STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365388	A. Building B. Wing	09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Plaza Extended Care	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure a safe, clean, comfortable and homelike environment for six (Residents #18, #146, #130, #65, #87 and #102) of 12 residents reviewed for environment. This had the potential to affect all residents residing in the facility. The facility census was 163. Findings include:1. 1. review of the medical record revealed Resident #130 was admitted to the facility on [DATE] with diagnoses including type II diabetes, injury of head, major depressive disorder, long term use of hypoglycemic, long-term use of inhaled steroids, hypertension, sciatica, adult failure to thrive, chronic pain, lack of coordination, history of falling, and reduced mobility. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #130's cognition was intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Resident #130 did not reject care or hallucinate or display delusional behaviors. Resident #130 was independent for toileting hygiene, independent to transfer to the toilet and to walk ten feet. Resident #130 was occasionally incontinent of urine and always continent of bowel. Observation on 08/28/25 at 10:40 A.M. revealed the door of the shared bathroom with Resident #18 revealed a sign posted on the bathroom door indicating that the toilet was out of order and directed Resident #130 to use the shower room toilet. Inside Resident #130's bathroom the toilet was nonfunctional and covered with a plastic sheet. Behind the toilet the wall exhibited visible damage of ceramic tiles that were displaced and protruded from the wall and floor that created an uneven edge. Interview on 08/28/25 at 10:45 A.M. with the Administrator verified the toilet was backed up and unsafe to use. The Administrator stated Resident #130 was not to use the common area bathroom that was two doors down from her room because there was no call light in the bathroom; therefore, it was unsafe for Resident #130 to use. Resident #130 was provided with a bedside commode and was to use the shower room. Observation on 08/28/25 at 10:50 A.M. revealed the common area was located two doors away from Resident #130's room. The common area had a restroom located in the room, the door was locked and had a sign posted on the door that read Visitors Restroom Only. The word visitors was circled multiple times, emphasizing restricted access for non-visitors. Housekeeping Supervisor #642 retrieved a key from the nurse's station to unlock the door and provide access to the common area restroom. The restroom was observed to be clean and orderly. A functional call light was positioned adjacent to the toilet; the call light was intact and available for use. At the nurse's station, the Administrator and Maintenance Director #772 confirmed that the call light within the restroom successfully rang, indicating the system was operable and able to alert staff when assistance was needed. Interview on 08/28/25 at 10:53 A.M. with Resident #130 revealed she could not use the bathroom in her room for the past two months. She stated sometimes she was incontinent and could not make it to the shower room. Resident #130 stated she felt this was inhumane and stated she asked to use the common area bathroom but was told it was for visitors only. Resident #130 stated she liked her room location and did not want to move. Resident #130 also stated she could not use the toilet shower because she did not know the code for using the room. On 08/28/25 at 11:00 A.M. the Administrator verified residents did not know the code for the shower room, and only staff had access to the shower room code. Observation on 08/28/25 at 11:08 A.M. of the 400-unit shower room revealed the shower room was situated approximately 20 steps from Resident #130's room. Upon entering the shower room, the toilet was non-functional due to a blockage. Fecal matter was within the toilet preventing flushing. Maintenance Director #772 confirmed the toilet was plugged and was not working until repairs were completed. Interview with the Administrator on 08/28/25 at 3:40 P.M. revealed the facility was aware of the sinking toilet in Resident #130's room, but the plumber was on vacation. 2. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including type II diabetes, pressure ulcer of right buttocks, hypertensive chronic kidney disease, atrial fibrillation, spinal stenosis, Cauda Equina, schizoaffective disorder, cerebral infarction, and anxiety disorder. Review of the MDS 3.0 admission assessment dated [DATE] revealed Resident #18's cognition was intact (BIMS 15/15). Resident #18 did not exhibit hallucinations or delusions and did not reject care. Resident #18 needed maximum assistance for toilet transfers and did not attempt to walk ten feet. Observation on 08/28/25 at 10:45 A.M. revealed a sign on Resident #18's bathroom door that stated, Out of Order use Shower Room. The Administrator verified Resident #18's toilet was shared with Resident #130 and was backed up, and the tiles behind the toilet were coming up that made the toilet unsafe to use. 3. Review of the medical record revealed Resident #146 was

