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	05/26/2026

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 medical record review, review of a fall investigation, staff interview, and policy review, the facility failed to make proper notifications after a fall. This affected one (#27) of three residents reviewed for falls. The facility census was 66.Findings include:Review of the medical record for Resident #27 revealed an admission date of 10/25/24 with diagnoses including chronic obstructive pulmonary disease, adult failure to thrive, repeated falls, and scoliosis.Review of the annual Minimum Data Set assessment, dated 03/24/26, revealed Resident #27 had intact cognition, required substantial/maximal assistance for personal hygiene, and was dependent on staff for toileting, moving from a sitting to standing position, transfers, and bed mobility. Further review revealed Resident #27 did not have a fall since the previous assessment.Review of a nursing progress note dated 04/08/26 revealed Resident #27's daughter came to the facility inquiring about the specifics of a fall Resident #27 sustained that neither she nor hospice were notified of. Review of the undated fall investigation revealed no indication Resident #27's representative was notified.Telephone interview on 05/19/26 at 11:01 A.M. with Registered Nurse (RN) #167 confirmed she was the nurse on duty during Resident #27's fall on 04/07/26. RN #167 stated it was a four-hour shift, and very busy, and further stated she did not notify the provider or Resident #27's representative of the fall. Additionally, RN #167 stated she did not tell the oncoming nurse about Resident #27's fall because there were so many things going on that night.Interview on 05/19/26 at 1:27 P.M. with the Director of Nursing (DON) confirmed notifications should have been made regarding Resident #27's fall on 04/07/26, and further confirmed timely notifications were not completed by the nurse on duty at the time of the fall.Review of the policy titled, Fall Prevention Program, approved 05/22/25, revealed physician and family will be notified after any resident experiences a fall. This deficiency represents non-compliance investigated under Complaint Number 2982457.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 medical record review, staff interview, and policy review, the facility failed to ensure residents were assessed for fall risk and were properly assessed following a fall. This affected one (#27) of three residents reviewed for falls. The facility census was 66.Findings include: Review of the medical record for Resident #27 revealed an admission date of 10/25/24 with diagnoses of chronic obstructive pulmonary disease, adult failure to thrive, repeated falls, and scoliosis. Review of the annual MDS assessment, dated 03/24/26, revealed Resident #27 had intact cognition, required substantial/maximal assistance for personal hygiene, and was dependent on staff for toileting, moving from a sitting to standing position, transfers, and bed mobility. Further review revealed Resident #27 did not have a fall since the previous assessment. Review of the fall risk evaluation, dated 06/02/25, revealed Resident #27 was at risk for falls. Review of a nursing progress note dated 04/08/26 revealed Resident #27's daughter came to the facility inquiring about the specifics of a fall Resident #27 sustained that neither she nor hospice were notified of and indicated she had footage of her mother falling out of bed and being returned to bed without being assessed. Review of Resident #27's electronic medical record revealed no evidence neurological checks were completed and no evidence a fall assessment was completed after the fall on 04/07/26. Telephone interview on 05/19/26 at 11:01 A.M. with Registered Nurse (RN) #167 revealed she worked on 04/07/26 when Resident #27 had an unwitnessed fall. RN #167 stated after the fall, she checked Resident #27's vital signs and orientation. RN #167 stated she did not perform range of motion prior to moving Resident #27, with assistance from additional staff, from the floor to the bed. Additionally, RN #167 stated she did not initiate neurological checks after the unwitnessed fall because Resident #27 was able to answer all orientation questions appropriately (such as name, date, time, and location). Interview on 05/19/26 at 1:27 P.M. with the Director of Nursing (DON) verified Resident #27 was not assessed appropriately after the unwitnessed fall on 04/07/26, and neurological assessments were not completed. Interview on 05/20/26 at 8:48 A.M. with the DON and concurrent review of Resident #27's fall investigation revealed the cause of the fall was recent medication changes causing acute confusion. The DON further confirmed the medication changes resulted from Resident #27's narcotic pain medication Percocet order not being refilled timely prior to 04/07/26, and Resident #27 not receiving five doses of Percocet; Resident #27 therefore received four doses of as needed narcotic pain medication Dilaudid resulting in the medication changes and acute confusion leading to the fall on 04/07/26. Interview on 05/26/25 at 10:20 A.M. with the DON confirmed fall risk evaluations were not completed every 90 days for Resident #27. Review of the policy titled, Fall Prevention Program, effective 05/22/25, revealed each resident will (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be assessed for fall risk every 90 days and as indicated when the resident's condition changes. Further, the policy stated when a resident experiences a fall, the facility will assess the resident, complete a post-fall assessment, and document all assessments and actions. This deficiency represents non-compliance investigated under Complaint Number 2982457.