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	11/13/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, resident interviews, staff interviews, and review of facility policy, the facility failed to ensure foul odors were maintained on A, B and C halls. This had the potential to affect all 54 residents on halls A, B, and C. The facility census was 70. Observation on 10/06/25 between 11:45 A.M. and 12:30 P.M. on A, B, and C halls revealed an intermittent foul urine odor throughout each hallway not associated with a resident, resident rooms, or soiled utility room.Observation on 10/07/25 at 11:15 A.M. on A hall revealed an intermittent foul urine odor throughout the hallway and into the adjacent dining room. The odor was not associated with a resident, adjacent resident rooms or soiled utility rooms.Observation on 10/08/25 at 9:10 A. M. at B hall nurse station revealed a foul urine odor in the hallway not associated with a resident, adjacent resident rooms or soiled utility rooms. Observation on 10/14/25 at 2:25 P.M. on A hall revealed an intermittent foul urine odor throughout the hallway and into the adjacent dining room. The odor was not associated with a resident, adjacent resident rooms or soiled utility rooms.Interview on 10/07/25 at 11:15 A. M. with Licensed Practical Nurse #559 confirmed A hall had a foul urine odor throughout the hallway and into the adjacent dining room. Continued interview revealed the urine odor was common on most days. Interview on 10/14/25 at 2:26 P.M. with Activities Assistant #550 confirmed there was a foul urine odor in the dining room adjacent to A hall, and the odor was common on most days.Interview on 10/14/25 at 2:40 P.M. with Resident #97's representative revealed the facility often had a bothersome foul urine odor throughout the hallways.Interview on 10/14/25 at 4:15 P.M. with Resident #37 revealed the facility often had a bothersome foul urine odor throughout the hallways.Review of facility policy dated 10/06/25 and titled Safe and Homelike Environment revealed the facility would provide a clean and homelike environment with general consideration to be given to minimize odors by reporting lingering odors and bathrooms needing cleaning to Housekeeping Department. Review of facility policy dated 10/07/25 and titled Routine Cleaning and Disinfection revealed the facility would ensure routine disinfection to provide a sanitary environment.This violation represents non-compliance investigated under Master Complaint Number 2630848 and Complaint Numbers 1305372, 2582511, and 2625891.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on review of facility documents, staff interviews, and review of facility policy the facility failed to ensure resident concerns and grievances were addressed timely. This had the potential to affect all residents. The facility census was 70. Review of the grievance logs and reports for April 2025 through September 2025 revealed 30 of 75 grievances filed had not been followed up on. Review of the Resident Council meeting minutes for June 2025 revealed resident concerns related to untimely medication administration and undercooked food. The concerns were not addressed or followed up on.Review of the Resident Council meeting minutes for July 2025 revealed resident concerns related to staffing, staff approach, and showers were not addressed or followed up on.Review of the Resident Council meeting minutes for August 2025 revealed a report Licensed Practical Nurse (LPN) #522 had been counseled for being untimely with medication administration.Review of the Resident Council meeting minutes for October 2025 revealed resident concerns related to staffing, medication times, and care preferences were not addressed or followed up on. Review of LPN #522 personnel file revealed no documentation to support LPN #522 being counseled for untimely medication administration. Interview on 10/08/25 at 4:45 P.M. with the Director of Nursing confirmed LPN #522 had not been counseled for untimely medication administration as indicated in the Resident Council meeting minutes from August 2025. Interview on 10/09/25 at 8:50 A.M. with the Administrator confirmed 30 grievances between April 2025 and September 2025 had not been followed up on. Continued interview confirmed the above noted resident concerns raised during Resident Council meetings in June, July, August and October 2025 had not been addressed or followed up on. Review of facility policy dated 03/05/25 titled Resident and Family Grievances revealed the Administrator was the designated Grievance Official, would be responsible for oversight of the grievance process through its conclusion, and would issue written grievance decisions.Review of facility policy dated 05/22/25 titled Resident Council Meetings revealed the facility would act upon concerns of the Council, attempt to accommodate recommendations, and communicate decisions to the Council.This violation represents non-compliance investigated under Master Complaint Number 2630848 and Complaint Numbers 1305376 and 2617497.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, staff interview, review of the facility Self-Reported Incident (SRI), and review of the facility policy the facility failed to timely report an allegation of abuse. This affected one (#105) of one resident reviewed for timely reporting. The facility census was 70. Review of the medical record revealed Resident #105 had an admission date of 08/21/24 with a diagnosis of dementia. Resident #105 was discharged on 06/23/25. Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/04/25, revealed Resident #105 was cognitively impaired. Interview on 10/16/25 at 11:10 A.M. with the Administrator stated on 05/19/25 the Former DON #610 met with Resident #105's daughter and the incident of alleged abuse was reported to Former DON #610. The Administrator further stated she was notified on 05/22/25 of the incident by Former DON #610 and she immediately suspended the alleged perpetrator Former Licensed Practical Nurse (LPN) #601 pending an investigation. Former DON #610 was also suspended pending the investigation for not timely reporting. Further interview with the Administrator stated the Former DON #610 had access into the SRI system to initiate a report of alleged abuse and to start the investigation. The Administrator verified that the alleged abuse incident was not reported timely. Review of SRI 260722 incident summary revealed an alleged abuse incident was reported to the former Director of Nursing (DON) #610 by Resident #105's family on 05/19/25. The incident details were not reported to the Administrator until 05/22/25, at which time the SRI was reported and the investigation was started. Review of the facility policy titled Abuse, Neglect, and Exploitation revised 07/22 revealed the facility will report all alleged violation to the Administrator, stated agency, and adult protective services within specified time frames according to the following: immediately, but not later than two hours after the allegation is made, if the event that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. This violation represents non-compliance investigated under Complaint Number 2572811.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility self-reported incidents (SRI), staff interviews, and review of the facility policy the facility failed to complete thorough investigations for five of five SRIs reviewed. This affected six (#39, #46, #54, #85, #105, and #108) residents reviewed for facility self-reported incidents. The facility census was 70. Review of the five facility reported self-reported incidents (SRI)'s: 259637 dated 04/23/25, 259639 dated 04/23/25, 259788 dated 04/28/25, 260722 dated 05/22/25, and 262712 dated 07/12/25 revealed thorough investigations were not completed to include any or all of the following: staff interviews and/or statements, resident statements, assessments of like residents, and/or staff education. 1. Review of the medical record for Resident #39 revealed an admission date of 09/20/24 with diagnoses of chronic obstructive pulmonary disease (COPD), diabetes mellitus, and congestive heart failure (CHF). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 was cognitively intact. 2. Review of the medical record revealed Resident #46 had an admission date of 12/26/24 with diagnoses of COPD, cerebral vascular accident (CVA) (stroke), high blood pressure, and systemic lupus. Review of the quarterly MDS assessment, dated 08/18/25 for Resident #46 revealed he was cognitively intact. 3. Review of the medical record for Resident #54 revealed an admission date of 01/20/23 with diagnoses of diabetes mellitus, dementia, and heart failure. Review of the annual MDS dated [DATE] for Resident #54 revealed had cognitive impairment. 4. Review of the medical record for Resident #85 revealed an admission date of 01/30/25 with diagnoses of congestive heart failure (CHF), peripheral vascular disease (PVD) and diabetes mellitus. Review of the quarterly MDS assessment dated [DATE] revealed Resident #85 had impaired cognition. 5. Review of the medical record revealed Resident #105 an admission date of 08/21/24 with diagnosis of dementia. Resident #105 was discharged on 06/23/25. Review of the quarterly MDS assessment, dated 06/04/25, revealed Resident #105 had impaired cognition. 6. Review of the medical record for Resident #108 revealed had an admission date of 07/08/25 with diagnoses of vascular dementia and disorientation. Resident #108 was discharged on 07/30/25. Review of the discharge MDS assessment, dated 07/30/25, revealed the resident was moderately cognitive impaired. Interview on 10/16/25 at 11:10 A. M. with the Administrator verified staff interviews or statements were not obtained for all of the investigations. Additionally, the Administrator verified resident interviews were not conducted, assessments of like residents were not conducted, and staff educated were not completed. Review of the facility policy titled Abuse, Neglect, and Exploitation revised 07/22 revealed the facility will complete an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. Procedures for the investigation included identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, providing complete and thorough documentation of the investigation. This violation represents non-compliance investigated under Complaint Number 2572811.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and review of the facility policy, the facility failed to notify the appropriate state agency (The Ohio Department of Mental Health) of a significant change in a resident's mental health condition as required. This affected one Resident (#77) of one resident reviewed for pre admission screening and resident review (PASRR) assessment. The facility census was 70. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, protein-calorie malnutrition, anxiety, sarcopenia, and epilepsy. Review of the significant change minimum data set (MDS) assessment dated [DATE] revealed Resident #77 had intact cognition. Resident #77 had moderately impaired vision and required supervision for mobility and received antipsychotic, antidepressant, and anticonvulsant medications. Review of medical record for Resident #77 revealed a new diagnosis of disorganized schizophrenia in March 2025. In April 2025, a diagnosis of schizophrenia was added. Neither diagnosis was accompanied by and updated PASRR, and the medical record contained no evidence that the appropriate state agency (The Ohio Department of Mental Health) was notified of the new diagnoses for PASRR review as required. Interview on 10/09/25 at 1:14 P.M. with the Director of Nursing (DON) verified there was no updated PASRR completed in March or April 2025 and therefore the required state agency was not notified. The DON further verified a PASRR should have been completed with the new diagnoses of schizophrenia and the increase in behaviors exhibited by Resident #77. Review of Policy titled Resident Assessment-Coordination with PASRR Program, reviewed 10/09/25, revealed any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: -A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). -A resident whose intellectual disability or related condition was not previously identified and evaluated through PASRR. -A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.

