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	04/03/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, resident interview, Power of Attorney (POA) interview, staff interview and review of facility policy, the facility failed to ensure dependent residents received feeding assistance and scheduled showers. This affected four (#1, #6, #10, and #9) of 14 residents reviewed for activities of daily living (ADLs). The facility census was 68. Findings include: 1. Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, stage III chronic kidney disease, osteoarthritis, muscle weakness, chronic obstructive pulmonary disease (COPD), hypothyroidism, anemia, hypertension, and chronic embolism and thrombosis deep veins of lower extremity. Review of the most current Minimum Data Set (MDS) assessment, dated 03/19/25, revealed Resident #1 was assessed with intact cognition and was dependent on staff for the completion of ADLs. Resident #1 was incontinent of bowel and bladder, received scheduled pain medication, and was at risk for pressure ulcer development with no current skin breakdown. Review of the plan of care, dated 12/21/24, revealed Resident #1 had a self-care deficit. Interventions included provide a sponge bath when a full bath or shower could not be tolerated. Review of the Certified Nursing Assistant (CNA) task documentation from 03/02/25 through 04/02/25 revealed documentation on 03/31/24 that a shower or bath was performed and Resident #1 required substantial or maximal staff assistance. Further review revealed no evidence of any additional baths or showers were provided between 03/02/25 and 04/02/25. Interview on 04/02/25 at 9:19 A.M. CNA #276 confirmed showers were not always completed as scheduled due to the extensive level of care required by residents and lack of sufficient staff to assist with transfer to and from the common shower/bath. 2. Review of Resident #6's medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included COPD, dementia, chronic respiratory failure, morbid obesity, osteoarthritis, delusional disorder, auditory hallucinations, visual hallucinations, anxiety disorder, suicidal ideation, major depressive disorder, and unsteadiness on her feet. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 03/02/25, revealed Resident #6 was severely cognitively impaired. Resident #6 utilized a wheelchair for mobility and required maximal staff assistance with toilet use, bed mobility, transfers and parts of dressing. Resident #6 was dependent on staff for bathing. Review of the plan of care, dated 07/14/24, revealed Resident #6 had an ADLs self-care deficit related to dementia and COPD. Interventions included resident required staff to provide a bath as necessary. Review of a physician order dated 09/22/24 revealed Resident #6 was to receive a shower or bed bath every evening shift on every Wednesday and Sunday. Review of the CNA task documentation from 03/02/25 through 04/02/25 revealed no documented evidence a shower or bed bath was provided to Resident #6 on 03/05/25 or 03/09/25. Interview on 04/02/25 at 7:35 A.M. with the Administrator verified there was no evidence Resident #6 received a shower or bed bath as scheduled on 03/05/25 or 03/09/25. 3. Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, hypertension, irritable bowel syndrome, cerebral infarction, Type II diabetes mellitus, and protein calorie malnutrition. Review of the most recent MDS assessment, dated 02/25/25, revealed Resident #10 had intact cognition, had a range of motion deficit to one side upper and lower extremities, was dependent on staff for the completion of ADLs, utilized a wheelchair propelled by staff for mobility, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no current skin breakdown. Review of a physician order dated 12/16/24 revealed Resident #10 was to receive a shower or bed bath every day shift on every Monday and Thursday. Review of the plan of care, dated 01/02/25, revealed Resident #10 had an ADLs self-care deficit related to limited mobility and hypertension. Interventions included resident required staff to provide a bath as necessary. Review of the CNA task documentation from 03/02/25 to 04/02/25 revealed nine opportunities for showers. Resident #10 received six bed baths, with no shower or bed bath documented on 03/27/25. Interview on 03/31/25 at 10:00 A.M. with Resident #10 revealed she was scheduled for a shower today and did not receive one prior to being assisted from her bed to a wheelchair. Resident #10 stated she did not receive showers and frequently received bed baths due to lack of staff. Interview on 03/31/25 at 12:27 P.M. with CNA # 275 confirmed she was assigned to provide care for Resident #10. CNA #275 verified she did not provide Resident #10 with a shower today, as scheduled. Further interview with CNA #275 revealed three of the four residents she was assigned to provide showers to today required a mechanical lift and extensive staff assistance and confirmed the residents would not receive their showers as scheduled due to the extensive workload and lack of staff assistance or availability. 37451 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of Resident #9's medical record revealed an admitted [DATE]. Diagnoses included fracture of lower end right humerus subsequent encounter (02/21/25), cerebral infarction, Type II diabetes, dysphagia, osteoarthritis, seizures, bipolar disorder, and anxiety disorder. Review of the MDS assessment, dated 03/18/25, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately cognitively impaired. Resident #9 was dependent on staff for toilet use, transfers, and bathing. Resident #9 received a mechanically altered therapeutic diet and required moderate assistance with eating. Review of the care plan, revised 03/04/25, revealed Resident #9 had an ADL self-care performance deficit. Interventions included staff to provide a bath as necessary, Resident #9 preferred showers, and the resident required staff assistance for feeding at mealtime. Review of Resident #9's bathing documentation for the last three months revealed the resident was to be bathed (either shower or bed bath based on her preference) every Tuesday and Saturday. Review of Resident #9's bathing tracking documentation revealed the resident was not bathed as scheduled 16 times in the last three months. The Tuesdays and Saturdays where there was no documentation of care provided were 01/04/25, 01/07/25, 