

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/02/2025
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)		
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.		

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
--	-------	-----------

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 09/02/2025
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)		
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. **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, (continued on next page)		

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 09/02/2025
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, hypothyroidism, anemia, hypertension, gastro esophageal reflux, glaucoma, cataract, and hearing loss. Review of the MDS 3.0 annual assessment dated [DATE] revealed resident #146's cognition was intact (BIMS 13/15). Resident #146 did not display hallucinations or delusions and did not reject care. Resident #146 needed supervision for toilet transfers. Interview on 08/28/25 at 8:58 A.M. with Resident #146 revealed she was upset because the last two days her toilet was not working and did not flush. She stated she had to use the toilet in the shower room and had to wait for staff to let her in because she did not know the code for the shower room. Observation on 08/28/25 at 9:00 A.M. revealed Licensed Practical Nurse (LPN) #618 attempted to flush Resident #146's toilet, but it would not flush. LPN #618 stated she would let maintenance know. Interview on 08/28/25 at 10:31 A.M. with Resident #146 revealed she was concerned because her toilet did not flush in her room when she held the lever down. Observation on 08/28/25 at 10:32 A.M. with the Maintenance Director #772 verified the toilet did not flush. Maintenance Director #772 stated Resident #146's toilet was shut off, and she needed to use the toilet in the shower room. 4. Review of the medical record for Resident #87 revealed an admission date of 12/09/24 with diagnoses including diabetes, schizoaffective disorder, and diarrhea. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #87 had cognitive impairment and required supervision with toileting hygiene and was independent with transfers. He was occasionally incontinent of urine and bowel. Review of the care plan dated 12/20/24 revealed Resident #87 had activities of daily living self-care performance deficit related to impaired mobility, anxiety, and major depression. Interventions included Resident #87 transferred independently including toilet transfers, and staff was to provide supervision or touching assistance with toileting hygiene. Interview on 08/25/25 at 9:58 A.M. with Resident #87 verified there was bowel movement in his toilet as he revealed his toilet was not working. He was unable to flush it, and this had been an issue since he was admitted . He revealed he was upset because he did not have a working toilet to use as he did not know what to do. Review of the medical record for Resident #102 revealed an admission date of 05/28/21 with diagnoses including congestive heart failure, anxiety, dementia, and schizoaffective disorder. Review of the care plan dated 06/08/21 revealed Resident #102 had an activity of daily living self-care deficit related to dementia and weakness. Interventions included supervision or touching assistance with toilet transfer and toileting hygiene. Review of the quarterly MDS assessment dated [DATE] revealed Resident #102 had impaired cognition. He required supervision with toileting hygiene and transfers. He was occasionally incontinent with urine but always continent of bowel. Attempted interview on 08/25/25 at 9:56 A.M. with Resident #102, but he was unable to participate due to cognitive ability. Review of the medical record for Resident #65 revealed an admission date of 10/21/13 with diagnoses including paranoid schizophrenia, Alzheimer's disease, and constipation. Review of the care plan dated 06/08/21 revealed Resident #65 had an activity of daily living self-care deficit related to dementia and weakness. Interventions included supervision or touching assistance with toilet transfer and toileting hygiene. Review of the quarterly MDS assessment dated [DATE] revealed Resident #65 had impaired cognition. He required supervision with toileting hygiene and transfers. He was always continent of urine and bowel. Attempted interview on 08/25/25 at 10:02 A.M. with Resident #65, but he was unable to participate due to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/02/2025
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive ability. Observation on 08/25/25 at 9:58 A.M. in the bathroom shared by Residents #65, #87, and #102 revealed in the toilet was a moderate amount of bowel movement. Interview on 08/25/25 at 10:00 A.M. with Registered Nurse (RN) #674 verified the toilet was unable to flush, and she would notify maintenance. She verified Residents #65, #87, and #102 utilized the toilet. Interview and observation with the Administrator and Maintenance Director #772 on 08/28/25 at 10:09 A.M. verified there was bowel movement in the toilet in Residents #65, #87, and #102's bathroom. Maintenance Director #772 attempted to flush the toilet, and the toilet would not flush. Maintenance Director #772 revealed he was not aware the toilet was not working. He revealed he needed to schedule to shut off the water on non-dialysis days. Review of the facility policy labeled, Resident Rights and Facility Responsibilities, dated 01/06/25, revealed the rights of residents of a home shall include the right to safe and clean-living environment which included lightly, sound, closet space, clean bed and lines and general maintenance of sanitary interior. This deficiency represents non-compliance investigated under Master Complaint Number 2603375 and Complaint Numbers 2589394 and 2568834.		