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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 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 observation, medical record review, resident interview, staff interview, and review of facility policy, the facility failed to ensure wound care orders were accurate and completed as ordered. This affected one (#60) of three residents reviewed for wound care. The facility census was 70. Review of the medical record for Resident #60 revealed an admission date of 07/01/25, diagnoses included disruption of wound healing, infection following procedure, dehiscence of amputated stump, gangrene, acidosis, and peripheral vascular disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #60 was cognitively intact, did not refuse care, and required assistance with activities of daily living. Review of physician orders for Resident #60 revealed right leg above the knee amputation (RAKA) wound care order dated 09/09/25 for betadine to be applied to the surgical incision and wrapped with fluff gauze once daily. Review of Resident #60's after visit summary with the vascular surgeon dated 10/06/25, obtained by staff on 10/15/25, revealed wound care orders to the RAKA site were to paint the surgical site with Betadine twice daily. Review of the treatment administration record for Resident #60 revealed LPN #507 documented the dressing change to Resident #60's RAKA site on 10/12/25. Continued review revealed Registered Nurse (RN) #560 documented the dressing change to Resident #60's RAKA site on 10/13/25. Interview on 10/14/25 at 8:40 A.M. with Resident #60 revealed wound care was not completed to her RAKA site on 10/13/25. Continued interview revealed the wound care orders for Resident #60's RAKA had been changed to twice daily on 10/06/25 when she saw the vascular surgeon, however the facility was only completing wound care once daily. Observation on 10/14/25 at 10:50 A.M. of the dressing change to Resident #60's RAKA site revealed the existing dressing was dated 10/12/25 and signed by Licensed Practical Nurse (LPN) #507. Concurrent interview with LPN #545 confirmed this observation. Interview on 10/14/25 at 2:10 P.M. with the Administrator confirmed the documentation of wound care on 10/13/25 completed by RN #560 was not accurate as the dressing had not been changed on 10/13/25. Continued interview with the Administrator confirmed the current wound care orders for Resident #60's RAKA site was incorrect and should have been updated on 10/06/25 to reflect the new order written by the vascular surgeon. Interview on 10/14/25 at 2:20 P. M. with LPN #545 confirmed the current wound care orders for Resident #60's RAKA site was incorrect and did not reflect the most current order written on 10/06/25. LPN #545 stated the wound care order should have been updated on 10/06/25. Interview on 10/15/25 at 11:50 A.M. with Resident #60's Vascular Surgeon Nurse #606 revealed the RAKA site wound care orders were changed on 10/06/25 and facility staff were notified via phone. Review of facility policy dated 05/22/25 titled Wound Treatment Management revealed the facility would provide wound treatments in accordance with physician orders. This violation represents non-compliance investigated under Master Complaint Number 2630848 and Complaint Number 2617497.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, hospital record review, and review of facility policy, the facility failed to ensure hazardous chemicals were properly stored in a secured area and outside the reach of residents. This resulted in Immediate Jeopardy and serious physical harm, injuries, and/or negative health outcomes on 09/02/25 when Resident #77 applied a mixture of cleaning chemicals to the top of both feet resulting in second degree chemical burns, followed by a repeat incident 30 days later on 10/01/25 when Resident #77 applied an assortment of chemicals to his peri-area and a verbal order was obtained on 10/02/25 to send Resident #77 out to the hospital for evaluation due to altered mental status. On 10/02/25 at 1:18 P.M., Resident #77 was admitted to the Intensive Care Unit (ICU) at 8:03 P.M. with a concern for sepsis (a body's extreme reaction to an infection). Resident #77 had a body temperature of 93.3, and a white creamy discharge from the gastrostomy tube site. Intravenous fluids were administered and medications to support blood pressure were started as the sepsis work up continued. This affected one (#77) of three residents reviewed for accident hazards. The facility census was 70. On 10/08/25 at 4:42 P.M., the Administrator, interim Director of Nursing (DON), Director of Reimbursement (#616), and Corporate Director of Clinical (#617) were notified the Immediate Jeopardy began on 09/02/25 at 4:30 P.M. when Resident #77 was sent out to the hospital, transferred to a burn unit, admitted , and treated for partial thickness (second degree) chemical burns to both feet after Certified Nursing Assistant (CNA) #521 responded to Resident #77's call light, removed Resident #77's wet socks when the resident complained of his feet hurting and found the top of Resident #77's feet bright red, inflamed, and blistered. CNA #521 and Licensed Practical Nurse (LPN) #578 searched Resident #77's room and found a spray bottle labeled Odor Control in Resident #77's bathroom. The warning label on the bottle stated if on skin, wash with plenty of water, if skin irritation or rash occurs get medical attention immediately, and keep out of reach of children. Resident #77 returned to the facility on [DATE]. The Immediate Jeopardy continued on 10/01/25 when CNA #521 found Resident #77 walking out of his bathroom with what smelled like hand sanitizer in the palm of one hand while holding a wet blue liquid-soaked brief to his genitals with the other hand. CNA #521 alerted LPN #506. LPN #506 assessed