01/18/25, 01/21/25, 01/25/25, 02/01/25, 02/04/25, 02/08/25, 02/11/25, 02/22/25, 03/01/25, 03/08/25, 03/15/25, 03/22/25, 03/25/25, and 03/29/25. Interview on 03/31/25 at 12:08 P.M. with Resident #9's POA revealed she came into the facility on a daily basis to feed the resident lunch. Resident #9's POA reported the resident had some declines and now required assistance with eating. Resident #9's POA reported there were not enough staff in the building to provide the necessary care to the resident, adding there were not enough staff to feed her or bath her as she needed and wanted. Observation on 03/31/25 at 12:15 P.M. of Resident #9 revealed the resident was seated in bed. Her hair appeared oily and uncombed. Resident #9 was unable to hold a spoon to move her lunch meal to her mouth. Resident #9's POA assisted Resident #9 with eating and Resident #9 ate 75% of her lunch meal. Coinciding interview with Resident #9 verified she needed assistance with eating and was not getting the showers she wanted. Interview on 03/31/25 at 12:52 P.M. with CNA #219 revealed residents were to be bathed twice a week and verified showers were not provided as they should due to there not being enough staff to get them done. Interview on 03/31/25 at 5:09 P.M. with CNA #314 revealed she was the only aide on the square (area within the facility) to provide care for approximately 58 residents. CNA #314 reported she worked from 7:00 A.M. to 6:30 P.M. There was another aide, CNA #219, who left at 5:00 P.M. CNA #314 reported there were times when there were no aides on the square from 6:00 P.M. to 11:00 P.M. CNA #314 stated there were three nurses in the building, but they had their own tasks to complete and did not typically assist with resident care. CNA #314 verified Resident #9 was to be bathed on second shift but often times only peri-care was completed and showers were not done because there was not enough staff to do them. CNA #314 reported Resident #9 was able to make her needs known, but she had to be asked what she needed, adding she would not use her call light or ask for help on her own. CNA #314 reported Resident #9 injured her wrist and now struggled at times with feeding herself. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/31/25 at 5:48 P.M. revealed Resident #9 received her dinner tray. Resident #9 was served a mechanical soft textured diet and was set up with a fork in the ground meat and a straw in her chocolate milk carton. Resident #9 was not asked if she needed assistance. Interview on 03/31/25 at 5:52 P.M. with Resident #9 confirmed staff had not checked on her or offered assistance with eating. Resident #9 was unsure if she could feed herself. Observations on 03/31/25 at 6:01 P.M. and 6:10 P.M. revealed Resident #9 still had not eaten any of her dinner and no staff checked on her to see if she needed help. Further observation at 6:21 P.M. revealed the resident had not eaten any of her dinner and staff had not checked to see if she needed assistance. Interview on 03/31/25 at 6:26 P.M. with Registered Nurse (RN) #208 revealed Resident #9 used to feed herself but recently had been asking for staff to assist her. RN #208 reported she tried to help the aides with resident care but she had her own responsibilities she was required to do. RN #208 stated she would ask Resident #9 if she needed assistance with eating, but she needed to complete a dressing change for another resident first. Observation on 03/31/25 at 6:29 P.M. revealed CNA #314 was at the nurses' station completing documentation in the electronic record. Resident #9's dinner tray continued to be untouched and no staff checked on her to see if she needed assistance. Coinciding interview with CNA #314 revealed she helped those who were dependent on staff with eating but, since she was the only aide working on the square, she was not able to check on those who were not always dependent for eating as there was not enough time. CNA #314 verified Resident #9 had not been checked on or assisted with her dinner meal. Observation on 03/31/25 at 6:33 P.M. revealed CNA #314 covered Resident #9's untouched dinner plate and removed the tray from the room. Resident #9 was not asked if she wanted something else or if she needed assistance. Interview on 04/03/25 at 8:00 A.M. with the Director of Nursing (DON) verified Resident #9's showers were not completed as scheduled. The DON was unable to find any additional information for the 16 showers that were missed for Resident #9. Review of the facility's shower scheduled revealed all residents were scheduled to receive two showers a week. Review of the facility policy titled, Activities of Daily Living, revised March 2018, revealed 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. In addition, appropriate care and services would be provided for residents who were unable to carry out the activities of daily living in accordance with their plan of care including appropriate assistance with dining. This deficiency represents non-compliance investigated under Complaint Numbers OH00162035, OH00162668 and OH00163320.

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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** 15816 Based on observation, medical record review, and staff interview, the facility failed to ensure timely repositioning and offloading was provided to dependent residents to assist in the prevention of pressure ulcers. This affected three (#1, #4, #10) of three residents reviewed for pressure ulcers. The facility census was 68. Findings include: 1. Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, stage III chronic kidney disease, osteoarthritis, muscle weakness, chronic obstructive pulmonary disease (COPD), hypothyroidism, anemia, hypertension, and chronic embolism and thrombosis deep veins of lower extremity. Review of the most current Minimum Data Set (MDS) assessment, dated 03/19/25, revealed Resident #1 was assessed with intact cognition and was dependent on staff for the completion of activities of daily living (ADLs), including transfer and bed mobility. Resident #1 was incontinent of bowel and bladder, received scheduled pain medication, and was at risk for pressure ulcer development with no current skin breakdown. Review of the plan of care, dated 12/21/24, revealed Resident #1 was at risk for skin breakdown due to immobility. Interventions included to encourage turning side to side when in bed to decrease pressure on her back. Additionally, Resident #1 had an ADLs self-care deficit with interventions including to reposition and turn in bed. Review of the scale for predicting pressure sore risk, dated 03/18/25, revealed Resident #1 scored 16, indicating the resident was assessed to be at risk for pressure ulcer development. Review of the Certified Nursing Assistant (CNA) task documentation revealed turning and repositioning was to occur at least every two hours. Further review of the documentation from 03/02/25 to 04/02/25 revealed evidence Resident #1 was only turned and repositioned five times during that timeframe. Observation on 04/02/25 at 5:56 A.M. revealed Resident #1 was in bed, positioned on her back. CNA #301 and CNA #215 entered the room and provided Resident #1 with incontinence care and proceeded to reposition the resident; however, the resident remained on her back. Observation on 04/02/25 at 9:19 A.M. revealed Resident #1 remained in bed, positioned on her back. Concurrent interview with CNA #276 revealed she assumed care of Resident #1 at 7:00 A.M. CNA #276 verified she had made no attempts to reposition Resident #1 since the beginning of her shift (approximately two hours and 20 minutes prior and approximately three hours and 25 minutes since the resident was last known to receive care). CNA #276 further confirmed she was unaware of the last time Resident #1 was repositioned and stated she did not receive that information from the previous shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #4's medical record revealed an admitted [DATE]. Diagnoses included fracture of the left pubis initial encounter (10/26/24), fracture of sacrum initial encounter (10/26/25), adult failure to thrive, repeated falls, Type II diabetes, osteoarthritis, major depressive disorder, anxiety disorder and scoliosis. Review of the MDS assessment, dated 03/25/25, revealed Resident #4 was cognitively intact. Further review revealed Resident #4 was dependent on staff for toilet use, bathing, dressing, and transfers. Review of the plan of care, dated 11/01/24, revealed Resident #4 had an ADLs self-care deficit due to fatigue and limited mobility. Interventions included two staff to reposition and turn in bed. Review of the CNA task documentation revealed turning and repositioning was to occur at least every two hours. Further review of the documentation from 03/02/25 to 04/02/25 revealed only seven entries indicating Resident #4 was repositioned in bed. Interview on 04/02/25 at 5:50 A.M. with CNA #301 revealed she had checked Resident #4 and provided incontinence care with repositioning at 5:20 A.M. Observation on 04/02/25 at 5:54 A.M. revealed Resident #4 was positioned on her back in bed. Observation on 04/02/25 at 9:12 A.M. of Resident #4, with CNA #276, revealed the resident was positioned on her back in bed. Resident #4 was soiled, with a moderate amount of urine and a small formed bowel movement in her adult incontinence brief. Concurrent interview with CNA #276 verified this contact was the first care she provided to Resident #4 since assuming her care at 7:00 A.M. (approximately two hours and 15 minutes prior and approximately three hours and 50 minutes since the resident last received care). CNA #276 stated she was unaware of the last time Resident #4 was last repositioned or checked for incontinence. 3. Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, hypertension, irritable bowel syndrome, cerebral infarction, Type II diabetes mellitus, and protein calorie malnutrition. Review of the most current MDS assessment, dated 02/25/25, revealed Resident #10 had intact cognition, had a range of motion deficit to one side upper and lower extremities, was dependent on staff for the completion of ADLs, utilized a wheelchair propelled by staff for mobility, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no current skin breakdown. Review of the plan of care, dated 01/02/25, revealed Resident #10 had a self-care performance deficit due limited mobility. Interventions included staff to reposition and turn in bed. Review of a physician order dated 03/15/25 revealed Resident #10 was to be repositioned every two hours while awake every shift. Interview on 04/02/25 at 5:45 A.M. with CNA #272 revealed Resident #10 was last checked for incontinence and repositioned in bed, on her right side, at 5:15 A.M. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/02/25 at 5:50 A.M. revealed Resident #10 was in bed, positioned on her right side. Observation on 04/02/25 at 8:15 A.M. revealed Resident #10 remained in bed, positioned on the right side. Concurrent interview with Resident #10 revealed she had not been checked on or repositioned since the night shift. Interview on 04/02/25 at 8:27 A.M. with CNA #275 verified she had not provided care for Resident #10 since assuming responsibility for her care at 7:00 A.M. (approximately one and on-half hours prior). CNA #275 confirmed she was unaware the last time Resident #10 was checked on or repositioned. Observation on 04/02/25 at 9:09 A.M. revealed Resident #10 remained in bed, in the same position on the right side. Concurrent interview with Resident #10 revealed she was experiencing left buttock prickly pain. Resident #10 stated many times that turning and repositioning did not occur every two hours and during an eight hour day shift, she was frequently only repositioned once. Observation on 04/02/25 at 9:30 A.M. revealed CNA #275 providing care to Resident #10, who was heavily soiled with urine. Concurrent interview with CNA #275 verified this was the first care she provided Resident #10 since assuming her care at 7:00 A.M. (approximately two and one-half hours prior and approximately four hours and 15 minutes since the last known time the resident received care). This deficiency represents non-compliance investigated under Complaint Numbers OH00161775 and OH00163320.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview, and review of facility policy, the facility failed to ensure timely incontinence care was provided. This affected three (#1, #4, and #10) of three residents reviewed for incontinence care. Additionally, the facility failed to ensure sufficient catheter care or physician orders regarding the maintenance of an indwelling urinary catheter for Resident #1. This affected one (#1) of one resident reviewed for catheter care. The facility identified six residents with indwelling catheters. The facility census was 68. Findings include: 1. Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, stage III chronic kidney disease, osteoarthritis, muscle weakness, chronic obstructive pulmonary disease (COPD), hypothyroidism, anemia, hypertension, and chronic embolism and thrombosis deep veins of lower extremity. Review of the most current Minimum Data Set (MDS) assessment, dated 03/19/25, revealed Resident #1 was cognitively intact, was dependent on staff for the completion of activities of daily living (ADLs), was incontinent of bowel and bladder, received scheduled pain medication, and was at risk for pressure ulcer development with no current skin breakdown. Review of the plan of care, initiated 12/21/24, revealed Resident #1 had an ADLs self-care performance deficit related to impaired balance. Interventions included assistance with personal hygiene care. Review of a physician order dated 03/18/25 revealed an order was initiated indicating a Foley catheter (indwelling urinary catheter) may be inserted if no significant output every three hours. Further review of the medical record revealed no additional physician orders related to catheter care or maintenance, diagnosis for the use of a catheter and no evidence of routine catheter care. Observation on 04/02/25 at 5:56 A.M. revealed Resident #1 in bed, positioned on her back, with an indwelling urinary catheter in place. Certified Nursing Assistant (CNA) #301 and CNA #215 entered the room and observed Resident #1 to be incontinent of a moderate amount of liquid stool. CNA #301 obtained wash cloths and a towels, applied soap and water to the wash cloths, and proceeded to Resident #1's bedside. CNA #301 cleansed the resident's anterior perineum and removed black/brown stool with the wash cloth; however, no attempts to cleanse the indwelling catheter tubing occurred. Interview with CNA #301, following the observation, verified she did not sufficiently cleanse Resident #1's catheter tubing. Review of the facility policy titled, Catheter Care, revised 05/10/23, revealed catheter care would be performed every shift and as needed by nursing personnel. For female residents, gently separate labia to expose urinary meatus, wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap), and use a new part of the cloth or different cloth for each side. With a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. Dry area with towel. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional observation on 04/02/25 at 9:19 A.M. with CNA #276 revealed Resident #1 was incontinent of liquid stool and had red excoriation to the anterior peridium. Concurrent interview with CNA #276 revealed she assumed care for Resident #1 at the beginning of her shift at 7:00 A.M. and verified she had not provided the resident with care since the beginning of her shift (approximately two hours and 20 minutes prior). CNA #276 confirmed she was unaware of the last time Resident #1 was checked on and received care as she did not receive that information from the previous shift. 2. Review of Resident #4's medical record revealed an admitted [DATE]. Diagnoses included fracture of the left pubis initial encounter (10/26/24), fracture of sacrum initial encounter (10/26/25), adult failure to thrive, repeated falls, Type II diabetes, osteoarthritis, major depressive disorder, anxiety disorder and scoliosis. Review of the MDS assessment, dated 03/25/25, revealed Resident #4 was cognitively intact. Additionally, Resident #4 was dependent on staff for toilet use, bathing, dressing, and transfers. Review of the plan of care, dated 11/01/24, revealed Resident #4 had urinary/bowel incontinence due to impaired mobility and physical limitations. Interventions included check for incontinence, change as needed (PRN), apply disposable briefs, and establish voiding patterns. Interview on 04/02/25 at 5:50 A.M. with CNA #301 revealed she had checked Resident #4 and provided incontinence care with repositioning at 5:20 A.M. Observation on 04/02/25 at 9:12 A.M. of Resident #4, with CNA #276, revealed the resident was soiled with a moderate amount of urine and a small formed bowel movement contained in an adult incontinence brief. CNA #276 confirmed her shift began at 7:00 A.M., approximately two hours and 15 minutes prior, and this was the first care she had provided to Resident #4. Further interview with CNA #276 revealed she was unaware of when Resident #4 had been last checked for incontinence. 3. Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, hypertension, irritable bowel syndrome, cerebral infarction, Type II diabetes mellitus, and protein calorie malnutrition. Review of the MDS assessment, dated 02/25/25, revealed Resident #10 was cognitively intact. Resident #10 had a range of motion deficit to one side upper and lower extremities, was dependent on staff for the completion of ADLs, utilized a wheelchair propelled by staff for mobility, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no current skin breakdown. Review of the plan of care, dated 01/02/25, revealed Resident #10 was at risk for urinary and bowel incontinence due to impaired mobility. Interventions included check for incontinence and apply disposable briefs. Interview on 04/02/25 at 5:45 A.M. with CNA #272 revealed Resident #10 was last checked for incontinence and repositioned in bed at 5:15 A.M. Interview on 04/02/25 at 8:15 A.M. with Resident #10 revealed she was soiled and no staff had been in her room to check on her since the night shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/02/25 at 8:27 A.M. with CNA #275 verified she had not checked on Resident #10 since the beginning of her shift at 7:00 A.M. and further confirmed she was unaware of the last time Resident #10 was checked for incontinence. Observation on 04/02/25 at 9:30 A.M. of Resident #10, with CNA #275, revealed the resident was heavily soiled with urine. Concurrent interview with CNA #275 verified this was the first time she had checked Resident #10 since the beginning of her shift at 7:00 A.M., approximately two and one-half hours prior. Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, revealed appropriate care and services would be provided for residents who were unable to carry out ADLs independently, including hygiene and elimination (toileting). This deficiency represents non-compliance investigated under Complaint Numbers OH00161775, OH00162056, OH00162035, OH00162173, OH00162668, and OH00163320.