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 09/02/2025
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)		
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. **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 plumbing 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 (continued on next page)		

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 09/02/2025
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#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, washable under pad that she had placed on the floor and placed them in the bag. Interview on 08/25/25 at 10:22 A.M. with CNA #746 verified she should not have put the dirty linens on the floor. Interview on 08/25/25 at 2:32 P.M. with the Director of Nursing (DON) verified dirty linen should not be placed on the floor as this was an infection control issue. Observation on 08/26/25 at 8:35 A.M., 08/26/25 at 1:31 P.M., 08/27/25 at 12:21 P.M., revealed the faucet in Resident #103 and #156's room was still running with a constant moderate flow and was unable to be shut off. Interview and observation with the Administrator and Maintenance Director #772 on 08/28/25 at 10:11 A.M. verified the faucet continued to run and was unable to be shut off. They also verified the telephone outlet cover by Resident #156's bed remained off with exposed wires. Maintenance Director #772 revealed he was not aware. 4. Review of the medical record for Resident #37 revealed an admission date of 04/14/14 with diagnoses including schizoaffective disorder, dementia, and chronic kidney disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #37 had impaired cognition. She required partial to moderate staff assistance with toileting hygiene and was frequently incontinent if urine. Attempted interview on 08/25/25 at 10:36 A.M. with Resident #37 was unsuccessful due to cognitive impairment. Observation on 08/25/25 at 10:36 A.M. revealed a strong pervasive urine odor in the hallway next to Residents #37 and #144's room. Observation revealed inside the bathroom of Residents #37 and #144's room was two disposable incontinent products lying on the floor next to the toilet. Observation and interview on 08/25/25 at 10:37 A.M. with CNA #746 revealed she walked into Resident #37 and #144's room and stated, wow and oh, that is strong as she took out of her pocket a spray scent deodorizer to cover up the pervasive smell. She verified there were two soiled incontinent briefs lying on the floor next to the toilet. She donned gloves to pick up the briefs and as she picked up the briefs she jumped back as several gnats flew out of the briefs. CNA #746 stated the incontinence briefs had to be lying on the floor a long time to have that many gnats on them. She revealed she believed the briefs belonged to Resident #37. 5. Review of medical record for Resident #143 revealed an admission date of 02/16/13 with diagnoses including dementia, schizoaffective disorder, and aphasia following cerebrovascular disease. Review of the quarterly MDS dated [DATE] revealed Resident #143 had impaired cognition as he was rarely or never understood. Observation on 08/25/25 at 11:20 A.M. revealed Resident #143 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. Attempted interview with Resident #143 was unsuccessful due to cognitive impairment. Interview and observation with the Administrator and Maintenance Director #772 on 08/28/25 at 10:17 A.M. verified Resident #143's bathroom was missing two ceiling tiles exposing a large hole in the ceiling and plumbing pipes. Maintenance Director #772 revealed he was not aware. Observation on 09/02/25 at 9:43 A.M. revealed Resident #143's bathroom continued to be missing two ceiling tiles. 6. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including hypertension, chronic kidney disease, congestive heart failure, type two diabetes, chronic pulmonary disease, anemia, depression and lymphedema. Review of the quarterly MDS assessment dated [DATE] revealed Resident #11's cognition was intact. Resident #11 had no hallucinations or delusions, and rejection of care was not exhibited. Observation on 08/28/25 at 10:42 A.M. of Resident #11's room revealed a plastic baseboard that led towards Resident #11's bathroom had a section peeled away from the wall that protruded outward. Maintenance Director #772 (continued on next page)		