Resident #77 and found the resident to have bright red skin to his entire peri area. Resident #77 voiced complaints of a sore penis. Upon searching the resident's room, LPN #506 found blue colored mouthwash, hand sanitizer, and liquid hand soap. The Immediate Jeopardy was removed on 10/09/25 at 4:07 P.M., the deficiency remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was continuing to implement corrective action and ensure ongoing compliance. On 10/08/25, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held. On 10/08/25, the facility was searched by Staff Development Coordinator (SDC) #555, Director of Facilities #552, and the Administrator for unsecured hazardous chemicals. Unsecured hazardous chemicals found were collected and secured and included the following: multiple packages of germicidal wipes and skin creams were collected from various common areas, nurse's station counter tops, and resident rooms. Spray bottles of bleach solution and odor control were removed from public bathrooms. Odor control and multi surface peroxide were removed from each of the four nurses' stations, several resident rooms and from the counter tops in the activity room and common sitting areas. Spray bottles of odor control, multi surface peroxide, floor cleaner, and bleach solution located on the top of the three housekeeping carts were relocated into a locking compartment on each of the housekeeping carts. On 10/08/25, SDC #555 conducted a facility wide audit to ensure all hazardous chemicals were properly stored, supply room doors and cabinets were locked, housekeeping carts were locked, and all hazardous chemicals were secured within the housekeeping cart if not in use. On 10/08/25, the DON/designee completed skin assessments on all residents. On 10/08/25, Director of Facilities #552/designee completed door audits to ensure all hazardous material storage rooms had properly functioning doors and that the doors locked securely. On 10/08/25, the DON/designee started education with all staff on policies related to chemical storage, how to handle chemicals and hazardous materials, what to do if hazardous materials get on you or the resident's skin, safe storage locations for harmful chemicals, ensuring storage locations are secured, and what to do if a hazardous storage location is not secured. On 10/09/25, any staff not yet educated will be educated by the DON/designee at the start of their first scheduled shift. On 10/09/25, new hires will be educated by the DON/designee or SDC #555 during new hire orientation on chemical storage, how to handle

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **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 a resident was seen by a provider during the duration of the admission from 05/07/25 through discharge on [DATE]. This affected one resident (#104) reviewed for physician services. The facility census was 70. Review of the medical record for Former Resident #104 revealed an admission date of 05/07/25 and a discharge date of 08/21/25. Review of the five-day Minimum Data Set (MDS) assessment dated [DATE] for Resident #104 revealed she was cognitively intact. Review of the medical record for Resident #104 for physician notes revealed there were no physician progress notes for the resident from admission to discharge. Review of the Facility assessment dated stated residents should expect a standard of care from medical practitioners and other healthcare professionals necessary to provide the level and types of support and care needed. This deficiency represents non-compliance investigated under Complaint Number 2572811.

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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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on review of medical records, staff interviews, resident interviews, and review of facility documents, the facility failed to ensure sufficient staffing to provide timely and adequate care to residents. The affected three (#37, #86, and #97) of three residents reviewed for activities of daily living with the potential to affect all residents. The facility census was 70. Review of the medical record for Specified Resident #37 revealed an admission date of 10/02/24, diagnoses included obstructive hypertrophic cardiomyopathy, left bundle branch block, cervical disc degeneration, solitary pulmonary nodule, depression, anxiety, and borderline personality disorder. Review of the Minimum Data Set (MDS) assessment revealed the resident did not refuse care, was occasionally incontinent, required set-up assistance with toileting and personal hygiene, and required supervision assistance with bathing. Review of task sheets for Residents #37 for the month of April 2025 revealed the absence of documentation to support daily living cares had been provided during the hours of 3:00 P.M. and 7:00 P.M. on 04/08/25. Continued review of April 2025 task sheets for personal hygiene revealed care was only documented as provided on 04/03/25 at 3:34 A.M. and 04/26/25 at 10:15 A.M. Review of the medical record for Resident #86 revealed an admission date of 06/22/23, diagnoses included myasthenia gravis, pneumonitis due to aspiration, schizophrenia, dysphagia, Parkinson's disease, and metabolic encephalopathy. Review of the MDS assessment revealed the resident did not refuse care, was incontinent of bowel and bladder, was dependent for toileting hygiene, and required maximal assistance for bathing and dressing. Review of task sheets for Residents #86 for the month of April 2025 revealed the absence of documentation to support daily living cares had been provided during the hours of 3:00 P.M. and 7:00 P.M. on 04/08/25. Continued review of April 2025 task sheets for personal hygiene revealed care documented as provided on 04/01/25 at 5:31 A.M. and 12:24 P.M., on 04/02/25 at 6:59 A.M., 04/03/25 at 11:47 A.M., 04/05/25 at 6:54 A.M., 04/06/25 at 6:36 A.M., 04/08/25 at 6:28 A.M., 04/11/25 at 1:59 A.M., 04/12/25 at 3:49 A.M., 04/14/25 at 3:36 A.M., 04/15/25 at 3:16 A.M., 04/1725 at 7:0 P.M., 04/21/25 at 12:48 P.M., 04/24/25 at 4:56 A.M., and 04/29/25 at 2:59 P.M. and 4:43 P.M. Review of the medical record for Resident #97 revealed an admission date of 10/25/24, diagnoses included fracture of sacrum, adult failure to thrive, repeat falls, depression, and anxiety. Review of the MDS assessment revealed the resident did not refuse care, was incontinent of bowel and bladder, and was dependent for activities of daily living including toileting, showering, and dressing. Review of task sheets for Residents #97 for the month of April 2025 revealed the absence of documentation to support daily living cares had been provided during the hours of 3:00 P.M. and 7:00 P.M. on 04/08/25. Continued review of April 2025 task sheets for personal hygiene revealed care was only documented as provided on 04/03/25 at 2:43 A.M. and 04/26/25 at 10:16 A.M. Interview on 10/06/25 at 11:48 A.M. with Resident #38 revealed staffing was always a problem, it took a long time to get the call light answered, especially on weekends. Interview on 10/07/25 at 8:35 A.M. with Licensed Practical Nurse (LPN) #522 revealed they had, at times, worked without nursing assistants and would prioritize care needs if there were no aides. Interview on 10/07/25 at 11:20 A.M. with Certified Nursing Assistant (CNA) #570 revealed staffing could be better and it was sometimes difficult to adequately fulfill resident needs. Interview on 10/08/25 at 9:10 A.M. with Registered Nurse #573 revealed there were not enough staff to meet resident needs, but they worked together and did the best they could. Interview on 10/09/25 at 4:15 P.M. with the Human Resources Director confirmed no CNAs were on duty in the facility on 04/08/25 between the hours of 3:00 P.M. and 7:00 P.M. Interview on 10/09/25 at 4:30 P.M. with the Administrator confirmed no CNAs were on duty in the facility on 04/08/25 between the hours of 3:00 P.M. and 7:00 P.M. Interview on 10/14/25 at 8:40 A.M. with Resident #60 revealed weekend staffing was low, and they would sometime have to urinate in their brief while waiting for help. Interview on 10/14/25 at 2:40 P.M. with Resident #37's representative revealed there were not enough staff to provide needed care for Resident #37, as the call light was not answered timely on most occasions. The representative stated Resident #37 often had a soaked brief that would need to be changed when visiting, and medications were often administered late. Additionally, Resident #37's representative stated there were no certified nurse assistants on duty the evening of 04/08/25. Interview on 10/15/25 at 9:37 A.M. with LPN #506 revealed some days staffing was an issue, and resident care suffered during those days, but they did the best they could. Interview on 10/15/25 at 9:45 A.M. with the Administrator confirmed the absence of documentation to support any daily living cares had been provided for Residents #37, #86, and #97 on 04/08/25 between the hours of 3:00 P.M. and 7:00 P.M., and on multiple days and shifts during the month of April. Continued interview

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	11/13/2025

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility policy, the facility failed to timely address psychosocial needs and failed to implement individualized interventions in a timely manner to maintain the highest level of mental and psychosocial functioning and well-being. The resident had a history of paranoia, hoarding behaviors, and the resident was identified to have a history of acquiring items from the facility including hazardous chemicals. This affected one (#77) of one resident reviewed for mood/behavior/emotional status. The census was 70.Review of the medical record for Resident #77 revealed an admission date of 08/08/22. Diagnoses included unspecified protein-calorie malnutrition, anxiety, sarcopenia, paranoia, and epilepsy. A diagnosis of schizophrenia with disorganized thoughts was added in April 2025. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition, but was noted to have poor decision-making skills. Resident #77 required supervision for mobility, set up assistance for eating, and partial to moderate assistance for showering or bathing. Resident #77 had moderately impaired vision and required supervision for mobility and received antipsychotic, antidepressant, and anticonvulsant medications. Review of the care initiated on 12/08/23 and revised on 02/25/2025 revealed Resident #77 had behaviors of potentially causing harm to self or others. The goal for Resident #77 was for the resident to remain safe. Interventions included if the resident posed a potential threat to injure self or others for the provider to be notified, if wandering or pacing, initiate visual supervision. Resident #77's care plan updated 07/27/25 revealed the resident was unable to care for himself independently and required 24-hour supervision, used psychoactive medications with the potential for complications, refused care from staff, and a new behavior of potentially causing harm to self or others. Review of the progress note written by LPN #578 revealed Resident #77 was sent out to the hospital on [DATE] at 4:30 P.M. for evaluation after CNA #521 responded to Resident #77's call light, upon entering the resident's room, Resident #77 complained his feet were hurting. CNA #521 looked down at the residents' feet and noticed Resident #77's socks were soaking wet. Upon removing the socks, CNA #521 noted the of both feet were bright red, inflamed, and blistered looking. Review of the emergency department medical record dated 09/02/25, revealed after evaluating Resident #77, the resident was transferred to a burn center. Review of the burn center medical record revealed Resident #77 arrived at the center on 09/03/25 at 12:55 A.M., was diagnosed with partial thickness (second degree) burns to both feet and was admitted to the burn unit. Interview on 10/06/25 at 2:16 P.M. with LPN #578 revealed that on 09/02/25 at approximately 1:00 P.M. CNA #521 summoned her to Resident #77's room because CNA #521 had discovered Resident #77's feet were bright red and blistered. After assessing Resident #77 and notifying the provider, Resident #77 was sent out to the hospital for evaluation. LPN #578 stated she and CNA #521 inspected Resident #77's room and found what appeared to be a spray bottle labeled Odor Control. LPN #578 stated however, the spray bottle appeared to have two different chemicals mixed in it as the chemicals appeared to have separated and a blue colored chemical was clumped in the bottom of the spray bottle. LPN #578 also stated that on the prior day, 09/01/25, other cleaning chemicals were found in Resident #77's room and were removed Interview on 10/06/25 at 3:36 p.m. With LPN #506 revealed Resident #77 had a history of acquiring medical and cleaning supplies spanning back several months. Interview on 10/07/25 at 8:45 A.M. with LPN #522 verbalized knowledge of Resident #77 getting hold of cleaning chemicals and believed the behavior was due to Resident #77 seeking attention. Interview on 10/15/25 at 1:55 P.M. with Psychiatric Nurse Practitioner #602 revealed that he had seen Resident #77 through June 2025 and again just recently on 10/08/25. NP #602 indicated that Resident #77 had schizophrenia with disorganized thoughts and paranoia. NP #602 was unaware of the recent events surrounding Resident #77's hospitalizations but added Resident #77 was noted to be having an increase in behaviors back in March and April of 2025. On 10/06/25 at 2:44 P.M., interview with the Administrator indicated the resident would hoard random items in his room which had been picked up when the resident was moving around the facility. The Administrator stated the resident knew he was not to have facility chemicals and when was educated by staff when hazardous chemicals were found in his room. The Administrator verified there was no evidence the interdisciplinary team attempted to address the resident's increase in behaviors and further verified there was no evidence the facility attempted to implement a psychosocial plan of care. Interview on 10/08/25 at 8:50 A.M. with CNA #521 stated that on 09/02/25

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	11/13/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record reviews, staff interviews, resident interviews, review of the facility investigation file, review of personnel files, and review of facility policies the facility failed to ensure accurate orders and documentation were in resident medical records. This affected three (Residents #37, #86, and #97) of three residents reviewed for accurate and complete documentation, one (Resident #37) of one resident reviewed for medication administration, and one (Resident #106) of one resident reviewed for treatment administration. The facility census was 70.1.Review of the medical record for Specified Resident #37 revealed an admission date of 10/02/24, diagnoses included obstructive hypertrophic cardiomyopathy, left bundle branch block, cervical disc degeneration, solitary pulmonary nodule, depression, anxiety, and borderline personality disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, did not refuse care, was occasionally incontinent, required set-up assistance with toileting and personal hygiene, required supervision assistance with bathing and required pain management. Review of task sheets for Residents #37 for the month of April 2025 revealed the absence of documentation to support daily living cares had been provided during the hours of 3:00 P.M. and 7:00 P.M. on 04/08/25. Continued review of April 2025 task sheets for personal hygiene revealed care was only documented as provided on 04/03/25 at 3:34 A.M. and 04/26/25 at 10:15 A.M. Further review of task sheets for Resident #37 for August 2025 through October 2025 revealed the absence of documentation to support daily living cares had been provided on multiple days and shifts. Interview on 10/15/25 at 9:45 A.M. with the Administrator confirmed the absence of documentation to support daily living cares had been provided on multiple days and shifts for Resident #97 from August 2025 through October 2025. 2. Review of the October 2025 narcotic count sheets for Resident #37's tramadol revealed medication was removed on 10/13/25, 10/14/25, and 10/15/25. Review of the October 2025 medication administration record for Resident #37 revealed no documentation to support tramadol was administered as ordered as was indicated on the related narcotic count sheets. Interview on 10/15/25 at 12:15 P.M. with Licensed Practical Nurse (LPN) #506 revealed she did not document tramadol administration in the medication administration record, and she would only document the administration of tramadol on the narcotic count sheet. Interview on 10/15/25 at 12:18 P.M. with Resident #37 revealed she received tramadol once each day on 10/13/25, 10/14/25, and 10/15/25. Interview on 10/15/25 at 12:20 P.M. with the Administrator revealed the administration of tramadol for Resident #37 should have been documented in the medication administration record. (continued on next page)

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	365907	A. Building B. Wing	11/13/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy dated 12/20/24 titled Medication Administration revealed medications administered to residents would be documented in the medication administration record. 3. Review of the medical record for Resident #86 revealed an admission date of 06/22/23, diagnoses included myasthenia gravis, pneumonitis due to aspiration, schizophrenia, dysphagia, Parkinson's disease, and metabolic encephalopathy. Review of the MDS assessment revealed the resident did not refuse care, was incontinent of bowel and bladder, was dependent for toileting hygiene, and required maximal assistance for bathing and dressing. Review of task sheets for Residents #86 for the month of April 2025 revealed the absence of documentation to support daily living cares had been provided during the hours of 3:00 P.M. and 7:00 P.M. on 04/08/25. Continued review of April 2025 task sheets for personal hygiene revealed care documented as provided on 04/01/25 at 5:31 A.M. and 12:24 P.M., on 04/02/25 at 6:59 A.M., 04/03/25 at 11:47 A.M., 04/05/25 at 6:54 A. M., 04/06/25 at 6:36 A.M., 04/08/25 at 6:28 A.M., 04/11/25 at 1:59 A.M., 04/12/25 at 3:49 A.M., 04/14/25 at 3:36 A.M., 04/15/25 at 3:16 A.M., 04/1725 at 7:0 P.M., 04/21/25 at 12:48 P.M., 04/24/25 at 4:56 A.M., and 04/29/25 at 2:59 P.M. and 4:43 P.M. Further review of task sheets for Resident #86 for August 2025 through October 2025 revealed the absence of documentation to support daily living cares had been provided on multiple days and shifts. Interview on 10/15/25 at 9:45 A.M. with the Administrator confirmed the absence of documentation to support daily living cares had been provided on multiple days and shifts for Resident #86 from August 2025 through October 2025. 4. Review of the medical record for Resident #97 revealed an admission date of 10/25/24, diagnoses included fracture of sacrum, adult failure to thrive, repeat falls, depression, and anxiety. Review of the MDS assessment revealed the resident did not refuse care, was incontinent of bowel and bladder, and was dependent for activities of daily living including toileting, showering, and dressing. Review of task sheets for Residents #97 for the month of April 2025 revealed the absence of documentation to support daily living cares had been provided during the hours of 3:00 P.M. and 7:00 P.M. on 04/08/25. Continued review of April 2025 task sheets for personal hygiene revealed care was only documented as provided on 04/03/25 at 2:43 A.M. and 04/26/25 at 10:16 A.M. Further review of task sheets for Resident #97 for August 2025 through October 2025 revealed the absence of documentation to support daily living cares had been provided on multiple days and shifts. Interview on 10/15/25 at 9:45 A.M. with the Administrator confirmed the absence of documentation to support daily living cares had been provided on multiple days and shifts for Resident #97 from August 2025 through October 2025. (continued on next page)

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	11/13/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the medical record for Former Resident (FR) #106 revealed an admission date of 05/30/25 and a discharge date of 06/19/25. admission diagnoses included sepsis, diabetes mellitus with ulcers, morbid obesity, stage two pressure ulcer to right buttock, unstageable pressure ulcer to buttock, gangrene, wound of lower back and pelvis without penetration into the retroperitoneum, chronic kidney disease stage five with dependence on kidney dialysis, and diabetes mellitus with circulatory problems. Review of the admission MDS assessment dated [DATE] for FR #106 revealed she had mild cognitive impairment and was admitted with pressure ulcers. Review of the current physician orders for 06/25 for FR #106 revealed she was required to have nothing to eat or drink on 06/18/25 at 8:00 A.M. for a scheduled procedure to her arterio-venous (AV) fistula (means to conduct kidney dialysis for a person in kidney failure), ceftazidime one gram intravenously (IV) to be given at dialysis every Tuesday, Thursday, and Saturday through 06/06/25, vancomycin 750 milligrams (mg) IV to be given at dialysis every Tuesday, Thursday, and Saturday through 06/06/25, and sacrum wound vacuum (wound-vac) cleanse wound with soap and water after removing the old dressing, apply skin prep to peri-wound (around the good skin of the wound), apply non adhering wound dressing over exposed bone, use with black foam to cover wound bed, set at 125 millimeters of mercury (Hg) (mmHg) continuously, medium intensity, move track pad off the wound to non-pressure area, change twice weekly on Sunday and Wednesday and as needed. Review of the TAR for 06/25 for FR #106 revealed on 06/15/25 and 06/18/25 revealed wound care was completed according to the EMR documentation. Review of the nursing progress notes for 06/15/25 and 06/18/25 for FR #106 revealed no documentation that indicated FR #106 refused any wound care on those days. Review of Former LPN #601 personnel file revealed disciplinary action dated 07/03/25 revealed LPN #601 received discipline for falsifying Electronic Medical Record (EMR) documentation providing misleading. Further review of the disciplinary action revealed LPN #601 charted a wound dressing was changed but did not actually complete the wound dressing and did not document FR #106's refusal of the dressing change. Interview on 10/09/25 at 4:30 P.M. with the Administrator verified an internal investigation was conducted that involved LPN #601 for documentation of completion of a wound dressing on 06/15/25 for FR #106, when in fact the wound dressing was not changed, and FR #106 actually refused the wound treatment and LPN #601 did not document the refusal of care by the resident that resulted in false documentation. Follow up interview on 10/13/25 at 7:35 A.M. with the Administrator stated the investigation was initiated as the result of the FR #106's daughter called and expressed a concern about the wound treatments for FR #106 and their completion. (continued on next page)

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	365907	A. Building B. Wing	11/13/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities investigation revealed two nurses, Former LPN #600 and LPN #601 both signed the Treatment Administration Record (TAR) for FR #106 that indicated wound care was completed on 06/15/25 and 06/18/25, assigned as a day shift wound care treatment, was signed off which indicated the treatment was completed and was not actually completed. Both nurses LPN #600 and LPN #601 were disciplined for the falsification of the EMR which led to misleading documentation that indicated the wound care was completed and it in fact was not. Review of the written statement, undated, by LPN #600 stated FR #106 was offered to change the wound dressing and refused and LPN #600 statement indicated he did not return to the EMR and document that refusal of the treatment. Review of the written statement by way of email correspondence, dated 06/30/25 from LPN #601 stated FR #106 was offered wound care and the treatment was refused by the resident. Further review of LPN #601's stated indicated that medications administered and the treatments were both signed off at the same time and LPN #601 did not go back and document the refusal of the wound care by FR #106. Review of the facility policy titled Wound Treatment Management, dated 05/22/25 stated wound treatments will be provided in accordance with physician orders and treatments will be documented in the resident's medical record to include the effectiveness of the treatment. This violation represents non-compliance investigated under Master Complaint Number 2630848 and Complaint Number 2617497.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, staff interview, and review of facility policy, the facility failed to ensure meal trays were served in a clean and sanitary manner. This affected eight (#34, #48, #51, #53, #54, #58, #65, and #81) of eight residents observed during meal tray service. The facility census was 70. Observation on 10/06/25 between 12:25 and 12:45 revealed Certified Nurse Assistant (CNA) #525 delivering meal trays to residents. CNA #525 did not perform hand hygiene before she retrieved a meal tray from the cart in the hallway and delivered it to Resident #81's bedside table. CNA #525 touched the bedside table and set up the meal tray for Resident #81; she opened silverware, removed lids from bowls and plates, and inserted a straw into a cup. CNA #525 did not perform hand hygiene before leaving Resident #81's room. CNA #525 returned to the meal tray cart in the hallway, did not perform hand hygiene, and retrieved another meal tray for Resident #51. CNA #525 delivered the meal tray to Resident #51's bedside table. CNA #525 touched the bedside table and did not perform hand hygiene prior to leaving Resident #51's room. CNA #525 returned to the meal tray cart in the hallway, did not perform hand hygiene, and retrieved another meal tray for Resident #58. CNA #525 delivered the meal tray to Resident #58's bedside table. CNA #525 touched the bedside table and set up the meal tray for Resident #58; she opened silverware, removed lids from bowls and plates, and inserted a straw into a cup. CNA #525 brought Resident #58's dirty water cup out of the room and placed it on the top of the meal tray cart in the hallway. CNA #525 did not perform hand hygiene. CNA #525 closed the meal tray cart, walked to the nurses' station, obtained a cup of ice from the cooler used to pass water to residents, filled the cup with water, and delivered the cup to a visitor. CNA #525 did not perform hand hygiene. CNA #525 went to a supply room to obtain straws, delivered straws to Resident #64 and Resident #48, and placed the remaining handful of straws on top of the meal tray cart. CNA #525 did not perform hand hygiene. CNA #525 retrieved a meal tray and delivered it to Resident #53's bedside table. CNA #525 set the meal tray up: she opened silverware, removed lids from bowls and plates, and inserted a straw into a cup. CNA #525 touched Resident #53's bedside table, wheelchair, and picked up a piece of paper from the floor. Resident #53 requested CNA #525 cut up her food. CNA #525 did not perform hand hygiene prior to using the silverware on the meal tray to cut the food into bite sized pieces. CNA #525 exited Resident #53's room and did not perform hand hygiene. CNA #525 returned to the meal tray cart in the hallway, did not perform hand hygiene, and retrieved a meal tray for Resident #34. CNA #525 delivered the meal tray to Resident #34's bedside table, assisted with cleaning up fluid on the floor with paper towels, removed a full trash bag from the trash can, then set up Resident #34's meal tray. CNA #525 did not perform hand hygiene before she touched two cups and inserted straws into the cups on Resident #34's meal tray. CNA #525 retrieved the bag of trash and left Resident #34's room. CNA #525 took the trash bag to the soiled utility room, did not perform hand hygiene, returned to the meal tray cart, touched her face, then retrieved a meal tray for Resident #54. CNA #525 delivered the meal tray to Resident #54's bedside table and set the tray up; she opened a soda can, put a straw into a cup, opened silverware, and moved the plate closer to Resident #54. CNA #525 exited Resident #54's room and did not perform hand hygiene. Interview on 10/06/25 at 12:47 P.M. with CNA #525 confirmed the above noted observations of meal tray service to Residents #34, #48, #51, #53, #54, #58, #65, and #81. CNA #525 confirmed she did not perform hand hygiene during the observation as she should have between residents, after cleaning the floor, and after handling trash. Review of facility policy dated 09/16/25 and titled Hand Hygiene revealed all staff would perform proper hand hygiene to prevent the spread of infection to staff, visitors, and residents. The policy indicated hand hygiene would be performed between resident contacts and after handling contaminated objects.