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	04/03/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37451 Based on observation, resident interview, Power of Attorney (POA) interview, staff interview, medical record review, review of the Payroll Based Journal (PBJ) Staffing Report and review of the facility's staffing schedule, the facility failed to ensure adequate staffing to meet resident needs. This affected four (#9, #1, #4 and #10) of 14 residents reviewed for staffing and had the potential to affect all residents in the facility. The facility census was 68. Findings include: 1. Review of Resident #9's medical record revealed an admitted [DATE]. Diagnoses included fracture of lower end right humerus subsequent encounter (02/21/25), cerebral infarction, Type II diabetes, dysphagia, osteoarthritis, seizures, bipolar disorder, and anxiety disorder. Review of Resident #9's Minimum Data Set (MDS) assessment, dated 03/18/25, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #9 was moderately cognitively impaired. Resident #9 was dependent on staff for toilet use, transfers, and bathing. Resident #9 received a mechanically altered therapeutic diet and required moderate assistance with eating. Review of the care plan, revised 03/04/25, revealed Resident #9 had a self-care deficit. Interventions included staff to provide bath as necessary, the resident preferred showers, and staff assistance for feeding at mealtime. Review of Resident #9's bathing documentation for the last three months revealed the resident was to be bathed (either shower or bed bath based on her preference) every Tuesday and Saturday. Review of Resident #9's bathing tracking revealed the resident was not bathed as scheduled 16 times in the last three months. The Tuesdays and Saturdays missed were 01/04/25, 01/07/25, 01/18/25, 01/21/25, 01/25/25, 02/01/25, 02/04/25, 02/08/25, 02/11/25, 02/22/25, 03/01/25, 03/08/25, 03/15/25, 03/22/25, 03/25/25, and 03/29/25. Interview on 03/31/25 at 12:08 P.M. with Resident #9's POA revealed she came into the facility on a daily basis over lunch to feeding Resident #9. The POA reported the resident had some declines and now required assistance with eating. Resident #9's POA reported there was not enough staff in the building to provide the necessary care to the resident, including bathing and feeding assistance as needed and wanted. Observation on 03/31/25 at 12:15 P.M. of Resident #9 revealed the resident was seated in bed. Her hair appeared oily and uncombed. Resident #9 was unable to hold a spoon to move her lunch meal to her mouth. Resident #9's POA assisted Resident #9 with eating and the resident ate 75% of her lunch meal. Coinciding interview with Resident #9 verified she currently needed assistance with eating and was not getting the showers she wanted. Interview on 03/31/25 at 12:52 P.M. with Certified Nursing Assistant (CNA) #219 verified residents were to be bathed twice a week and showers were not done as they should due to there not being enough staff to do them. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/31/25 at 5:07 P.M. revealed CNA #219 left for the day. Interview on 03/31/25 at 5:09 P.M. with CNA #314 verified she was the only aide on the square to provide care for approximately 58 residents. CNA #314 reported she worked from 7:00 A.M. to 6:30 P.M. and there was another aide, CNA #219, who left at 5:00 P.M. CNA #314 reported there were times when there were no aides on the square from 6:00 P.M. to 11:00 P.M. CNA #314 stated there were three nurses in the building currently but they had their own tasks to complete and did not typically assist with resident care. CNA #314 verified Resident #9 was to be bathed on second shift but often only received peri-care and showers were not provided because there were not enough staff to do them. CNA #314 reported Resident #9 was able to make her needs known, but she had to be asked what she needed because she would not use her call light or ask for help on her own. CNA #314 reported Resident #9 had injured her wrist and now struggled at times with feeding herself. Observation on 03/31/25 at 5:48 P.M. revealed Resident #9 received her dinner tray. Resident #9 received a mechanical soft textured diet and was set up with a fork in the ground meat and a straw in her chocolate milk carton. Resident #9 was not asked if she needed assistance. Interview on 03/31/25 at 5:52 P.M. with Resident #9 revealed no one checked on her to see if she needed help. Resident #9 stated she was not sure she could feed herself. Observation on 03/31/25 at 6:01 P.M. and 6:10 P.M. revealed Resident #9 still had not eaten any of her dinner and no staff checked on her to see if she needed help. Continued observation at 6:21 P.M. revealed Resident #9 still had not eaten any of her dinner and no staff checked on her to see if she needed help. Interview on 03/31/25 at 6:26 P.M. with Registered Nurse (RN) #208 verified Resident #9 used to be able to feed herself but recently had been asking for staff to assist her. RN #208 reported she would try and help the aides with resident care but had her own responsibilities she was required to do. RN #208 reported she would ask Resident #9 if she needed assistance with eating, but she needed to complete a dressing change for another resident first. Observation on 03/31/25 at 6:29 P.M. revealed CNA #314 at the nurses station completing documentation in the electronic record. Resident #9's dinner tray continued to be untouched and no staff checked on her to see if she needed assistance. Coinciding interview with CNA #314 revealed she had helped those who were dependent on staff with eating, but since she was the only aide working in the square she was not able to check on those who were not always dependent for eating as there was not enough time. CNA #314 verified Resident #9 had not been checked on or assisted. Observation on 03/31/25 at 6:33 P.M. revealed CNA #314 covered Resident #9's untouched dinner plate and removed the tray from the room. Resident #9 was not asked if she wanted something else or if she needed assistance. Observation on 03/31/25 at 6:35 P.M. revealed the Administrator, Director of Nursing (DON) and a corporate staff were still in the facility, but were seated in the front of the facility, away from resident care areas, in the Administrator's office and not providing assistance on the floor. 15816 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, stage III chronic kidney disease, osteoarthritis, muscle weakness, chronic obstructive pulmonary disease (COPD), hypothyroidism, anemia, hypertension, and chronic embolism and thrombosis deep veins of lower extremity. Review of the most current Minimum Data Set (MDS) assessment, dated 03/19/25, revealed Resident #1 was assessed with intact cognition and was dependent on staff for the completion of activities of daily living (ADLs). Resident #1 was incontinent of bowel and bladder, received scheduled pain medication, and was at risk for pressure ulcer development with no current skin breakdown. Review of the plan of care, dated 12/21/24, revealed Resident #1 had a self-care deficit. Interventions included provide a sponge bath when a full bath or shower could not be tolerated. Review of the CNA task documentation from 03/02/25 through 04/02/25 revealed documentation on 03/31/24 that a shower or bath was performed and Resident #1 required substantial or maximal staff assistance. Further review revealed no evidence of any additional baths or showers provided between 03/02/25 and 04/02/25. Interview on 04/02/25 at 9:19 A.M. CNA #276 confirmed showers were not always completed as scheduled due