

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365907	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Franciscan Care Ctr Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident and staff interview, and facility policy review, the facility failed to ensure dependent residents received timely bathing. This affected two (#515 and #569) of three residents reviewed for showers. The facility census was 70. Findings included: 1. Review of Resident #569's medical record revealed an admission date of 05/25/24. Diagnoses included dementia, peripheral vascular disease, chronic obstructive pulmonary disease, and chronic pain syndrome. Review of Resident #569's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition and required substantial assistance with activities of daily living (ADLs). Review of Resident #569's care plan revealed the resident had an ADLs self-care deficit due to chronic obstructive pulmonary disease, dementia, depression, and obesity. Interventions include staff assistance was required to provide a bath or shower, and a sponge bath was to be completed when a full bath or shower could not be tolerated. Review of Resident #569's physician order dated 05/08/25 revealed showers or bed baths were to be administered every Monday and Friday every evening shift. Review of Resident #569's nurse aide task documentation in the electronic medical record (EMR) between 10/21/25 and 11/20/25 revealed the resident received a shower on 11/03/25 and 11/10/25, and refused a shower on 11/06/25. Further review revealed the resident was not offered a shower or bed bath on 10/24/25, 10/27/25, 10/31/25, 11/07/25, 11/14/25, and 11/17/25. Interview with Resident #569 on 11/18/25 at 1:20 P.M. revealed showers were not given on her scheduled days because staff were too busy to provide them. 2. Review of Resident #515's medical record revealed an admission date of 02/01/23. Diagnoses included hemiplegia, cerebral vascular accident, sickle-cell disease, and seizures. Review of Resident #515's quarterly MDS assessment dated [DATE] revealed she had an intact cognition and required partial to moderate assistance for showers and bathing. Review of Resident #515's most recent care plan revealed she had an ADLs care performance deficit due to hemiplegia and a cerebral vascular accident. The resident preferred showers and required staff to assist. Showers were to be given timely every Monday and Thursday on first shift. Review of Resident #515's physician order dated 05/08/25 revealed showers or bed baths were to be completed every Monday and Thursday on day shift. Review of a printed document provided by the Director of Nursing (DON) revealed Resident #515's bathing was completed on 03/03/25, 03/24/25, 04/03/25, 04/21/25, and 04/29/25 in March and April 2025. Further review revealed showers were not offered or completed on 03/06/25, 03/10/25, 03/13/25, 03/17/25, 03/20/25, 03/27/25, 04/07/25, 04/10/25, 04/14/25, 04/17/25, 04/20/25, 04/24/25, and 04/28/25. Review of the EMR dated 10/20/25 through 11/20/25 revealed Resident #515 received showers on 10/21/25, 10/27/25, 11/02/25, 11/03/25, 11/06/25, and 11/13/25. Interview with Resident #515 on 11/18/25 at 1:20 P.M. revealed showers were not completed timely and she missed having a regular shower. Interview with the DON on 11/20/25 at 10:55 A.M. verified the medical record was absent of documentation regarding shower/bath completion for Resident #569 and Resident #515 on the above listed dates for each resident. The DON could not speak to the shower completion prior to November 2025 as she was not employed with the facility at that time. Interview with Certified Nurse Aides (CNA) #171 and CNA #172 on 11/20/25 at 12:06 P.M. revealed staff were to document shower completions in the task area in the residents' EMR. CNA #171 and CNA #172 verified if the documentation was blank the shower task was not completed. Review of the facility policy titled, Activities of Daily Living, dated 10/06/25, revealed the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing, dressing, grooming and oral care. This deficiency represents non-compliance investigated under Complaint Number 2637315, Complaint Number 2610132, and Complaint Number 1305370 (OH00164351).</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the National Library of Medicine webpage, the facility failed to ensure resident bowel movements were monitored to provide interventions to prevent constipation. This affected two (#523 and #552) of two residents reviewed for constipation. The facility census was 70. Findings included:1. Review of the medical record for Resident #523 revealed she was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), fracture of the sacrum, type two diabetes mellitus, heart disease, osteoarthritis, depression, and anxiety.