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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 02/24/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, staff interview, physician interview, medical record review, review of resident skin assessments, and review of facility policy, the facility failed to ensure timely physician notification of a change in condition for a resident. This affected one(#7) of three residents reviewed for change in condition. The facility census was 71.Findings include: Review of the medical record for Resident #7 revealed an admission date of 09/24/24 with diagnoses including chronic obstructive pulmonary disease (COPD), cardiac arrythmia, other signs and symptoms involving the musculoskeletal system, obstructive sleep apnea (OSA), congestive heart failure (CHF), lymphedema, rheumatoid arthritis (RA), atherosclerotic heart disease, hypertension (HTN), morbid obesity, major depressive disorder, and anxiety. Review of Resident #7's most recent quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, revealed a Brief Interview of Mental Status (BIMS) score of 13, indicating Resident #7's cognition was relatively intact. Further review of this MDS assessment revealed she had unilateral impairment of her upper extremities and was dependent or required maximal assistance for all functional abilities including, but not limited to, hygiene, toileting, rolling, and transferring.Review of Resident #7's most recent skin assessment, dated 02/11/26, revealed the resident had no skin impairments. Observation on 02/18/26 at 1:44 P.M. of incontinence care for Resident #7 revealed a large open area of skin on the resident's coccyx. Certified Nursing Assistant (CNA) #147 notified Registered Nurse (RN) #127 of the open area on Resident #7's coccyx. RN #127 assessed the open area and applied a cream. Interview on 02/18/26 at 2:04 P.M. with CNA #147 verified the large open area on Resident #7's coccyx was a new skin impairment. Review of Resident #7's medical record on 02/19/26 at approximately 8:30 A.M. revealed no documentation of physician notification of the new skin impairment on Resident #7's coccyx. Interview on 02/19/26 at 8:37 A.M. with RN #148 revealed she completed Resident #7's last skin assessment on 02/11/26 and confirmed the resident had no skin impairments at that time. Interview on 02/19/26 at 12:48 P.M. with Physician #204 revealed he most recently saw Resident #7 on 02/11/26 and, at that time, the resident's coccyx was reddened, but not opened. Physician #204 confirmed he was not notified of Resident #7's new wound until today and his expectation was that new wounds were reported to him the same day that they were discovered. Review of the facility policy titled, Notification of Change, dated 07/25/25, revealed the facility was to promptly consult the resident's physician when there was a change requiring notification. Circumstances that required notification included a significant change in the resident's physical, mental or psychosocial condition such as deterioration in health.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, resident interview, staff interview, medical record review, and review of facility policy, the facility failed to ensure that residents who were dependent on staff for Activities of Daily Living (ADLs) received grooming and feeding assistance. This affected two (#7 and #55) of three residents reviewed for ADL care. The facility census was 71.Findings include:1. Review of the medical record for Resident #7 revealed an admission date of 09/24/24 with diagnoses including chronic obstructive pulmonary disease (COPD), cardiac arrythmia, other signs and symptoms involving the musculoskeletal system, need for assistance with personal care, generalized muscle weakness, osteoarthritis, obstructive sleep apnea (OSA), congestive heart failure (CHF), lymphedema, rheumatoid arthritis (RA), atherosclerotic heart disease, hypertension (HTN), morbid obesity, major depressive disorder, and anxiety. Review of Resident #7's most recent quarterly Minimum Data Set (MDS) assessment, dated 12/30/25, revealed a Brief Interview of Mental Status (BIMS) score of 13, indicating Resident #7's cognition was relatively intact. Further review revealed she had unilateral impairment of her upper extremities and was dependent or required maximal assistance for all functional abilities including, but not limited to, hygiene, toileting, rolling, transferring, and mobilizing in her wheelchair. Observation on 02/18/26 at 1:20 P.M. of Resident #7 revealed she had multiple long, coarse hairs on her chin and upper lip. Concurrent interview with Resident #7 revealed the facility did not assist her with grooming her facial hair as much as she liked and it bothered her when her facial hair was long enough to be visible. Interview on 02/18/26 at 2:04 P.M. with Certified Nursing Assistant (CNA) #147 verified Resident #7 had multiple long, coarse hairs on her chin and upper lip. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 10/06/25, revealed care and services would be provided for bathing, dressing, grooming, and oral care. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 2. Review of the medical record for Resident #55 revealed an admission date of 06/11/24. Diagnoses included Type II diabetes mellitus, hypothyroidism, hypokalemia, adult failure to thrive, and anxiety disorder. Review of the quarterly MDS assessment, dated 12/16/25, revealed this resident had impaired cognition, as evidenced by a BIMS score of eight. This resident was assessed to require assistance with meals and was dependent on staff for ADL care. Review of the care plan dated 06/20/24 revealed Resident #55 had an ADL self-care performance deficit related to impaired vision and arthritis. Interventions included staff assistance with eating and encourage to feed self, if possible. Resident #55 was blind and required staff to set up her meal and tell her how the plate was set up using the clock system. Further review of the care plan revealed Resident #55 was at risk for nutrition and hydration deficits related to Type II diabetes mellitus, hypothyroidism, hypertension, depression, hypokalemia, adult failure to thrive, and received diuretic treatment which may have caused weight changes. Interventions included providing and serving supplements as ordered, monitoring intake, and weight as ordered. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility identified listing of assisted dining residents revealed Resident #55 required assistance with eating. Observation on 02/19/26 from 12:06 P.M. to 12:38 P.M. revealed Resident #55 was in bed, with the head of the bed at approximately 50 degrees. The resident was laying on her right side. Resident #55's tray table was on the left side of the bed (resident was facing right) and contained a plate with food. A chair next to Resident #55's room door had a tray with a hot plate holder, a full carton of milk, a mighty shake (nutritional supplement), and a fruit cup. There was an open straw wrapper inside the full fruit cup. Continued observation revealed staff did not enter Resident #55's room to assist the resident with eating. Interview on 02/19/26 at 12:06 P.M. with Resident #55 revealed the resident was not aware her lunch was on her bedside table and further stated no staff had been in the room to assist her. Interview on 02/19/26 at 12:38 P.M. with CNA #145 confirmed Resident #55 had not been assisted to eat her lunch meal and further stated, well she likes to just eat her cheerios. CNA #145 further confirmed she had not been in Resident #55's room and was unsure who uncovered the food and placed it on the tray table. Interview on 02/19/26 at 12:39 P.M. with Housekeeper #182 revealed when she passed Resident #55's room at approximately 12:00 P.M., she noticed her food tray was sitting on the chair next to the door and entered Resident #55's room and set the plate of food on the tray table. Housekeeper #182 further stated that she did not see staff in the room assisting Resident #55, so she tried to help her when she could. Interview on 02/23/25 with Dietary Technician (DT) #177 confirmed Resident #55 should be assisted at meals by staff and offered what the facility served for the meal. DT #177 stated if Resident #55 refused what the facility was serving, an alternative should be offered. Review of the facility policy titled, Meal Supervision and Assistance, dated 02/18/26, revealed the facility would utilize a systemic approach to ensure safety throughout the resident's environment and among all staff. The staff was to check the tray before serving to the resident to be sure that it was the correct died ordered. The staff were to arrange dishes and silverware so that the resident could reach them easily, open all cartons, remove all lids from items on the tray, give the napkin to the resident, and use clothing protectors as needed. If the resident refused to eat, inform the supervisor.