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and review of a facility policy, the facility failed to ensure residents had accurate orders for and received pertinent medications to provide effective pain management. This affected two (#18 and #27) of three residents reviewed for pain. The facility census was 66.Findings include: 1. Review of the medical record for Resident #18 revealed she was admitted on [DATE] with diagnoses including acute kidney injury, adjustment disorder, need for assistance with personal care, anxiety, irritable bowel syndrome, cerebral infarction, and type two diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #18 revealed she was cognitively intact, did not display any behaviors, and did not refuse care. She required supervision to maximal assistance with activities of daily living. She indicated her worst pain was eight on a scale of one to 10 and her pain occasionally interfered with her daily activities and sleep. Review of physician orders for Resident #18 revealed an active order dated 10/22/25 for 50 milligrams (mg) of tramadol to be administered every eight hours as needed for pain for three days. Review of medication administration records (MARs) for Resident #18 from October 2025 through February 2026 revealed duplicate orders for tramadol were concurrently active. In addition to the order noted above dated 10/22/25, there was an order dated 04/25/25 through 02/25/26 for 50 mg of tramadol to be administered as needed up to three times daily for pain. Review of the MAR for Resident #18 for December 2025 revealed 50 mg of tramadol was administered on 12/15/25 against the order dated 10/22/25 that was written for three days only. Review of the MAR for Resident #18 for January 2026 revealed 50 mg of tramadol was administered twice on 01/05/26 and once on 01/27/26 against the order dated 04/25/25. Additionally, 50 mg of tramadol was administered once on 01/25/26 against the order dated 10/22/25 that was written for three days only. Review of the MAR for Resident #18 for February 2026 revealed 50 mg of tramadol was administered on 02/08/26, 02/29/26, 02/18/26, 02/23/26, 02/25/26, 02/26/26, and 02/27/26 against the order dated 10/22/25 that was written for three days only. Additionally, 50 mg of tramadol was administered once on 02/23/25 against the order dated 04/26/25. Review of the MAR for Resident #18 for March 2026 revealed 50 mg of tramadol was administered eight times against the order dated 10/22/25 that was written for three days only. Review of the MAR for Resident #18 for April 2026 revealed 50 mg of tramadol was administered once against the order dated 10/22/25 that was written for three days only. Review of the MAR for Resident #18 for May 2026 revealed 50 mg of tramadol was administered twice against the order dated 10/22/25 that was written for three days only. Interview on 05/20/26 with the Director of Nursing (DON) confirmed there were two active orders for (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tramadol as needed from 10/22/25 through 02/25/26. Continued interview confirmed the order dated 10/22/25, written for three days only, was still being used to administer the tramadol. Review of facility policy titled, Medication Administration, dated 12/20/25, revealed the facility would administer medications as ordered by the physician. 2. Review of the medical record for Resident #27 revealed an admission date of 10/25/24 with diagnoses of chronic obstructive pulmonary disease, adult failure to thrive, repeated falls, and scoliosis. Review of the annual MDS assessment, dated 03/24/26, revealed Resident #27 had intact cognition, required substantial/maximal assistance for personal hygiene, and was dependent on staff for toileting, moving from a sitting to standing position, transfers, and bed mobility. Review of the physician order dated 10/27/25 revealed Resident #27 received the narcotic pain medication Percocet oral tablet 10-325 milligrams with instructions to give one tablet by mouth every four hours for pain. Review of the physician order initiated 10/27/25 and discontinued 05/15/26 revealed Resident #27 was prescribed a different narcotic pain medication, Dilaudid oral liquid one (1) mg/milliliter (ml) with instructions to give three (3) ml by mouth every two hours as needed for pain. Review of the MAR, dated April 2026, revealed Resident #27 did not receive five doses of Percocet on 04/07/26 at 12:00 A.M., at 4:00 A.M., at 8:00 A.M., at 12:00 P.M., and at 4:00 P.M. Further review revealed Resident #27 received four doses of Dilaudid on 04/07/26 at 6:00 A.M. (pain level two), at 10:16 A.M. (pain level nine), at 2:46 P.M., (pain level eight), and at 5:02 P.M. (pain level six). Further review of the April 2026 MAR revealed Resident #27's pain levels ranged from zero to nine most days. Interview on 05/17/26 at 2:28 P.M. with Licensed Practical Nurse (LPN) #182 confirmed Resident #27's Percocet was not ordered by facility staff and was not available on 04/07/26. LPN #182 stated she was the usual nurse on the hall, but did not work on the hall 04/06/26 or 04/07/27. Interview on 05/19/26 at 4:38 P.M. with LPN #177 revealed she worked 04/07/26 and received in report from the night nurse the facility should provide Dilaudid while Percocet was out of stock. Additionally, LPN #177 stated hospice staff visited Resident #27 on 04/07/26 and further reiterated to LPN #177 to use Dilaudid until Percocet was delivered. Interview on 05/19/26 at 1:27 P.M. with the DON confirmed the facility staff and hospice staff were expected to coordinate to ensure residents medications remained restocked and available. Interview on 05/19/26 at 1:31 P.M. with RN #152 and concurrent review of Resident #27's April 2026 MAR confirmed five doses of Percocet were not given on 04/07/26. Interview on 05/26/26 at 9:58 A.M. with the DON revealed the Dilaudid was not given every four hours on 04/07/26 because the received order did not specifically indicate the Dialudid should be given every four hours. The DON stated the order was to use as-needed Dilaudid until the Percocet was replaced. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number 2982457.