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #523 revealed was assessed with moderate cognitive impairment, did not refuse care, was always incontinent of bowel and bladder, and was dependent for activities of daily living.Review of the active physician orders as of 11/19/25 for Resident #523 revealed medication orders Colace 100 milligrams (mg) twice daily for the management of constipation and Bisacodyl 10 mg via rectal suppository every 24 hours as needed for constipation. Further review of the physician orders revealed an order dated 06/03/25 to monitor for medication side effects which included monitoring for constipation. Review of the task sheets for the month of November 2025 for Resident #523 revealed she did not have a bowel movement for six days between 11/12/25 through 11/17/25.Review of Resident #523's November 2025 medication administration record (MAR) revealed the resident did not receive any doses of her ordered as-needed medication for constipation.Review of the progress notes and nursing assessments for Resident #523 for the month of November 2025 revealed the absence of documentation to indicate she was assessed for constipation and offered her as-needed medication for constipation.Interview on 11/19/25 at 11:00 A.M. with the Director of Nursing (DON) confirmed the task sheets for Resident #523 indicated she did not have a bowel movement for six days. Continued interview with the DON confirmed the absence of documentation to indicate Resident #523 was assessed for constipation and offered the ordered as-needed medication for constipation.2. Review of the medical record for Resident #552 revealed he was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, anemia in chronic kidney disease, cerebral infarction, dysphagia, malnutrition, and right hemiplegia.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #552 revealed he was cognitively intact, did not refuse care, was always incontinent of bowel and bladder, and was dependent for activities of daily living and mobility. Review of the active physician orders as of 11/19/25 for Resident #552 revealed medication orders docusate sodium 10 milliliters twice daily for the management of constipation and Miralax 17 grams once daily for the management of constipation. Additional orders included monitoring for constipation every shift.Review of the task sheets for the month of November 2025 for Resident #552 revealed he did not have a bowel movement for five days on 11/13/25 through 11/17/25.Review of the progress notes and nursing assessments for Resident #552 for the month of November 2025 revealed the absence of documentation to indicate he was assessed for constipation.Interview on 11/19/25 at 11:00 A.M. with the DON confirmed the task sheets for Resident #552 indicated he did not have a bowel movement for five days. Continued interview with the DON confirmed the absence of documentation to indicate Resident #552 was assessed for constipation.Interview on 11/19/25 at 11:15 A.M. with the DON, the Administrator, and Registered Nurse (RN) #122 confirmed standard of practice for the management of constipation was monitoring for daily bowel movements, assessment for constipation, and beginning interventions to relieve constipation after three days without a bowel movement.Review of the National Library of Medicine Medline Plus webpage at, https://medlineplus.gov/ency/patientinstructions/000120.htm, revealed constipation is when stool is not passed as often as normal and the stool may become hard and dry, making it difficult to pass. A provider should be contacted after three days without a bowel movement.This deficiency represents an incidental finding discovered during the complaint investigations and continued non-compliance from the survey dated 11/13/25.</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of a facility protocol, the facility failed to ensure staff received a physician's order prior to removing an indwelling urinary catheter. This affected one (#572) of six residents reviewed with urinary catheters. The facility census was 70. Findings included: Review of Resident #572's medical record revealed an admission date of [DATE]. Diagnoses included bacteremia, chronic kidney disease, and neuromuscular dysfunction of the bladder. The resident expired under hospice care on [DATE].</p> <p>Review of Resident #572's Minimum Data Set assessment dated [DATE] revealed the resident had an intact cognitive function. The resident was always incontinent of bowel and bladder and dependent on staff for all activities of daily living.</p> <p>Review of Resident #572's care plan dated [DATE] revealed she had an indwelling Foley catheter due to a neurogenic bladder. Interventions were to monitor for pain or discomfort due to the catheter.</p> <p>Review of Resident #572's nursing progress note dated [DATE] at 2:47 P.M. revealed a nurse contacted urology for an order to remove the resident's urinary catheter (Foley).</p> <p>Further review of the nursing progress notes and physician orders for Resident #572 revealed no return call nor orders were received to remove Resident #572's Foley catheter.</p> <p>Review of a nursing progress note dated [DATE] revealed Resident #572 informed the nurse she was in severe urinary pain and rated her pain as a nine out of 10. The nurse administered pain medication and then the nurse then removed the Resident #572's Foley catheter per resident request. The resident was then transferred to the hospital to rule out a urinary tract infection.</p> <p>Interview with the Director of Nursing (DON) on [DATE] at 12:40 P.M. verified that no physician order could be located in the medical record to removed Resident #572's Foley catheter.</p> <p>Review of a bladder management protocol, revised [DATE], revealed staff are to confer with a provider and obtain an order for indwelling urinary catheter (IUC) if indicated. An order is needed from a physician for insertion of an IUC. If a registered nurse is uncertain as to whether to remove the IUC, the provider must be contacted.</p> <p>This deficiency represents an incidental finding discovered during the complaint investigations.</p>		