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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. Based on observation, staff interview, medical record review, and facility policy review, the facility failed to ensure pressure ulcers treatments were implemented per physician order and further failed to ensure pressure ulcer prevention interventions were implemented. This affected two (#27 and #7) of three residents reviewed for pressure ulcers. Findings include:1. Review of the medical record for Resident #27 revealed an admission date of 10/29/25 with diagnoses including acute onset osteomyelitis, stage four pressure ulcer of other site, need for assistance with personal care, cellulitis of right lower limb, lymphedema, hereditary and idiopathic neuropathy, non-pressure chronic ulcer of right ankle, stage four pressure ulcer of right heel, and hypertension (HTN).Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 02/03/26, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #27's cognition was intact. Further review revealed Resident #27 required supervision to moderate assistance for all functional abilities including, but not limited to, hygiene, toileting, dressing, turning and repositioning, transferring, and utilizing his wheelchair. Review of the physician orders revealed an order dated 11/06/25 for Tubigrip compression stockings, medium strength. Apply a double layer of Tubigrips to the right lower (extremity) and a single layer Tubigrip to the left lower (extremity), ace wrap over Tubigrip to the right lower (extremity). Apply Tubigrips from base of toes to below both knees to both legs, every morning and remove at bedtime for wound care. Review of the Treatment Administration Record (TAR) from November 2025 through 02/23/26 revealed no documentation that Resident #27's physician ordered Tubigrips were applied on 11/06/25, 11/07/25, 11/26/25, 11/30/25, 12/30/26, 01/01/26, 01/07/26, 01/20/26, 01/22/26, 01/26/26, 02/13/26, 02/14/26, 02/15/26, 02/16/26, or 02/23/26. Further review of the TAR revealed no documentation that the Tubigrips were removed, as ordered, on 11/17/25, 11/18/25, 11/19/25, 12/23/26, 12/30/26, 01/02/26, 01/11/26, 01/15/26, 01/22/26, 01/23/26, 01/27/26, 02/02/26, 02/03/26, 02/05/26, 02/09/26, 02/10/26, 02/18/26, 02/19/26, 02/21/26, or 02/22/26. Interview on 02/24/26 at 10:36 with Registered Nurse (RN) #100 verified there was no documentation that Resident #27's physician ordered Tubigrips were applied on 11/06/25, 11/07/25, or 11/26/25, 11/30/25, 12/30/26, 01/01/26, 01/07/26, 01/20/26, 01/22/26, 01/26/26, 02/13/26, 02/14/26, 02/15/26, 02/16/26, or 02/23/26. Further interview with RN #100 verified there was no documentation that the Tubigrips were removed, as ordered, on 11/17/25, 11/18/25, 11/19/25, 12/23/26, 12/30/26, 01/02/26, 01/11/26, 01/15/26, 01/22/26, 01/23/26, 01/27/26, 02/02/26, 02/03/26, 02/05/26, 02/09/26, 02/10/26, 02/18/26, 02/19/26, 02/21/26, or 02/22/26. Review of the facility policy titled, Wound Treatment Management, dated 05/22/25, revealed treatments would be documented on the Treatment Administration Record or in the electronic health record.2. Review of the medical record for Resident #7 revealed an admission date of 09/24/24 with diagnoses including chronic obstructive pulmonary disease (COPD), cardiac arrythmia, osteoarthritis, obstructive sleep apnea (OSA), congestive heart failure (CHF), lymphedema, rheumatoid arthritis (RA), atherosclerotic heart disease, HTN, morbid obesity, major depressive disorder, and anxiety. Review of Resident #7's most recent quarterly MDS assessment, dated 12/30/25, revealed a BIMS score of 13, indicating Resident #7's cognition was relatively intact. Further review revealed she had unilateral impairment of her upper extremities and was dependent or required maximal assistance for all functional abilities including, but not limited to, hygiene, toileting, rolling, transferring, and mobilizing in her wheelchair. Review of the most recent care plan, dated 12/23/25, revealed Resident #7 was to be assisted with turning and repositioning and was to have a pressure relieving mattress on her bed.Observation on 02/18/26 at 1:24 P.M. revealed Resident #7 did not have a pressure reliving mattress on her bed. Interview on 02/19/26 at 8:37 A.M. with RN #148 verified Resident #7 did not have a pressure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	relieving mattress on her bed. Interview on 02/19/26 at 1:15 P.M. with Licensed Practical Nurse (LPN) #128 verified Resident #7 is not turned and repositioned every two hours or routinely.Interview on 02/23/26 at 3:21 P.M. with RN #100 verified there was no documentation that Resident # 7 was turned and repositioned on 12/01/25, 12/02/25, 12/20/25, 12/22/25, 12/31/25, 01/04/26, 01/10/26, 01/12/26, 01/18/26, 01/25/26, 01/29/26, 02/14/26, or 02/15/26. Review of the facility policy titled, Turning and Repositioning, dated 09/11/25, revealed it was the facility's policy to implement turning and repositioning as part of their systemic approach to pressure injury prevention and management. The frequency of turning and repositioning would be documented in the resident's plan of care.This deficiency represents non-compliance investigated under Master Complaint Number 2743940 and Complaint Numbers 2725662 and 2719477.