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, time punch review and review of the facility policy, the facility failed to ensure timely incontinence care was provided. This affected one (Resident #156) out of two residents reviewed for incontinence care. This had the potential to affect 63 (Residents #1, #2, #3, #6, #9, #13, #22, #26, #30, #31, #36, #37, #39, #44, #50, #53, #55, #57, #58, #59, #60, #67, #70, #73, #78, #81, #89, #91, #92, #97, #99, #100, #103, #105, #114, #117, #125, #126, #128, #131, #133, #134, #135, #138, #140, #143, #144, #145, #150, #154, #155, #156, #157, #158, #160, #161, #162, #165, #167, #168, #170, #171, and #174) identified by the facility as incontinent. The facility census was 163. Findings include: Review of the medical record for Resident #156 revealed an admission date of 09/09/22 with diagnoses including congestive heart failure, diabetes, dementia, and adult failure to thrive. Review of the care plan dated 09/26/22 revealed Resident #156 had an activities of daily living self-care mobility and performance deficit related to impaired physical mobility, weakness, and cognitive deficit. Interventions included staff was to provide total assistance with toileting hygiene, and she required assistance with bed mobility. Review of the care plan dated 09/26/22 revealed Resident #156 had bladder incontinence related to dementia, impaired mobility, and diabetes. Interventions included check for wetness before and after meals, at night and on rounds during the night, monitor for signs of urinary tract infection, and note any changes in urine including amount, frequency and odor. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #156 had impaired cognition. She was dependent on staff for toileting hygiene, personal hygiene, rolling left and right and transfers. She was always incontinent with bowel and bladder. Review of the time punch report dated 08/25/25 revealed Certified Nursing Assistant (CNA) #746 had punched in on 08/25/25 at 7:00 A.M. Observation on 08/25/25 at 10:04 A.M. revealed upon entrance into Resident #156's room a strong foul urine smell was identified, and Resident #156 was lying in bed positioned on her side towards the wall partially uncovered. Resident #156's gown was noted to have yellow-brownish stains from her left hip region all the way up under her shoulder/back region. Attempts interview Resident #156 were unsuccessful due to cognitive impairment. Interview on 08/25/25 at 10:09 A.M. with Registered Nurse (RN) #674 verified the yellow-brownish stains on Resident #156 were from dried urine. She revealed Resident #156 had not been changed for a while to have dried urine stains from her buttocks to her shoulder region. Interview on 08/25/25 at 10:10 A.M. with CNA #746 revealed she was assigned to Resident #156 and was called into the facility to work as it was her day off. She revealed she thought she had punched-in around 8:00 A.M. but was unsure of exact time. She was unsure when the last time Resident #156 was changed, but she had not changed her since her arrival at the facility. She revealed she was unsure who was assigned to Resident #156 prior to her as she did not receive report of when the last time Resident #156 was changed. Observation on 08/25/25 at 10:14 A.M. of incontinence care for Resident #156 completed by CNA #746 revealed Resident #156 had dried yellow-brownish discolorations to her gown from her buttocks to her shoulder as well as a large yellow-brownish ring to her washable under pad that was laying underneath her, and her incontinence brief was moderately saturated in urine. CNA #746 verified the above findings and revealed Resident #156 appeared to have urinated several times since the last time she was changed. Interview on 08/25/25 at 2:32 P.M. with the Director of Nursing (DON) revealed CNA #746 was assigned to Resident #156 on 08/25/25 at 7:00 A.M. and that was what her time clock punch revealed. She revealed she was unsure why CNA #746 stated she had not started work until 8:00 A.M. She verified CNA #746 should have provided incontinence care prior to 10:14 A.M., and Resident #156 should not have had dried yellow-brown urine stains if timely incontinence care was provided. Review of the facility policy labeled, Incontinence Care, dated 01/06/25, revealed the purpose of the policy was to keep the resident's skin clean, dry, free of irritation, and odor, identify skin problems as soon as possible, prevent skin breakdown, and prevent infection. The policy did not identify frequency incontinence care was to be completed. This deficiency represents non-compliance investigated under Complaint Number 2588569.