to the extensive level of care required by residents and lack of sufficient staff to assist with transfer to and from the common shower/bath. 3. Review of Resident #4's medical record revealed an admitted [DATE]. Diagnoses included fracture of the left pubis initial encounter (10/26/24), fracture of sacrum initial encounter (10/26/25), adult failure to thrive, repeated falls, Type II diabetes, osteoarthritis, major depressive disorder, anxiety disorder and scoliosis. Review of the MDS assessment, dated 03/25/25, revealed Resident #4 was cognitively intact. Further review revealed Resident #4 was dependent on staff for toilet use, bathing, dressing, and transfers. Review of the plan of care, dated 11/01/24, revealed Resident #4 had an ADLs self-care deficit due to fatigue and limited mobility. Interventions included two staff to reposition and turn in bed. Review of the CNA task documentation revealed turning and repositioning was to occur at least every two hours. Further review of the documentation from 03/02/25 to 04/02/25 revealed only seven entries indicating Resident #4 was repositioned in bed. Interview on 04/02/25 at 5:50 A.M. with CNA #301 revealed she had checked Resident #4 and provided incontinence care with repositioning at 5:20 A.M. Observation on 04/02/25 at 5:54 A.M. revealed Resident #4 was positioned on her back in bed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/02/25 at 9:12 A.M. of Resident #4, with CNA #276, revealed the resident was positioned on her back in bed. Resident #4 was soiled, with a moderate amount of urine and a small, formed bowel movement in her adult incontinence brief. Concurrent interview with CNA #276 verified this contact was the first care she provided to Resident #4 since assuming her care at 7:00 A.M. (approximately two hours and 15 minutes prior and approximately three hours and 50 minutes since the resident last received care) due to inadequate staffing. CNA #276 stated she was unaware of the last time Resident #4 was last repositioned or checked for incontinence. 4. Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, hypertension, irritable bowel syndrome, cerebral infarction, Type II diabetes mellitus, and protein calorie malnutrition. Review of the most recent MDS assessment, dated 02/25/25, revealed Resident #10 had intact cognition, range of motion deficit to one side upper and lower extremities, was dependent on staff for the completion of ADLs, utilized a wheelchair propelled by staff for mobility, was incontinent of bowel and bladder, and was at risk for pressure ulcer development with no current skin breakdown. Review of a physician order dated 12/16/24 revealed Resident #10 was to receive a shower or bed bath every day shift on every Monday and Thursday. Review of the plan of care, dated 01/02/25, revealed Resident #10 had an ADLs self-care deficit related to limited mobility, and hypertension. Interventions included resident required staff to provide a bath as necessary. Review of the CNA task documentation from 03/02/25 to 04/02/25 revealed nine opportunities for showers. Resident #10 received six bed baths, with no shower or bed bath documented on 03/27/25. Interview on 03/31/25 at 10:00 A.M. with Resident #10 revealed she was scheduled for a shower today and did not receive one prior to being placed from her bed to a wheelchair. Resident #10 stated she did not receive showers and frequently received bed baths due to lack of staff. Interview on 03/31/25 at 12:27 P.M. with CNA # 275 confirmed she was assigned to provide care for Resident #10. CNA #275 verified she did not provide Resident #10 with a shower today, as scheduled. Further interview with CNA #275 revealed three of the four residents she was assigned to provide showers to today required a mechanical lift and extensive staff assistance and confirmed the residents would not receive their showers as scheduled due to the extensive workload and lack of staff assistance or availability. Interview on 04/02/25 at 7:20 A.M. with the Administrator verified there were a number of holes in the staffing schedule and the facility did not meet the state minimum staffing requirement of 2.5 hours of direct resident care per resident per day. The Administrator reported they had interviews set up but the hiring process took time and they were trying to get staff to fill in for call offs or no shows but the process was not efficient and the management staff were often required to come in and cover shifts. The Administrator further verified, even with management in the building trying to assist, there were still not enough staff to meet the needs of the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the staffing schedules from 03/17/25 to 03/23/25 revealed the facility identified a total of nine licensed nurses and 22 CNAs were needed on each of the dates to cover all shifts. Further review revealed the following: on 03/17/25, there were only 7.1 licensed nurses schedule and 5.6 CNAs scheduled; on 03/18/25, there were only 6.8 licensed nurses scheduled and 9.8 CNAs scheduled; on 03/19/25, there were 10.7 licensed nurses (1.7 more than identified) but only 12.3 CNAs scheduled; on 03/20/25, there were 10.7 licensed nurses scheduled (1.7 more than identified) but only 10 CNAs scheduled; on 03/21/25, there were only 8.8 licensed nurses scheduled and 10.2 CNAs scheduled; on 03/22/25, there were nine nurses scheduled but only nine CNAs scheduled; and on 03/23/25, there were only 8.8 licensed nurses scheduled and 11.2 CNAs scheduled. On each of the dates, the facility had significantly lower staffing than the need identified on the staffing schedules. Review of the staffing schedules from 03/31/25 to 04/02/25 revealed the facility required 22 CNAs and nine licensed nurses on each of the days. Further review revealed the following: on 03/31/25, there were only seven licensed nurses scheduled and 14.6 CNAs; on 04/01/25, there were 9.1 licensed nurses scheduled but only 10.4 CNAs; and on 04/02/25, there were 11.7 (2.7 more than the identified need) licensed nurses scheduled but only 12.7 CNAs. On each of the dates, the facility had significantly lower staffing than the need identified on the staffing schedules. Review of the staffing tool from 03/17/25 to 03/23/25 revealed the facility failed to meet the state minimum staffing requirement of 2.5 hours per resident per day on 03/17/25 at 2.0 hours, 03/18/25 at 2.37 hours, 03/21/25 at 2.23 hours, 03/22/25 at 2.01 hours, and 03/23/25 at 2.08 hours. Review of the PBJ Staffing Report for fiscal year 2024, quarter four (07/01/25 through 09/30/25) revealed the facility triggered for excessively low weekend staffing and had a one star staffing rating (indicating low staffing and/or high staff turnover). This deficiency represents non-compliance investigated under Complaint Numbers OH00162056, OH00162035, OH00162173, OH00162566, OH00162668, OH00163320, and OH00164016.