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 09/02/2025
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verified the baseboard needed repaired at the time of the observation. 7. review of the medical record revealed Resident #155 was admitted to the facility on [DATE] with diagnoses including respiratory failure, type two diabetes, colostomy, chronic obstructive pulmonary disease, congestive heart failure, atherosclerotic heart disease, pulmonary hypertension, myocardial infarction, adjustment disorder, and dependence on oxygen. Review of the physician order dated 06/14/25 revealed Resident #155 was to have oxygen at three liters per minute via nasal cannula. Review of the quarterly MDS assessment dated [DATE] revealed Resident #155's cognition was intact. Resident #155 did not display hallucinations or delusions but had rejected care one to three days during the seven-day look back period. Observation on 08/28/25 at 10:35 A.M. of Resident #155's room revealed three empty oxygen tanks in the room. Housekeeping Supervisor #642 verified the three empty oxygen tanks in the room and stated nurse's aides were to take the oxygen tanks out of resident's rooms. 8. Review of the medical record revealed Resident #160 was admitted to the facility on [DATE] with diagnoses including fibromyalgia, multiple sclerosis, hyperlipidemia, neuromuscular dysfunction of bladder, hypothyroid, anxiety, borderline personality disorder, overactive bladder, difficulty walking, and lack of coordination. Review of the quarterly MDS assessment dated [DATE] revealed Resident #160's cognition was intact. Resident #160 did not exhibit hallucinations or delusions and did not reject care. Observation on 08/28/25 at 10:42 A.M. revealed Resident #160's door had a large circular area of chipped paint on its front surface. Maintenance Director #772 verified that the chipped region measured five by five (inches) and confirmed that the paint chip could be peeled off the door. 9. Observation on 08/28/25 at 10:20 A.M. revealed on floor tile block on the 200-hall by the receptionist desk had a loose tile that moved back and forth when stepped on. The Administrator verified the loose tile and stated the tile was loose due to the shifting of the building. 10. Observation on 08/08/25 at 10:25 P.M. of the Two [NAME] shower rooms revealed dark mildew on the shower's right wall and floor and four ceiling tiles exhibiting a blackish substance. The shower on the left side had rust like stains at the corners where the walls met. Maintenance Director #772 verified these findings and stated that the showers needed recaulking. Review of the undated facility document titled Room Inspection Checklist revealed housekeeping was to keep bathroom floors free of debris check all crevices, scrub and clean for mold and mildew, scrub and clean toilets and put in maintenance work-orders for wall patch paint any scuffs, chips, holes or damage. Review of the facility policy labeled, Resident Rights and Facility Responsibilities, dated 01/06/25, revealed the rights of residents of a home shall include the right to safe and clean-living environment which included lightly, sound, closet space, clean bed and lines and general maintenance of sanitary interior. Review of the facility policy labeled, Incontinence Care, dated 01/06/25, revealed to dispose of soiled linen appropriately but did not have anything in the policy not to place soiled linen on the floor. This deficiency represents non-compliance investigated under Master Complaint Number 2603375 and Complaint Numbers 2589394, 2568834 and 2560412.		

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 09/02/2025
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)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure advanced directives were accurate. This affected one (Resident #129) of one resident reviewed for advanced directives. The facility census was 163. Findings include: Medical record review revealed Resident #129 was admitted to the facility on [DATE] with diagnoses including type two diabetes, right foot ulcer, weakness, tachycardia, and gastro esophageal reflux. A Brief Interview for Mental Status (BIMS) dated [DATE] revealed a score of 15/15, which indicated Resident #129's cognition was intact. Further review of Resident #129's medical records revealed the electronic medical record and the hard copy chart included conflicting advanced directives. The electronic medical record physician orders dated [DATE] revealed an order for Do Not Resuscitate-Comfort Care (DNR-CC), this specified cardiopulmonary resuscitation (CPR) was not to be initiated in the case of cardiac arrest. The DNR-CC was ordered by the physician in the electronic medical record on admission [DATE]. Review of the hard copy medical record for Resident #129 revealed a DNR-CC form was in front of the medical record that was not signed by the physician or the resident. Review of the admission assessment dated [DATE] revealed Resident #129 was admitted to the facility on [DATE] at 8:00 P.M. The code status revealed Resident #129 was to be Full Code. Review of the care plan initiated on [DATE] revealed Resident #129 had chosen advanced directives of Full Code. The care plan was revised by Activities Director #637. Interventions included facility would review code status when significant change in condition warranted discussion. Interview on [DATE] at 10:13 A.M. with Registered Nurse (RN) #655, revealed nursing staff was to look in the electronic medical record or the front of the hard copy of the medical record to see what code status a resident was. RN #655 verified the DNR-CC form in Resident #129's hard copy medical record was not signed or filled out and the order in Resident #129's electronic medical record was DNR-CC. Interview on [DATE] at 10:29 A.M. with RN Shift Supervisor #651 verified a code status paper was located in the front of the hard copy medical record and verified the DNR-CC form for Resident #129 was not signed by the physician and should be signed by a physician. Interview with RN #655 on [DATE] at 10:50 A.M. revealed he spoke with Resident #129, and Resident #129 stated he wanted to be a Full Code and not a DNR-CC. Interview on [DATE] at 10:55 A.M. with Resident #129 revealed he wished to be a Full Code and wanted CPR to be done in the event of an emergency. Interview on [DATE] at 2:43 P.M. with Activities Director #637 verified she updated the advanced directive care plan to Full Code on [DATE] after she noticed the order was changed. Interview on [DATE] at 2:00 P.M. with the Administrator revealed the facility did not have a policy for advanced directives. Review of the facility policy titled Do Not Resuscitate Order, dated [DATE], revealed a Do Not Resuscitate (DNR-CC) order must be obtained by the resident's attending physician and the physician's order sheet maintained in the medical record. Review of DNR-CC Form would be completed upon admission, if not completed prior to admission.		

