

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 12/22/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on staff interviews, review of facility investigation, review of a police report, review of the facilities Self-Reported Incidents (SRIs), and review of the facility policy, the facility failed to report an allegation of neglect by a nurse to the State Survey Agency, Ohio Department of Health. This had the potential to affect 13 residents (#3, #5, #16, #18, #25, #32, #34, #47, #56, #60, #65, #66, and #67) in which the nurse was responsible for the night of the allegation of neglect. The facility census was 64. Findings include: Review of the facility provided timeline for 12/12/25 revealed Licensed Practical Nurse (LPN) #200 punched in for work on 12/12/25 at 10:20 P.M. and received report from the off-going LPN, LPN #152, at approximately 11:00 P.M. At approximately 11:12 P.M. on 12/12/25 LPN #152 and Certified Nursing Assistant (CNA) #144 drove LPN #200 to the gas station and he did not return to the facility until 11:27 P.M. on 12/12/25. Review of the police report revealed on 12/12/25, a resident of the nursing home called emergency 9-1-1 and reported her nurse was intoxicated and smelled like alcohol. Upon police arrival, LPN #200 had glossy eyes, slurred and abnormal speech. Police asked Registered Nurse (RN) #158 to contact a supervisor and RN #158 reported she contacted administrative staff. Due to LPN #200's impairment, policy began an investigation to determine if resident neglect had occurred, was occurring, or was going to occur. On 12/13/25 at 12:45 A.M., LPN #200 was arrested for disorderly conduct: public intoxication; offensive behavior or to cause alarm. Review of the facilities SRI revealed the facility did not report the allegation of neglect by LPN #200 to the State Survey Agency. Interview on 12/22/25 at 10:46 A.M. with CNA #144 revealed LPN #200 convinced LPN #152 to take him to the gas station. She stated that she observed a strong smell of alcohol on LPN #200 and called the facilities Administrator and left a voicemail. She stated that she also called the facility and spoke to RN #158 that was working in the facility at that time. Interview on 12/22/25 at 12:03 P.M. with the Administrator verified the facility did not file a SRI for this incident. The facility identified LPN #200 was responsible for 13 residents (#3, #5, #16, #18, #25, #32, #34, #47, #56, #60, #65, #66, and #67) on 12/12/25. Review of the facility policy titled Abuse, Neglect, and Exploitation, dated 05/22/25, revealed report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes, not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. This deficiency represents non-compliance investigated under Complaint Number 2696625.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365907
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on staff interviews, review of the police report, review of facility policy, and review of the facility's investigation, the facility failed to complete and thorough investigation of possible resident neglect by a nurse. This had the potential to affect 13 residents (#3, #5, #16, #18, #25, #32, #34, #47, #56, #60, #65, #66, and #67) which the nurse was responsible for the night of the allegation of neglect. The facility census was 64. Findings include: Review of the police report revealed on 12/12/25, a resident of the nursing home called emergency 9-1-1 and reported her nurse was intoxicated and smelled like alcohol. Upon police arrival, Licensed Practical Nurse (LPN) #200 had glossy eyes, slurred and abnormal speech. Due to LPN #200's impairment, policy began an investigation to determine if resident neglect had occurred, was occurring, or was going to occur. LPN #200 was walking around the facility speaking in a loud voice and using vulgar language in front of residents. On 12/13/25 at 12:45 A.M., LPN #200 was arrested for disorderly conduct: public intoxication; offensive behavior or to cause alarm. Review of the facility provided timeline for 12/12/25 revealed LPN #200 punched in for work on 12/12/25 at 10:20 P.M. and received report from the off-going LPN, LPN #152, at approximately 11:00 P.M. At approximately 11:12 P.M. on 12/12/25, LPN #152 and Certified Nursing Assistant (CNA) #144 drove LPN #200 to the gas station and he did not return to the facility until 11:27 P.M. on 12/12/25. The facility interviewed two residents about the allegation of neglect. The facility identified LPN #200 was responsible for 13 residents (#3, #5, #16, #18, #25, #32, #34, #47, #56, #60, #65, #66, and #67) on 12/12/25. Interview on 12/22/25 at 10:46 A.M. with CNA #144 revealed LPN #200 convinced LPN #152 to take him to the gas station. She stated that she observed a strong smell of alcohol on LPN #200 and called the facilities Administrator and left a voicemail. Interview on 12/22/25 at 11:35 A.M. with the Director of Nursing (DON) revealed she reviewed the medicals records including the medication administration record (MAR) for all 13 residents assigned to LPN #200 and it was determined he did not administer any medication or provide any care to any residents on 12/12/25. The DON verified the facility did not assess or interview all 13 residents that were assigned to the care of LPN #200. Review of the facility policy titled Abuse, Neglect, and Exploitation dated 05/22/25 revealed an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigation include focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause; and providing complete and thorough documentation of the investigation. This deficiency represents non-compliance investigated under Complaint Number 2696625.</p>		