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, resident interview, medical record review and staff interview, the facility failed to ensure medications were available for administration per physician order. This affected one (#1) of seven residents reviewed for medication administration. The facility census was 68. Findings include: Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, stage III chronic kidney disease, osteoarthritis, muscle weakness, chronic obstructive pulmonary disease (COPD), hypothyroidism, anemia, hypertension, and chronic embolism and thrombosis deep veins of lower extremity. Review of the Minimum Data Set (MDS) assessment, dated 03/19/25, revealed Resident #1 was cognitively intact. Resident #1 was dependent on staff for the completion of activities of daily living (ADLs), was incontinent of bowel and bladder, received scheduled pain medication, and was at risk for pressure ulcer development with no current skin breakdown. Review of the plan of care, dated 12/21/24, revealed Resident #1 had chronic pain related to fibromyalgia. Interventions included encourage to ask for medication, encourage to tell staff what increased or alleviated pain, and monitor effectiveness of pain medication. Review of physician orders dated 03/18/25 revealed Resident #1 was ordered acetaminophen oral tablet, two tablets to equal 1000 milligrams (mg) every eight hours as needed (PRN) for pain or Roxicodone oral tablet 5 mg, one tablet by mouth every six hours as needed for pain. Review of the Medication Administration Record (MAR) for March 2025 revealed on 03/28/25 at 9:42 P.M., Resident #1 received Roxicodone for pain level of 5 on a scale from one to ten. Further review revealed no evidence Resident #1 was administered Roxicodone after 03/28/25. Observation on 04/03/25 at 5:54 A.M. revealed Resident #1 was awake and in bed. Concurrent interview with Resident #1 revealed she was experiencing level 8 to 9 pain and had received pain medication at approximately 5:00 A.M. Resident #1 stated she had been without her preferred pain medication, Roxicodone, for several days and was told it was unavailable. Resident #1 confirmed the facility had administered Tylenol (acetaminophen) for pain for a few days, but she would have preferred the Roxicodone as it was more effective. Interview on 04/03/25 at 5:57 A.M. with Licensed Practical Nurse (LPN) #211 confirmed Resident #1's Roxicodone had been unavailable for administration for several days. Concurrent observation of medications available for Resident #1 in the medication cart revealed a medication card containing Roxicodone 5 mg with an order/fill date of 04/02/25. LPN #211 confirmed Resident #1's Roxicodone had not been available for administration for several days and was not received until this morning from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/03/25 at 6:04 A.M. with Unit Manger Registered Nurse (UMRN) #318 verified Resident #1's Roxicodone was not reordered timely, resulting in the medication not being available for administration for approximately five days. This deficiency represents non-compliance investigated under Complaint Number OH00162668 and OH00164016.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on medical record review, staff interview and review of the pharmacy delivery manifest, the facility failed to ensure medications were obtained and administered as ordered by the prescribing physician, resulting in a significant medication error. This affected one (#7) of seven residents reviewed for medication administration. The facility census was 68. Findings include: Review of Resident #7's medical record revealed an admitted [DATE]. Diagnoses included anemia, cirrhosis, hepatic encephalopathy, chronic kidney disease, Type II diabetes mellitus, major depressive disorder, gastrointestinal hemorrhage, chronic viral hepatitis C, facial weakness, and vitamin d deficiency. Review of the Minimum Data Set (MDS) assessment, dated 01/23/25, revealed Resident #7 was cognitively intact, utilized a wheelchair for mobility, required partial to moderate staff assistance with activities of daily living (ADLs), was incontinent of bowel and bladder, had no fall history, no known weight loss, received a therapeutic diet, and was at risk for pressure ulcer development with no skin breakdown. Review of a physician order, dated 12/20/24, revealed Resident #7 was ordered Rifaximin (used to treat gastrointestinal and liver-related conditions) oral tablet 550 milligrams (mg) two times a day for hepatic (relating to the liver). Review of the Medication Administration Record (MAR) from 12/23/24 to 12/27/24 revealed Rifaximin was documented at unavailable for administration. Further review revealed the medication was not administered again until 01/01/25 at 8:00 P.M. Review of the nursing progress notes from 12/23/24 through 12/27/24 revealed Rifaximin was documented as unavailable for administration on 12/23/24, 12/24/24, and 12/25/24. Review of a social services progress note dated 12/27/24 revealed Resident #7's daughter learned the resident had not been receiving a medication (Rifaximin) that she was supposed to be getting and a Registered Nurse (RN) was working on resolving this. Further review of the medical record from 12/23/24 through 12/27/24 revealed no evidence the physician was notified Rifaximin was unavailable for administration to Resident #7. Review of the facility pharmacy manifest, dated 12/31/24, revealed Rifaximin 550 mg was delivered to the facility for Resident #7. Interview on 04/03/25 at 12:50 P.M. with the Director of Nursing (DON) verified Rifaximin was not available for administration to Resident #7 from 12/23/24 through 12/27/24, when the resident was transferred to the hospital. The DON stated the resident brought a partial bottle of the medication to the facility upon admission on 12/20/24; however, the medication ran out on 12/23/24 and was unavailable for administration until it was delivered on 12/31/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00161775 and OH00164016.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, resident interview, medical record review, and staff interview, the facility failed to ensure physician ordered meal textures were served to residents. This affected one (#5) of four residents reviewed for meal textures. The facility census was 68. Findings include: Review of Resident #5's medical record revealed an admitted [DATE]. Diagnoses included psychosis, chronic obstructive pulmonary diseases (COPD), major depressive disorder, generalized anxiety disorder, hallucinations, morbid obesity, and osteoporosis. Review of the Minimum Data Set (MDS) assessment, dated 03/02/25, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Resident #5 was dependent on staff for dressing and transfers, required set up assistance for eating and received a mechanically altered therapeutic diet. Review of the care plan, revised 03/04/25, revealed Resident #5 had a self-care deficit, had impaired cognitive function, was at risk for pain, and was at nutrition and hydration risk. Interventions for nutritional risk included monitor for signs and symptoms of dysphagia, provide and serve diet as ordered, and monitor intakes. Review of Resident #5's physician orders revealed an order dated 04/21/22 for a regular diet, mechanical soft texture, thin consistency, and no straws. Review of the Nutritional Assessment, dated 06/24/24, revealed Resident #5 was to receive a mechanical soft diet with no straws. Resident #5's meal intakes varied, and she frequently consumed snacks in her room. Observation on 03/31/25 at 12:41 P.M. revealed Resident #5 had been provided her lunch meal of a chicken patty on a bun with tomato and lettuce. Resident #5 was observed taking the bun apart and asked how she was expected to eat it. Resident #5's meal ticket was observed on the tray and indicated Resident #5 was to have a mechanical soft textured diet. Coinciding interview with Resident #5 verified she was to have ground meat. Resident #5 stated her food texture was not baby food, but also was not whole like she had been served. Interview on 03/31/25 at 12:43 P.M. with Licensed Practical Nurse (LPN) #305 verified Resident #5 was provided the wrong textured diet and did not receive ground meat as she required. This deficiency represent non-compliance investigated under Complaint Number OH00162035.