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, review of the mechanical lift manufactures user manual, medical record review, and review of facility policy, the facility failed to ensure mechanical lifts were maintained in a safe working condition. This affected one (#24) of one resident reviewed for mechanical lifts. The facility identified 22 residents who utilized mechanical lifts for transfers. The facility census was 71.Findings include:Review of the medical record for Resident #24 revealed an admission date of 03/04/23 with a diagnosis of lumbar spinal stenosis.Review of the most recent annual Minimum Data Set (MDS) assessment for Resident #24, dated 12/11/25, revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #24's cognition was relatively intact. Further review of this MDS assessment revealed Resident #24's upper and lower extremities were impaired on both sides, and she was dependent for all functional abilities including, but not limited to, toileting, showering/bathing self, dressing, hygiene, turning and repositioning, and transferring. Observation on 02/18/26 at 1:29 P.M. of Certified Nursing Assistant (CNA) #125 and CNA #147 providing incontinence care and transferring Resident #24 from her bed to a shower bed utilizing a mechanical lift revealed that five of the six safety latches on the lift hooks were missing. Interview on 02/18/26 at 1:29 P.M. with CNA #125 and CNA #147 verified five of the six safety latches on the lift hooks were missing. Neither CNA #125 nor CNA #147 were sure how long the latches had been missing. Review of the manufacturer's user manual revealed to check all sling attachments and hardware each time the lift was used to ensure proper connection and patient safety. Review of the facility policy titled, Maintenance Inspection, dated 02/19/26, revealed the facility would utilize a maintenance checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of the facility policy, the facility failed to obtain Resident #48's weight in January 2026, resulting in an unrecognized, significant unplanned weight loss. This had the potential to affect two residents who the facility identified as having unplanned weight loss. The facility census was 71.Findings include:Review of the medical record for Resident #48 revealed an admission on [DATE]. Diagnoses included unspecified systolic congestive heart failure, muscle weakness, and unspecified intestinal obstruction.Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #48 had impaired cognition. Further review of the MDS revealed Resident #48 required use of a wheelchair for mobility and required supervision or touching assistance with eating. Resident #48 required substantial assistance with Activities of Daily Living (ADL's).Review of the care plan dated 02/18/25 revealed Resident #48 had self-care performance deficit related to limited mobility, anemia, and cognitive communication impairment. Interventions included setting up meal trays and encouraging resident to feed self as able. Assist as needed. Offer to feed resident or give finger foods. Open and cut food up on tray, and notify nurse if not eating. Further review of the care plan revealed Resident #48 was at risk for nutrition and hydration deficits related to recent small bowel resection and planned significant weight gain. Interventions included weighing as ordered, provide and serve supplements as ordered. Monitoring for signs and symptoms of malnutrition such as emaciation (Cachexia), muscle wasting, significant weight loss greater than 5 percent (%) in 1 month, greater than 7.5% in 3 months, and greater than 10% in 6 months. Resident #48 had an ADL self-care performance deficit related to limited mobility, polyneuropathy, hypotension, and congestive heart failure. Interventions included supervised assistance by one staff to eat. The resident requires extensive assistance by one staff to move between surfaces and as necessary. Resident #48 had tremors, allow time to adjust and stand up.Review of the physicians' orders revealed an order on 06/13/26 for a regular diet, regular texture, thin consistency. Further review of the physicians' orders revealed an order on 02/07/26 for Ensure (dietary supplement), two times a day for weight loss.Review of the medical record weights for Resident #48 revealed on 12/02/25 Resident #48 weighed 142 pounds (lbs). There was no weight obtained in January 2026. On 02/05/26 Resident #48 weighed 123.6 lbs, and on 02/06/26 weighed 121.4 lbs.Review of the dietician progress note on 02/06/26 revealed the dietician spoke with Resident #48 who reported a decreased appetite. Resident #48 received Ensure every day which resident stated she enjoyed and was receptive to increasing to twice a day. Resident #48 had moderate decrease in food intake in the last three months. Resident #48 had a mini nutrition score of five, which meant she was malnourished. It was further noted in the dietician notes there was no weight recorded in January 2026. Doctor was updated and agreed to increasing Ensure to twice a day.Interview on 02/23/26 at 2:45 P.M. with Diet Technician (DT) #177 revealed Resident #48 had a significant weight loss and should have been weighed weekly. DT #177 confirmed that Resident #48 was not weighed in January and further stated it must have been missed during their daily interdisciplinary team meetings. DT #177 stated that Resident #48's weight loss came on suddenly however she frequently refused to eat. DT #177 confirmed if Resident #48 had been refusing meals, the staff should have notified nursing or DT #177.Review of the facility policy titled Weight Monitoring dated 09/16/25, revealed the facility will utilize a systemic approach to optimize a resident's nutritional status. A weight monitoring schedule will be developed upon admission for all residents, which included monitoring monthly. Residents with weight loss will have weight monitored weekly.

