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	10/22/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 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 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 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