the request for HHC services which included a wheeled walker (two days after discharge). There was a delay in placing the order for the needed equipment and care due to the Certified Nurse Practitioner being unavailable to sign the discharge paperwork. Interview with SSD #100 on 01/17/25 at 1:28 P.M. SSD #100 verified FR #9 was discharged to home the referral for HHC services was not completed until 11/27/24. The SSD stated she does not complete referrals until all therapy notes were in the medical record system which typically took one to two days after discharge. Review of the facility policy titled, Discharge Planning Process dated 02/27/23 revealed the facility will assist residents and their resident representative in choosing an appropriate post-acute care provider (HHA) that will meet the resident's needs, goals and preferences. This deficiency represents non-compliance investigated under Complaint Number OH00161252.