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 09/02/2025
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)		
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of facility policy, the facility failed to ensure Resident #59 was free from restraint. This affected one (Resident #59) out of one resident reviewed for use of a device/restraint. The facility census was 163. Findings include: Review of the medical record for Resident #59 revealed an admission date of 03/28/24 with diagnoses including schizoaffective disorder, dementia, severe protein calorie malnutrition, bilateral osteoarthritis of the hips, and history of falling. Review of the care plan dated 06/22/23 revealed Resident #59 wandered aimlessly and was disoriented. Interventions included distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and book, monitor for fatigue, and document wandering behavior. There was nothing in the care plan regarding tilting her wheelchair back, preventing her from getting up. Review of the care plan dated 06/23/23 revealed Resident #59 was at risk for falls due to dementia, history of falls, poor safety awareness, and weakness. Interventions included call light in reach, offer tabletop activities, restorative ambulation program, non-skid footwear, offer assistance with toileting and fall mat to floor. There was nothing in the care plan regarding tilting her wheelchair back, preventing her from getting up. Review of the care plan dated 10/05/23 revealed Resident #59 was on a restorative ambulation program for impaired physical mobility related to balance problems, cognitive deficit, limited endurance, limited range of motion, unsteady gait and weakness. Interventions included ambulation program three to seven days a week, prompting the resident to ambulate 50 feet with handheld assistance, encouragement to wear non-skid footwear, and monitoring the resident for fatigue. Review of the Occupational Therapy Discharge Summary, dated 02/06/25, completed by Rehabilitation Director/Occupational Therapist #675 revealed at discharge Resident #59 was able to transfer from bed to chair with minimal assist of one person. The discharge instructions were to use the tilt in space wheelchair when out of bed for meals and positioning out of bed. The geri chair (a chair that reclines back on wheels) was as needed when resident was restless or had behaviors lifting legs and hips causing it to be unsafe to stay in the tilt in space wheelchair. Review of the Restorative Enabler assessment dated [DATE] and completed by Restorative/Licensed Practical Nurse (LPN) #786 revealed under initial analysis the following devices were evaluated to determine impact on the resident's function: geri chair without tray, bed against wall, hi low bed, and transfer handlebar. The evaluation noted that none of the above devices restricted the freedom of Resident #59's movement. The assessment revealed Resident #59 had physical limitations as she required the assistance of one staff and her standing balance was fair. There was nothing in the assessment regarding the evaluation of her tilt in space wheelchair including if her wheelchair was tilted all the way back with leg rests above her waist. Review of the quarterly Minimum data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #59 had impaired cognition as she was rarely or never understood. She had behaviors including physical, verbal and other behaviors identified. She utilized a wheelchair and a walker. She required substantial to maximum assistance to transfer and partial to moderate assistance to ambulate up to 50 feet. She was not identified to have a restraint. Review of the August 2025 physician's orders revealed Resident #59 had an order for a tilt in space wheelchair for comfort and positioning, and geri chair while up for proper positioning, comfort and safety. There was nothing in the orders regarding frequency of reclining the wheelchair. Interview on 08/25/25 at 3:02 P.M. with Resident #59's son revealed that since she received the new wheelchair, staff always reclined it all the way back causing her feet to dangle preventing her from being able to get up. He revealed he was concerned Resident #59 was losing her ability to transfer and ambulate since they kept her in her chair almost upside down all day as that was how far they reclined the chair back. He revealed when he visited, he walked her all around the unit to try to maintain her strength and that she was able to ambulate by herself. (continued on next page)		

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 09/02/2025
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)		
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/26/25 at 1:53 P.M. revealed Resident #59 was in her a tilt in space wheelchair that was reclined all the way back with her footrests above her waist. Resident #59 was rocking back and forth in the chair appearing to sit upright. Interview on 08/26/25 at 1:55 P.M. with LPN #745 verified Resident #59's tilt in space wheelchair were reclined all the way back causing her footrests to be above her waist because she stated if the chair was not reclined Resident #59 will get up. LPN #745 revealed Resident #59 can ambulate by taking a few steps but would fall which was why they kept her chair reclined. Interview on 08/26/25 at 2:01 P.M. with Certified Nursing Assistant (CNA) #721 revealed she frequently was assigned Resident #59, and Resident #59 was able to stand and ambulate up to five minutes but at times was unsteady. She revealed she always kept her tilt in space wheelchair reclined all the way back because if Resident #59 sat upright, she would attempt to stand and possibly fall. Observation on 08/27/25 at 8:15 A.M. revealed Resident #59 was up in her tilt in space wheelchair sitting in the dining room. The chair was reclined all the way back with her feet at waist level. Observation on 08/27/25 at 8:30 A.M. revealed Resident #59 was sitting at the dining room table in her tilt in space wheelchair upright being assisted per CNA #744 with breakfast. Observation on 08/27/25 at 8:45 A.M. revealed after breakfast Resident #59 was taken to in front of the nursing station and her tilt in space wheelchair reclined back causing her leg rests to be above her waist. She was rocking back and forth attempting to sit upright. Interview on 08/27/25 at 8:46 A.M. with CNA #744 revealed she reclined Resident #59 back in her tilt in space wheelchair as she stated to stop from getting up. CNA #744 revealed Resident #59 can ambulate and stated she ambulated pretty good as she could ambulate throughout the unit. She revealed if Resident #59 ambulated on the unit, then she started pulling on the linen, pulling on other residents', and getting into things. She verified that was the reason they reclined her back in her chair. Interview on 08/27/25 at 11:24 A.M. with Director of Nursing (DON) revealed Resident #59 was reclined back in her chair for comfort and that it was not considered a restraint. Reviewed interviews (LPN #745, CNA #721, and CNA #744) with the DON as they had stated they reclined Resident #59 to prevent her from either ambulating, getting up, falling, getting into items, pulling on other residents' and/or getting into things. She verified based on the interviews how that can then appear as a restraint. Interview on 08/27/25 at 11:39 A.M. with Restorative/LPN #786 revealed he had been responsible for the restorative program for three years including looking at devices to see if they were a potential restraint. He verified he had completed the Restorative Enabler Assessment dated 06/25/25 for Resident #59 but he was unsure if he evaluated her tilt in space as a possible restraint. He verified the tilt in space wheelchair was not identified in the assessment. He was unsure if the tilt in space was reclined, if Resident #59 was able to get out of the chair, and he had not assessed if she could. He was asked if he remembered if he knew if she was on a restorative ambulation program and he stated he was unsure. Interview on 09/02/25 at 10:22 A.M. with Rehabilitation Director/Occupational Therapist #675 revealed she had consulted February 2025 when they had ordered and received Resident #59's new tilt in space wheelchair. She revealed they had recommended the tilt in space wheelchair especially for Resident #59 to sit upright with better posture to eat. Resident #59 was able to ambulate and was on a restorative ambulation program. They had not assessed Resident #59's tilt in space wheelchair for a potential restraint when in a reclined position. Review of the facility policy labeled, Resident Rights and Facility Responsibilities, dated 01/06/25, revealed residents had the right to be free from physical or chemical restraints or prolonged isolation except to the minimum extent necessary to protect the resident from injury to self, others or to property as authorized in writing by the attending physician for specified and limited period of time and documented in the resident's record. Prior to authorizing the use of a physical or chemical restraint the attending physician shall make a personal examination of the resident and an individualized determination of the need to use the restraint. Review of the facility policy labeled, Restraint and/ or Enabler, dated 01/06/25, revealed the definition of a physical restraint was defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/02/2025
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)		
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The policy revealed each time a device was considered for a resident the facility would determine how the device affects the resident. The facility would complete an enabler assessment to clearly define the benefit of the device and educate for proper use.		

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 09/02/2025
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to accurately complete resident assessments. This affected one (Resident #15) of three residents reviewed for resident assessments. The facility census was 163. Findings include: Review of the medical record for Resident #15 revealed an admission date of 09/02/11. Diagnoses included schizoaffective disorder bipolar type, bipolar disorder, anxiety disorder and dementia. Review of the significant change in condition Preadmission Screening and Resident Review (PASRR) identification screen completed on 01/18/22 due to a decline revealed Resident #15 had indications of serious mental illness and within the previous two years had utilized psychiatric services including emergency mental health services and inpatient psychiatric hospitalization due to the mental disorder. Review of the notice of PASRR level II outcome dated 01/24/22 revealed Resident #15 was approved for continued nursing facility services with recommended mental health services and supports put into place by the facility. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed section A1500 for PASRR was coded as no for Resident #15 being considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Review of the annual MDS assessment dated [DATE] revealed section A1500 for PASRR was coded as no for Resident #15 being considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Interview on 08/27/25 at 11:55 A.M. with MDS nurses, Licensed Practical Nurses (LPNs) #660, #738 and #800, verified Resident #15's annual MDS assessments dated 01/27/24 and 12/13/24 were inaccurately coded.		

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 09/02/2025
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and observations, the facility failed to revise care plans for Resident #62 and Resident #63. This affected two (Residents #62 and #63) of two residents reviewed for revision of care plans. The facility census was 163. Findings include: 1. Review of the medical record for Resident #62 revealed an admission date of 11/09/23 with diagnoses of malignant neoplasm of prostate, history of falling, need for assistance with personal care, anxiety disorder and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #62 was cognitively intact and had no history of falls. He required substantial assistance for toileting and supervision for showers. He had no recent falls. Review of the Annual MDS 3.0 dated 08/02/25 revealed Resident #62 was cognitively impaired. He required substantial assistance with toileting and set-up for showers. Review of progress note dated 12/26/24, timed for 3:22 P.M. revealed the team reviewed a fall from 12/25/24 at 12:00 P.M. Resident #62 was found on the floor between his bed and wheelchair with two skin tears behind his ear. Hospice was notified. Review of the fall assessment on 12/25/24 revealed Resident #62 was a high risk for falls. Review of the August 2025 orders for Resident #62 revealed an order dated 07/22/25 for bed against wall on right side for safety and an order dated 05/03/24 for Call don't fall sign in room. Review of the care plan initiated on 11/24/23 for Resident #62 revealed a care plan related to fall risk due, in part, to impaired balance and mobility, incontinence and poor coordination. Interventions included an electric high/low bed in low position at all times while the resident was lying in bed added 07/11/24 and call staff for assistance sign posted in room on wall added on 04/13/24. Review of restorative progress noted dated 08/02/25 and timed at 5:08 P.M. revealed device used was hi/low bed in low position. Review of the Annual Fall assessment dated [DATE] for Resident #63 revealed he was at a high risk for falls indicating he was unable to stand without physical assistance and was unsteady while standing without physical support. 2. Review of the medical record for Resident #63 revealed an admission date of 11/09/23 with diagnoses of dementia, arthritis and hyperlipidemia. Review of the orders for Resident #63 revealed an order dated 11/09/23 for a high/low bed with instructions to keep in low position except during care; an order dated 07/22/25 for call don't fall sign in room; and an order on 07/22/25 for bed against the right wall for safety. Review of the care plan dated 11/09/23 for Resident #63 revealed a care plan for fall risk related to confusion and impaired balance and mobility. Interventions included a high/low bed which was to be kept in low position except during care and visual reminder call don't fall sign posted in room. Review of progress notes dated 07/28/25 and dated 12:34 P.M. revealed the resident was complaining of back pain stating she had a fall on 07/25/25 around 5:00-6:00 P.M. but did not report it. Nursing continued to follow plan of care. Review of the annual MDS 3.0 dated 08/01/25 revealed she was cognitively intact. Observation on 08/25/25 at 11:03 A.M. revealed Resident #62 and Resident #63 lying in a bariatric bed together with the head of the bed positioned against the wall and the length of the bed positioned out toward the center of the room with approximately four feet of space on either side of the bed. No call staff for assistance sign was noted. Resident #62 was lying on the right side of Resident #62. The bed was in a standard height position. There was no other bed in the room. Interview on 08/25/25 at 11:14 A.M. with Certified Nursing Assistant (CNA) #606 verified Resident #62 and Resident #63 were sharing a bed and it was in the standard height position. Observation and interview on 08/27/25 at 10:54 A.M. revealed Resident #62 was alone in the bariatric bed which was in the standard position. Interview with CNA #606 verified the resident was in bed in standard position, and there was no signage on wall about asking for help. Interview on 08/27/25 at 11:07 A.M. with Registered Nurse (RN) #641 and RN #651 revealed the bed was new to the residents approximately three weeks ago per residents' request. They stated they thought hospice ordered the bed. Neither RN was sure about current fall (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/02/2025
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions. Review of Resident #62 and Resident #63's hard charts with RN #641 revealed hospice note dated 07/31/25 mentioning bariatric bed but no order. Further interview with RN #641 verified orders in the electronic medical record and hard chart, for both residents, had current orders for fall interventions (bed against wall, bed in low position); however, there was no order in either chart for bariatric bed. She also verified there was no care plan revisions about falls or any mention of their preference to share a bed. Subsequent interview on 08/27/25 at 11:31 A.M. with RN #641 revealed she spoke to hospice nurse who stated she gave a verbal order for the bed but not a written order. Interview and review of the orders and care plan on 08/27/25 at 12:13 P.M. with Director of Nursing (DON) verified there were no revisions made to the care plan and the orders were not added or changed.		

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 09/02/2025
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)		
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. **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, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/02/2025
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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		

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 09/02/2025
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)		
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, facility policy review and review of facility staff training, the facility failed to provide trauma-informed care to Residents #17 and #28. This affected two (Residents #17 and #28) out of two residents reviewed for trauma-informed care. The facility reported nine Residents #2, #4, #17, #18, #28, #74, #93, #117 and #119) who had trauma-related diagnoses. The facility census was 163. Findings include: 1. Review of the medical record for Resident #17 revealed an admission date of 03/20/25 with diagnoses of schizoaffective disorder depressive type, bipolar disorder and chronic post-traumatic stress disorder (PTSD). Review of Resident #17's hospital transfer dated 03/10/25 indicated the resident had PTSD with a history of cocaine and alcohol abuse. Resident #17 was a poor historian and not forthcoming with information. Review of the admission Minimum Data Set (MDS) assessment completed 03/27/25 revealed Resident #17 had no cognitive impairment and PTSD. Review of Resident #17's social service admission assessment dated [DATE] and the social service quarterly assessment dated [DATE] indicated the resident denied experiencing or witnessing a traumatic event. There was no additional trauma-related information collected on these assessments to promote trauma-informed care. Review of Resident #17's progress notes from March 2025 to August 2025 revealed no documentation relevant to the resident's trauma or trauma-informed care. Review of Resident #17's psychiatric notes dated 03/25/25, 05/28/25, 07/08/25 and 08/26/25 revealed a documented history of PTSD, alcohol and cocaine abuse, and reports of six previous psychiatric hospitalizations for instability. There was no detailed information related to the resident's trauma history for staff to provide trauma-informed care. Review of Resident #17's plan of care initiated 06/11/25 revealed a focus for psychosocial well-being problem related to PTSD. Interventions included to assist with developing coping skills to manage situational crises related to history of trauma; assist, encourage and/or support to set realistic goals; attempt to identify, reduce or eliminate causes and contributing factors; encourage to relax or participate in relaxing activities of interest; provide pastoral care, social services, psychiatric services and/or community services as needed; and when conflict arises, move to a calm, safe environment and allow to vent/share feelings. Interview on 08/27/25 at 10:58 A.M. with Resident #17 described the staff as not always understanding his personal care needs related to trauma but was unable to provide an example. Interview on 08/27/25 at 11:01 A.M. with Licensed Practical Nurse (LPN) #787 regarding Resident #17's trauma care denied having knowledge of any triggers or details about the trauma. LPN #787 indicated not witnessing any behaviors but would report any to the psychiatrist, and if the nursing assistants needed to be aware of any needs, it would be put on the care card. Review of Resident #17's Certified Nursing Assistant (CAN) care card dated 08/27/25 revealed under behaviors, the aides were to assess comfort levels and treat as needed and encourage interaction and participation during care. There was no information specific to promote trauma-informed care. Interview on 08/27/25 at 11:19 A.M. with CNA #610 regarding Resident #17's trauma care denied being aware of the resident having any trauma history or needs related to the trauma. Interview on 08/27/25 at 11:34 A.M. with Licensed Social Worker (LSW) #788 denied addressing any resident needs who had PTSD, but if someone mentioned any concerns then the psychiatric nurse practitioner would be contacted to receive guidance. Thereafter any services needed would be set up. LSW #788 indicated initial and quarterly assessments were completed in which questions were asked such as if a trauma had occurred, but if a resident answered no, then there were no additional questions asked to probe for information. LSW #788 denied being aware of Resident #17 having trauma related diagnoses, but explained the staff relied on psychiatric services to identify needs and relate those to nursing or social services to be care planned. Interview on 08/27/25 at 1:05 P.M. with MDS nurse, LPN #800 indicated because Resident #17 failed to divulge any trauma-related information on the social service admission assessment dated [DATE] and the social service quarterly assessment dated [DATE], (continued on next page)		

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 09/02/2025
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)		
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then there was nothing to care plan, but because there was a diagnosis of PTSD and potential for issues, there was a general focus put into the care plan, but confirmed it was not individualized. 2. Review of the medical record for Resident #28 revealed an admission date of 11/01/23 with diagnoses of schizoaffective disorder bipolar type, PTSD, generalized anxiety disorder, borderline personality disorder, alcohol dependence, cannabis dependence, auditory hallucinations, a personal history of suicidal behavior, and suicidal ideations. Review of Resident #28's hospital transfer dated 10/28/23 indicated the resident had PTSD, was a victim of rape/sexual assault as a child, had a history of 33 psychiatric hospitalizations, had multiple previous suicide attempts and a history of polysubstance use disorder including nicotine, alcohol and cannabis. Review of the admission MDS assessment completed 11/07/23 revealed Resident #28 had moderate cognitive impairment and PTSD. Review of Resident #28's social service admission assessment dated [DATE] and the social service quarterly assessments dated 02/01/24, 08/20/24, 11/07/24, 02/04/25, 05/09/25 and 06/10/25 indicated the resident acknowledged experiencing a traumatic event involving sexual abuse as a child. Social service notes included Resident #28 having no cognitive impairment and denied issues with appetite, focus, concentration, energy level, taking pleasure in doing things, and thoughts of worthlessness, self-harm or harming others. Resident #28 expressed depression but was working with a therapist and counselors, which was helpful. There was no additional trauma-related information collected on these assessments to promote trauma-informed care. Review of Resident #28's progress notes from November 2023 to August 2025 revealed the resident had multiple incidences of suicidal ideations in which staff provided 15-minute safety checks, auditory hallucinations and desire for self-harm. The staff provided psychiatric services as an intervention until 08/14/25 when staff forced Resident #28 to be hospitalized via pink slip (involuntary hospitalization) due to suicidal thoughts which did not subside with distractions, conversation and sitting by the nurse's station. There was no documentation relevant to providing trauma-informed care. Review of Resident #28's psychiatric notes dated 01/07/25, 01/21/25, 02/05/25, 03/13/25, 04/15/25, 07/01/25, 08/05/25, 08/14/25 and 08/22/25 revealed a documented history of PTSD and self-injurious behaviors. There was no detailed information related to the resident's trauma history for staff to provide trauma-informed care. Review of Resident #28's plan of care initiated 11/02/23 revealed a focus for a psychosocial well-being problem related to traumatic life events and PTSD. Interventions included assisting in developing coping skills to manage situational crises related to history of trauma; attempt to identify, reduce or eliminate causes and contributing factors; provide pastoral care, social services, psychiatric services and/or community services as needed; and provide emotional support. Interview on 08/26/25 at 8:25 A.M. with Resident #28 described the staff as not fully understanding her trauma care needs and provided an example of staff forcing her to go to the hospital by a pink slip in the previous week knowing that hospitals really upset her. Interview on 08/27/25 at 11:05 A.M. with LPN #618 expressed being aware of Resident #28 having behaviors but was unable to identify any triggers for the behaviors related to the resident's trauma history, but indicated staff watch closely for depression, self-injury and suicidal behavior. LPN #618 indicated if there were any triggers it would be outlined in the care plan and on the care card for the nursing assistants. Interview on 08/27/25 at 11:34 A.M. with LSW #788 denied addressing any resident needs who had PTSD, but if someone mentioned any concerns then the psychiatric nurse practitioner would be contacted to receive guidance. Thereafter any services needed would be set up. LSW #788 indicated initial and quarterly assessments were completed in which questions were asked such as if a trauma had occurred but if a resident answered no, then there were no additional questions asked to probe for information. LSW #788 denied being aware of Resident #28 having trauma related diagnoses, but explained the staff relied on psychiatric services to identify needs and relate those to nursing or social services to be care planned. Interview on 08/27/25 at 11:55 A.M. with MDS nurses, LPNs #660, #738 and #800, verified Resident #28's care plan was non-specific to the trauma, but more detailed trauma information was drawn together by social service assessments before being included. Review (continued on next page)		

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 09/02/2025
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)		
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident #28's CNA care card dated 08/27/25 revealed under behaviors, the aides were to assess comfort levels and treat as needed and encourage the resident to express feelings. There was no information specific to promote trauma-informed care. Interview on 08/28/25 at 12:35 P.M. with the Director of Nursing (DON) confirmed although Resident #28's CNA care card and care plan were not specific or individualized, the resident was followed by psychiatry and a therapeutic behavioral services (TBS) therapist at least weekly and would contact the provider to obtain more detailed information related to the resident's trauma. Interview on 08/28/25 at 9:58 A.M. with MDS nurses, LPNs #660, #738 and #800, confirmed although Resident #28 had a documented history of sexual assault, it care planning process was the responsibility of social services to complete that portion. During an interview on 08/28/25 at 10:10 A.M. with the DON the trauma history of both Residents #17 and #28 was discussed. The DON verified the staff's approach to both residents' care lacked detailed trauma-related information and was unable to provide evidence of such. However, the DON provided medical record information she had just received from Resident #28's psychiatric provider which included trauma counseling notes and a trauma care plan dated 07/17/25, but verified it was just obtained and was not used by facility staff to provide trauma-informed care. Review of the staff training related to trauma informed care dated 01/03/25 revealed all facility staff were educated on the definition of trauma, to identify causes and effects of trauma, and how the facility's structured environment could trigger traumatic memories including noise, smell, temperature, physical sensation, and visual scenes. A trauma-informed approach included recognizing signs of trauma through assessments, training, and integrating knowledge about trauma into policies, procedures and practices, and to resist re-traumatization by recognizing how organizational practices may trigger painful memories and re-traumatize residents. Staff were to exercise strategies to become trauma informed including demonstrating active listening skills and a knowledge of resident history, be aware of resident's personal preferences, identify indications of stress, and incorporate person-centered care planning processes. Review of the facility policy, Trauma Informed Care, revised 01/06/25, revealed trauma informed clinical practices include demonstrating active listening skills, demonstrating knowledge of resident history, being aware of resident's personal preferences, identifying indications of stress and providing sufficient notice and preparation when changes are necessary.		

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 09/02/2025
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)		
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **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 amnesic 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 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/02/2025
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)		
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		