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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. Based on resident interview, staff interview, review of facility call light logs, review of facility staffing tool, and review of facility policy, the facility failed to ensure sufficient staffing to meet resident needs. This had the potential to affect all facility residents. The facility also failed to timely respond to resident call lights. This affected 42 residents who's call lights alarmed for greater than 30 minutes on 02/15/26 through 02/18/26. The facility census was 71.Findings Include:Review of facility call light logs from 02/15/2026 through 02/18/2026 revealed that 42 residents had call lights that remained activated and unanswered for 30 minutes or longer prior to staff response.Review of the Facility Staffing Tool for 02/12/26 through 02/18/26 revealed facility staffing fell below the Minimum Staffing Requirement on 02/13/25, 02/14/26, and 02/15/26. Interview on 02/18/26 at 11:25 A.M. with Resident #20 revealed call lights are not responded to timely, and she often has to wait for her call light to be answered for greater than 30 minutes. Interview on 02/18/26 at 12:51 P.M. with Resident #36 revealed call lights are not responded to timely, and she often has to wait for her call light to be answered for greater than 30 minutes. Interview on 02/18/26 at 1:11 P.M. with Resident #47 revealed call lights are not responded to timely, and she often has to wait for her call light to be answered for greater than 30 minutes. Interview on 02/18/26 at 1:24 P.M. with Resident #7 revealed call lights are not responded to timely, and she often has to wait for her call light to be answered for greater than 30 minutes. Interview on 02/18/26 at 2:05 P.M. with Resident #8 revealed call lights are not responded to timely, and she often has to wait for her call light to be answered for greater than 30 minutes. Interview on 02/18/26 at 2:46 P.M. with Resident #27 revealed call lights are not responded to timely, and he often has to wait for his call light to be answered for greater than 30 minutes. Interview on 02/19/26 at 6:30 A.M. with Resident #42 revealed call lights are not responded to timely, and she often has to wait for her call light to be answered for greater than 30 minutes. Interview with the Administrator on 02/19/26 at approximately 3:30 P.M. verified the facility staffing fell below the Minimum Staffing Requirement on 02/13/25, 02/14/26, and 02/15/26. Interview with Registered Nurse (RN) #100 on 02/24/26 at 10:36 A.M. verified from 0215/26 through 02/18/26 42 residents had call lights that remained activated and unanswered for 30 minutes or longer prior to staff response. Review of the facility policy titled, Call Lights: Accessibility and Timely Response, dated 12/01/25, revealed call lights will directly relay to a staff member or centralized location to ensure appropriate response. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. This deficiency represents non-compliance investigated under Complaint Number 2743940.