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and job description review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for Resident #26. This affected one (Resident #26) of two residents investigated for medically related social services. The facility census was 163. Findings include:Review of the medical record for Resident #26 revealed he was admitted on [DATE] with diagnoses of schizoaffective disorder, alcohol dependence with alcohol-induced persisting dementia, alcohol dependence with alcohol-induced persisting amnestic disorder, bipolar disorder, delusional disorders, paranoid personality disorder, hearing loss, legal blindness. Pertinent orders for August 2025 in the medical record included Risperdal Oral Tablet 0.5 milligrams (mg) (Risperidone) give 0.5 mg (antipsychotic) by mouth two times a day for schizophrenia, Advanced Directives: Do Not Hospitalize, no percutaneous endoscopic gastrostomy (PEG) tube per legal guardian, Aricept tablet 10 mg (Donepezil HCl) ((medication to treat dementia) give one tablet by mouth one time a day for dementia. Review of the care plan for Resident #26 dated 01/24/17 revealed Resident #26 displayed impaired cognitive function/impaired thought processes due to dementia and impaired decision making. Review of the Minimum Data Set (MDS) 3.0 assessment for Resident #26 dated 07/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The MDS also revealed Resident #26 was dependent on staff for all activities of daily living (ADL) and required substantial/maximum assistance with mobility. Observation of Resident #26 on 08/26/2025 at 10:53 A.M. revealed his pleasant confusion and inability to participate in meaningful conversation. He was an unreliable historian during an attempted interview at this time. He did not make eye contact and was unable to follow simple directions during the attempted interview. On 08/26/25 at 11:00 A.M., a phone call was placed in an attempt to contact the primary contact person listed on Resident #26's face sheet for representative interview, an employee at Adult Protective Services (APS). The unnamed person who answered the phone stated that the primary contact listed on Resident #26's face sheet no longer worked at APS. A call was then placed to the APS hotline to confirm; spoke with a representative who confirmed resident #26's primary contact no longer worked for APS, and they had no active case for Resident #26 since a legal guardian was appointed in March 2023. A call was then placed to the Cuyahoga County Probate Court for additional information and confirmed Resident #26's legal guardian resigned, and the Probate Judge confirmed the resignation in July 2024. These court documents were uploaded into Resident #26's medical record. Interview with Social Worker #788 on 08/26/2025 at 2:40 P.M. revealed multiple people were responsible for making sure the medical record was correct. Social Worker #788 went on to say when she received updated information, she updated the record. She further confirmed that no one was responsible for Resident #26. She stated several people dropped ball regarding Resident #26. She was unaware who staff called for changes in Resident #26's condition, who authorized his money to be spent, or who represented him at his annual Medicaid redetermination. She also confirmed incorrect and outdated emergency contact information on Resident #26's face sheet and confirmed Resident #26's medical record contained direction for staff to refer to the legal guardian for direction about hospitalization and other medical interventions. An additional interview with Social Worker #788 on 08/26/2025 at 4:09 P.M. revealed the former business office manager uploaded documents to the medical record when the guardian resigned. Review of Social Worker #788's job description revealed the Social Worker is required to ensure medically related social services are provided to maintain or improve each resident's ability to control everyday mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose). The job description also stated the Social Worker is responsible to address the residents' need for legal services and to refer residents/families to appropriate social service agencies when the facility does not provide the services or needs of the resident. This deficiency represents noncompliance investigated under Complaint Number 2588569.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility policy review, the facility failed to maintain the kitchen area in a clean and sanitary manner and failed to ensure foods were labeled and dated properly. This had the potential to affect all but four (Residents #3, #158, #99 and #153) identified by the facility who received nothing by mouth and did not receive food from the kitchen. The facility census was 163. Findings include:Tour of the facility kitchen area on 08/25/25 between 8:28 A.M. and 9:00 A.M. with Dietary Manager (DM) #713 revealed the following undated containers of the following in the walk-in cooler including: Four cups of milk 12 bowls of chocolate pudding Nine cups of prune juice 28 bowls of Jell-O Two chocolate pies in original packaging with broken seals A brown, crusty substance stuck on the outside of nine cups and 12 bowls in the walk-in cooler. A large amount of greasy food residue on the left outside wall of an oven. DM #713 was unable to say when that oven was last cleaned. Black spotted substance on right inside wall of ice bin; DM #713 stated it appears to be mold. All of the above findings were confirmed by the Dietary Manager #713 upon discovery during the initial kitchen tour on 08/25/25. Review of the undated policy entitled Food Preparation and Storage revealed food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and keep free of harmful organisms and substances. The policy also stated foods will be received, checked and stored properly as soon as they are delivered and food in broken packages or swollen or dented cans, cans with a compromised seal, or food with an abnormal appearance or odor will not be served. This deficiency represents noncompliance investigated under Complaint Number 2560412.