

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/22/2025
NAME OF PROVIDER OR SUPPLIER  Franklin Plaza Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE  3600 Franklin Boulevard Cleveland, OH 44113	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on resident and staff interviews, observation, review of the facility's Self-Reported Incident (SRI) and investigation, record review, and review of the facility policy, the facility failed to thoroughly investigate an allegation of resident-to-resident sexual abuse. This affected one (Resident #1) of three residents reviewed for sexual abuse. The facility census was 165. Findings include: Record review for Resident #1 revealed an admission date of 05/30/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle weakness and cognitive communication deficit. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 was moderately cognitively impaired. Resident #1 used a walker for mobility and was independent with ambulation and dressing. Resident #1 had no hallucinations or delusions. The Smoking Evaluation dated 10/03/25 revealed Resident #1 required supervised smoking. Record review for Resident #2 revealed an admission date of 03/04/25. Diagnoses included injury of the head and essential hypertension. Record review revealed Resident #2 was Resident #1's roommate. The quarterly MDS assessment dated [DATE] revealed Resident #2's short- and long-term memory was ok. Resident #2 was able to recall the season, location of room, staff names and faces, and they were in a nursing home. Record review for Resident #93 revealed an admission date of 06/17/21. Diagnoses included type two diabetes mellitus, cognitive communication deficit, and nicotine dependence. The quarterly MDS assessment dated [DATE] revealed Resident #93 was cognitively intact. Resident #93 was independent with eating, used a walker for mobility and was independent for chair/bed to chair transfers. Resident #93 had no hallucinations or delusions and had no behavioral symptoms directed towards others. The Smoking Evaluation dated 09/02/25 revealed Resident #93 required supervised smoking. Review of the SRI tracking number 266056 dated 10/06/25 at 2:08 P.M. created by the Director of Nursing (DON) revealed an allegation of sexual abuse involving Resident #1. There was no effect on the resident and also revealed there was no perpetrator. The narrative summary included Resident #1's husband reported to the Administrator he received a voicemail stating another resident (#93) pulled his wife's (Resident #1) pants down and touched her. The husband played the voicemail which was left by another resident. Resident #1 refused to go to the hospital stating no one touched her, revealing another resident (#93) pulled at her pants in a joking manner. Resident #1 initially revealed it was during smoke break then revealed it was not during the smoke break, it was in the common area. Resident #1 could not recall if anyone else was around. The DON and Administrator interviewed named Resident #93 (male resident) who stated nothing happened, they were sitting near each other making jokes but he never touched her. The allegation was unsubstantiated. Review of the typed statement dated 10/06/25 signed by the DON and Administrator included Resident #1 stated that yesterday after smoke break her and Resident #93 were sitting in the common area and he made a joke about pulling her pants down. Ahe stated she could not remember if anyone else was around. Review of the typed statement dated 10/07/25 signed by the DON and Administrator included Resident #93 stated that after smoke break</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>they (#1 and #93) were both sitting in the common area and talking. Resident #93 stated they were joking around but he never touched her. Resident #93 stated he was told she was telling people he pulled her pants down. Resident #93 denied the allegation and revealed there were no staff or other residents in the area at that time. The facility's investigation did not have any staff statements and did not identify what staff members supervised smoke breaks on 10/05/25, did not include staff statements to identify who assisted with smoke breaks on 10/05/25, and did not identify who worked with Residents #1 and #93 to investigate if anyone staff members heard or witnessed the incident. The investigation did not have Resident #2's statement who reported it to Resident #1's husband. Interview and observation on 10/22/25 at 10:22 A.M. revealed Resident #1 was well groomed and sitting on the edge of her bed. Resident #1 revealed there was a man who pulled her pants down, he would go out to smoke with the smoking group. Resident #1 revealed he did not touch her private area and stated, He just came up from behind me and pulled them down. Resident #1 demonstrated while stating that he grabbed the sides of her pants and pulled them down to her lower thighs. Resident #1 stated she told him (#93), You're an idiot pulled her pants up and went directly to her room. Resident #1 confirmed she was upset and when she returned to her room, her roommate (Resident #2) was present and discussed why she was so upset. Resident #1 stated she forgets things but not that. Resident #1 stated he (Resident #93) was just joking or something. Interview on 10/22/25 at 10:39 A.M. with Resident #2 stated her roommate (Resident #1) was sexually assaulted on 10/05/25 and she came up to their room upset. Resident #2 stated Resident #1 came from smoking, she was crying, she said she was grabbed by the waist, he (Resident #93) pulled her (Resident #1) pants down and grabbed her 'private'. Resident #2 revealed Resident #1's husband came the following morning. Interview on 10/22/25 at 11:32 A.M. with the Administrator revealed Resident #2 reported the allegation to Resident #1's husband via telephone. An SRI was initiated, and the allegation was investigated. The SRI was unsubstantiated. Resident #1 refused to go to the hospital for an evaluation. The Administrator revealed the incident occurred where residents wait to go outside to smoke according to Resident #1. Resident #93 denied he pulled her pants down and said there were no witnesses. The Administrator stated Resident #1 said 'someone' pulled her pants down, and Resident #1 could not remember who did it. Resident said the resident was joking. Interview on 10/22/25 at 1:31 P.M. with the DON revealed she interviewed Resident #1 with her husband and the Administrator. The DON stated she asked Resident #1 what happened and Resident #1 said after the smoke break, her and a guy (#93) were sitting in the common area near where the residents go out to smoke. Resident #1 said he (#93) pulled her pants down. She asked if he touched her inappropriately (in her private area), she stated no. The DON told Resident #1 the facility would send her to the hospital for an evaluation. Resident #1 refused and said no one touched her, they were joking around. The DON confirmed Resident #1 told her that he pulled her pants down but did not touch her private area. The DON confirmed there were no staff interviewed regarding the incident or for potential like behaviors from Resident #93 with other residents. The DON stated Resident #1 had never made up stories in the past while residing at the facility. The DON confirmed the facility's investigation did not have any staff interviews and confirmed no staff were interviewed regarding the incident or any potential like incidents. The DON confirmed the facility did not interview the residents and staff who went on the same smoke break as Resident #1 and #93. The DON confirmed the police was not called regarding the incident. Observation on 10/22/25 at 1:44 P.M. revealed a small room near the exit to the smoking area. Observation revealed eight residents were outside smoking. Resident #1 and #93 were present but not near each other. Activities Assistant #395 was also present and assisted residents' back into the facility from the smoking break. Resident #93 ambulated with a</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>steady gait while using a walker without staff assistance. Review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 01/06/25 revealed it is the facility's policy to investigate all alleged violations involving abuse, neglect, misappropriation of resident property, exploitation or mistreatment including injuries of unknown source. Facility staff should immediately report all such allegations to the Ohio Department of Health (ODH). In cases where a crime is suspected, the Administrator will report the same to local law enforcement. Sexual Abuse included non-consensual sexual contact of any type with a resident. The investigation protocol included to interview the resident, the accused and all witnesses. Witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members), and employees who worked closely with the accused employees and or alleged victim the day of the incident. If there are no direct witnesses, then the interviews may be expanded. For example, you may wish to interview all employees on the shift or the unit, as appropriate, as well as other residents on the unit. This deficiency represents non-compliance investigated under Complaint Number 2647625.</p>