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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** Based on observation, medical record review, staff interview, and review of the facility policy, the facility failed to ensure treatments were completed by a licensed nurse. This affected one (#20) of four residents reviewed for administration of treatments. The facility census was 71.Findings include:Review of the Medical Record for Resident #20 revealed an admission on [DATE]. Diagnoses included cerebral palsy, osteoarthritis, and morbid obesity.Review of the Minimum Data Set (MDS) dated revealed Resident #20 was cognitively intact. Resident #20 was dependent on staff for transfers using a mechanical lift.Review of the care plan dated 06/25/25 revealed Resident #20 had a break in skin integrity. Interventions included treatments as ordered, and weekly skin checks. Further review of the care plan revealed Resident #20 was at risk for skin breakdown. Interventions included clean and dry skin after each incontinent episode and treatments as ordered. Additional review of the care plan revealed Resident #20 had an Activities of Daily Living (ADL) self-care performance deficit related to limited mobility. Interventions included transferring residents with a mechanical lift, with two assist.Review of the physician's orders for Resident #20 revealed an order dated 12/10/25 for Triamcinolone Acetonide External Cream 0.1 percent (%), apply to shoulders and thighs topically two times a day for psoriasis, and an order dated 12/14/25 for Nystatin External Powder 100,000 unit per grams, apply to thighs, under breast topically two times a day for fungus.Observation on 02/19/26 at 10:50 A.M. revealed Certified Nursing Assistant (CNA) #146 completing ADL care before assisting Resident #20 out of bed. CNA #146 had a four-ounce cup approximately half full of a cream. CNA #146 was unsure of areas that needed cream applied. Resident #20 instructed CNA #146 on where to apply the cream, including the left armpit area that Resident #20 stated had psoriasis. CNA #146 did not agree that the area was psoriasis and stated it looked like a pimple. CNA #146 also at this time applied powder under Resident #20's breast and to bilateral thighs.Observation on 02/19/26 at 10:55 A.M. revealed Licensed Practical Nurse (LPN) #110 enter Resident #20's room. CNA #146 asked LPN #110 if the area under Resident #20's left armpit was psoriasis, and LPN #110 did not respond. LPN #110 measured a new open area to Resident #20's abdominal fold, cleaned the area, applied a dressing and left Resident #20's room.Interview on 02/19/26 at 10:33 A.M. with Resident #20 revealed the nurse gives the CNA's the cream and powder, and the CNA's apply her Triamcinolone Acetonide cream, and Nystatin Powder.Interview on 02/19/26 with CNA #146 at 10:50 A.M. confirmed the cream in the four-ounce cup was Resident #20's prescription psoriasis cream and that the nurse gave the cream to apply to Resident #20. CNA #146 further confirmed she was unsure where the cream should be applied and goes based off where Resident #20 said to apply it.Interview on 02/19/26 with LPN #110 at 10:55 A.M. confirmed that the cream she gave for CNA #146 to apply was Triamcinolone Acetonide External Cream 0.1%, and the powder was Nystatin External Powder 100,000 unit per grams. LPN #110 further stated that she was not sure if CNA's should be applying prescription cream and powder on Resident #20. LPN #110 confirmed she did not instruct CNA where to apply the cream and did not look at the area under Resident #20's left armpit to observe if the area was psoriasis.Interview on 02/19/26 with the Director of Nursing (DON) at 11:46 A.M. confirmed a nurse should be applying prescription cream and powder and further confirmed the nurse should be observing and charting on any areas of concern. DON stated LPN #110 should have observed the area under Resident #20's left armpit to determine what the area was.Review of the facility policy titled Medication Administration dated 12/30/24, revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent (continued on next page)

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 02/24/2026
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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contamination or infection.This deficiency represents non-compliance investigated under Complaint Number 2725662.

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 02/24/2026
NAME OF PROVIDER OR SUPPLIER Franciscan Care Ctr Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and facility staff interview the facility failed to ensure residents received meals to meet the resident's nutrition needs. This affected one (Resident #55) of three reviewed for feeding assistance The facility census was 71.Findings include:Review of the medical record for Resident #55 revealed an admission on [DATE]. Diagnoses included Type II Diabetes Mellitus, hypothyroidism, hypokalemia, adult failure to thrive, and anxiety disorder.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of eight. Resident #55 was assessed to require assistance with meals and was dependent on staff for Activities of Daily Living (ADL) care.Review of the care plan dated 06/20/24 revealed Resident #55 had ADL self-care performance deficit related to impaired vision, and arthritis. Staff were to help Resident #55 eat and encourage to feed self if possible. Resident #55 was blind and required staff to set and tell how the plate was set up using the clock system. Further review of the care plan revealed Resident #55 was at risk for nutrition and hydration deficits related to Type II Diabetes Mellitus, hypothyroidism, hypertension, depression, hypokalemia, adult failure to thrive, and received diuretic treatment which may have caused weight changes. Interventions included providing and serving supplements as ordered, monitoring intake, and weight as ordered.Review of the facility identified assisted dining revealed Resident #55 required feeding assistance.Observation on 12/23/26 at 11:39 A.M., Resident #55 was observed in her room during the scheduled lunch meal service. No meal tray was present in the room.Observation on 02/23/26 at 11:52 A.M. revealed hall trays delivered to Resident #55's hallway. Further observation on 02/23/26 at 11:58 A.M. revealed hall trays being delivered to resident rooms.Observation on 02/23/26 from 12:02 P.M. through 12:40 P.M. revealed Resident #55 did not have a lunch meal tray.Interview on 02/23/26 at 12:45 P.M. with Certified Nursing Assistant (CNA) #203 revealed she was unaware that Resident #55 did not receive a lunch tray. CNA #203 stated she was not familiar with the residents or how the facility does lunch trays as it was her first time in the facility. CNA #203 further confirmed she did not check to ensure all residents had their lunch trays.Interview on 02/23/26 with Registered Nurse (RN) #127 at 12:49 P.M. revealed Resident #55 always refuses her meals, RN #127 further confirmed Resident #55 was not offered a tray because she likes cheerios. RN #127 further stated Resident #55 will not allow a plate to sit on her tray table and again confirmed they did not offer Resident #55 lunch.

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 02/24/2026
NAME OF PROVIDER OR SUPPLIER: Franciscan Care Ctr Sylvania		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of the Facility Assessment, staff interview, and review of facility policy, the facility failed to be administered in a manner that enabled it to use its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, by failing to ensure there was adequate staff per their facility assessment. This affected all facility residents. The facility census was 71.Findings Include:Review of the Facility Assessment, dated 11/15/25, revealed the facility would staff Certified Nursing Assistants (CNAs) at a ratio of one CNA to every 15 to 18 residents.Review of the facility census report for 02/15/26 revealed the facility had a census of 69 residents. Review of overnight staffing records for 02/15/26 revealed that two CNAs were assigned to the facility. Based on a census of 69 residents the two CNAs on duty were responsible for the care of 34.5 residents each. The ratio of residents to CNAs was 1 to 34.5.Review of the facility census report for 02/16/26 revealed that the facility had a census of 70 residents. Review of overnight staffing records for 02/16/26 revealed two CNAs were assigned to the facility. Based on a census of 70 residents the two CNAs on duty were responsible for the care of 35 residents each. The ratio of residents to CNAs was 1 to 35.Review of the facility census report for 02/17/26 revealed that the facility had a census of 71 residents. Review of overnight staffing records for 02/17/26 revealed that two CNAs were assigned to the facility. Based on a census of 71 residents the two CNAs on duty were responsible for the care of 35.5 residents each. The ratio of residents to CNAs was 1 to 35.5.Interview with the Administrator on 02/19/26 at 12:27 P.M. verified the facility's overnight census, the overnight staffing records including the number of CNAs assigned to work the nights on 02/15/26 through 02/17/26, and the Administrator also verified the CNA to resident ratio's on 02/15/26 through 02/17/26. Review of the facility policy titled, Staffing Policy, dated 11/05/25, revealed the facility shall have a sufficient number of trained staff on duty. To determine the appropriate level of staff, consideration will be taken on the individual day-to-day resident needs and activity, and the intensity of staff assistance. There shall be sufficient number of trained staff members on duty to ensure each resident's physical, social, and emotional health, care, and safety needs are met in accordance with their individualized care plan. This deficiency represents non-compliance investigated under Complaint Number 2743940.