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility policy, the facility failed to ensure a safe, functional, sanitary and comfortable environment. This affected 10 (Residents #11, #37, #53, #94, #103, #143, #144 #155, #156, and #160) out of 12 residents reviewed for environment and had the potential to affect all residents residing in the facility. The facility census was 163. Findings include:1. Review of the medical record for Resident #53 revealed an admission date of 03/30/23 with diagnoses including diabetes, anxiety, and chronic obstructive pulmonary disease (COPD). Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had impaired cognition. Observation on 08/25/25 at 9:41 A.M. revealed Resident #53 was lying in bed and above his bed was a large circular brown stain approximately one foot (ft) by one ft. Attempts to interview Resident #53 were unsuccessful due to his cognitive ability. Interview and observation with the Administrator and Maintenance Director #772 on 08/28/25 at 10:06 A.M. verified the large circular brown stain above Resident #53's bed. Maintenance Director #772 revealed the stain was from an old water leak but he started in July 2025, and he was not aware of the stained ceiling tile. Observation on 09/02/25 at 9:28 A.M. revealed Resident #53's ceiling tile above his bed remained with a large circular brown stain. 2. Review of the medical record for Resident #94 revealed an admission date of 08/06/21 with diagnoses including schizoaffective disorder, Parkinson's disease, and dementia. Review of the quarterly MDS dated [DATE] revealed Resident #94 had impaired cognition as he was rarely or never understood. Observation on 08/25/25 at 9:43 A.M. revealed Resident #94's bathroom was missing two ceiling tiles (approximately two ft by four ft each) in the bathroom exposing a large hole in the ceiling and plumbing pipes. The ceiling tile in the center of the bathroom had a large circular brown stain approximately one ft by one ft. Attempts to interview Resident #94 were unsuccessful due to his cognitive ability. Interview on 08/25/25 at 9:44 A.M. with Certified Nursing Assistant (CNA) #767 verified there were missing ceiling tiles exposing the plumping fixtures and a stained ceiling tile in the center in Resident #94's bathroom. He revealed Resident #94's tiles were missing and/or stained for about a month. Interview and observation with the Administrator and Maintenance Director #772 on 08/28/25 at 10:06 A.M. verified the missing and stained tiles in Resident #94's bathroom. Maintenance Director #772 revealed he was not aware. Observation on 09/02/25 at 9:29 A.M. revealed Resident #94's bathroom continued to have two missing tiles exposing plumbing fixtures, and the ceiling tile in the center was stained. 3. Review of the medical record for Resident #156 revealed an admission date of 09/09/22 with diagnoses including congestive heart failure, diabetes, dementia, and adult failure to thrive. Review of the annual MDS assessment dated [DATE] revealed Resident #156 had impaired cognition. She was dependent on staff for toileting hygiene, personal hygiene, rolling left and right and transfers. She was always incontinent with bowel and bladder. Attempts to interview Resident #156 on 08/25/25 at 10:04 A.M. were unsuccessful due to cognitive impairment. Review of the medical record for Resident #103 revealed an admission date of 05/22/23 with diagnoses including dementia and diabetes. Review of the quarterly MDS assessment dated [DATE] revealed Resident #103 had impaired cognition. Observation on 08/25/25 at 10:04 A.M. revealed Residents #103 and #156's sink faucet in their room was running and unable to be turned off. Resident #156's telephone outlet cover by her bed was off and hanging with exposed wires. Resident #103 register cover by her bed was off and lying on the floor. Interview on 08/25/25 at 10:09 A.M. with Registered Nurse (RN) #674 verified the sink in Residents #103 and #156's room was moderately running and was unable to be turned off. RN #674 revealed the faucet had been constantly running and stated it had been like that for a while. She also verified the telephone outlet cover by Resident #156's bed was off with exposed wires, and the register cover by Resident #103's bed was off and on the floor. Observation on 08/25/25 at 10:14 A.M. of incontinence care for Resident #156 completed by CNA #746 revealed during the incontinence care she removed Resident #156's gown that had yellow-brown urine stains and put it on the floor. She then washed Resident #156 with a towel and put the towel on the floor. She then proceeded to rinse and dry Resident #156 and put both towels on the floor. She then removed the washable under pad that also had a yellow-brown urine stain and placed on the floor. After CNA #746 placed the items on the floor she revealed I know not supposed to throw on the floor, but I do not have a bag. She then proceeded to dry Resident #156 with a towel and put the towel on the floor. After applying a new incontinence brief, new washable under pad, gown, and sheet, she took a plastic bag out of her pocket and picked up the dirty towels, gown, sheet