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	04/03/2025

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 37451 Based on review of the Payroll-Based Journal (PBJ) Staffing Data Report, staff interview and review of the facility policy, the facility failed to submit required staffing information. This had the potential to affect all 68 residents who resided in the facility. The facility census was 68. Findings include: Review of the PBJ Staffing Data Report for Quarter Four of 2024 (July 1 - September 30) revealed the facility triggered for failure to submit data for the quarter. Interview on 04/03/25 at 11:48 A.M. with the Administrator verified the PBJ data was not submitted for Quarter Four of 2024 (July 1- September 30). The Administrator reported Human Resources (HR) was responsible for submitting the data and it was not done. The Administrator stated she did not know why the data was not submitted as required. The Administrator provided a copy of the updated policy and reported she submitted the data for the quarter including the months of October, November, and December 2024. Review of the facility policy titled, PBJ Protocol, revised 11/19/24, revealed staffing data was to be collected, and the facility would ensure data submission was completed monthly before the 15th of each month.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15816 Based on observation, medical record review, staff interview and review of facility policy, the facility failed to ensure staff applied personal protective equipment (PPE) when providing high contact care to residents on enhanced barrier precautions (EBP). This affected one (#1) of one resident reviewed for EBP. The facility census was 68. Findings include: Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included congestive heart failure, stage III chronic kidney disease, osteoarthritis, muscle weakness, chronic obstructive pulmonary disease (COPD), hypothyroidism, anemia, hypertension, and chronic embolism and thrombosis deep veins of lower extremity. Review of the Minimum Data Set (MDS) assessment, dated 03/19/25, revealed Resident #1 was cognitively intact, was dependent on staff for the completion of activities of daily living (ADLs), was incontinent of bowel and bladder, received scheduled pain medication, and was at risk for pressure ulcer development with no current skin breakdown. Review of a physician order dated 03/18/25 revealed a Foley catheter (indwelling urinary catheter) may be inserted if no significant output every three hours. Further review revealed no further physician orders related to catheter care, maintenance, or instructions regarding EBP. Observation on 04/02/25 at 5:56 A.M. revealed Resident #1 was in bed, positioned on her back, with an indwelling urinary catheter in place. Further observation revealed at the room entry there was an isolation cart containing disposable gloves and gowns. No signage was observed indicating PPE was needed when providing care for Resident #1. Continued observation revealed Certified Nursing Assistant (CNA) #301 and CNA #215 entered Resident #1's room and applied disposable gloves. However, no gown or additional PPE were applied. Resident #1 was found to be incontinent of a moderate amount of liquid stool. CNA #301 obtained wash cloths and a towels, applied soap and water to the wash cloths, and proceeded to Resident #1's bedside. CNA #301 cleansed the resident's anterior perineum and removed black/brown stool with the wash cloth. CNA #301 and CNA #215 left the room and disposed of the soiled items. Concurrent interview with CNA #301 and CNA #215 revealed they were unaware Resident #1 was on EBP due to having an indwelling urinary catheter and verified they did not don a gown prior to providing high contact care for the resident. CNA #301 and CNA #215 further confirmed there was no signage posted at the room entry to instruct them on applying PPE. Observation on 04/02/25 at 6:20 A.M., with Unit Manager Registered Nurse (UMRN) #318 verified Resident #1 had an indwelling catheter in place and no signage was posted to instruct staff to apply PPE for EBP. Additional observation on 04/02/25 at 9:19 A.M. revealed CNA #276 applied disposable gloves and entered Resident #1's room. CNA #276 proceeded to provide incontinence and catheter care for the resident. Following care, CNA #276 exited the room and discarded the soiled items. Concurrent interview with CNA #276 verified Resident #1 was on EBP due to having an indwelling catheter and further confirmed she did not wear a gown while providing high contact care for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Enhanced Barrier Precautions, revised 2/13/25, revealed EBP were implemented for the prevention of transmission of multi-drug-resistant organisms. Clear signage would be posted on the door or wall outside of the resident's room indicating the type of precautions, required PPE, and the high-contact resident care activities that required the use of gown and gloves. An order for EBP would be obtained for residents with wounds or indwelling medical devices even if the resident was not known to be infected. Indwelling medical devices included urinary catheters. Make gowns and gloves available immediately outside of the resident's room. High contact resident care activities included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheters).