STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366394	A. Building B. Wing	10/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avenue Care and Rehabilitation Center, The	4120 Interchange Corporate Center Road Warrensville Heights, OH 44128

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility Self-Reported Incident (SRI), interview and policy review, the facility failed to ensure Resident #14 was free of sexual abuse from another resident (Resident #86). This affected one (Resident #14) of three residents reviewed for sexual abuse. The facility census was 93. Findings include:Review of the medial record for Resident #14 revealed an admission date of 07/03/23 with diagnoses including cerebral infarction (stroke), hemiplegia (paralysis) affecting right dominant side, chronic respiratory failure and paranoid schizophrenia (condition that includes paranoia, delusions and hallucinations).Review of Resident #14's care plan revealed it was originally dated 07/03/23. There were no updates to her care plan noted after 09/16/25. She was noted to have a communication problem and self-care deficit both related to impaired cognition.Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 had highly impaired vision, highly impaired hearing, sometimes understood staff and sometimes staff understood her. She was noted to have severely impaired cognition. She was dependent on staff for hygiene, dressing and transfers. Review of a nursing progress note by Licensed Practical Nurse (LPN) #204 dated 09/17/25 at 9:32 P.M. for Resident #14 revealed the nurse observed Resident #14 and Resident #86 in the common area kissing. LPN #204 stated she intervened and separated the two residents. The incident was reported to management and a head to toe assessment was performed. The physician and Resident #14's representative were updated. Staff were aware to keep the residents separated. Review of the facility investigation dated 09/17/25 for Resident #14 and Resident #86 revealed LPN #204 was walking through the dining area and she witnessed Resident #14's and Resident #86's heads turned towards each other and they kissed on the lips, a peck. She stated she immediately separated the two residents and reported it to the manager. There was a nursing progress note in Resident #86's medical record by Director of Social Services #207 created on 09/30/25 at 10:06 A.M. with the effective date of 09/17/25 at 2:01 P.M. stating that herself and Registered Nurse (RN) #205 met with Resident #86 to discuss the inappropriate relationship including inappropriate touching of Resident #14. It stated Resident #86 was educated on the inappropriate relationship with Resident #14 pertaining to kissing. The note stated Resident #86 understood. The Director of Social Services #207 and RN #205 discussed the difference of mental capabilities and her inability to give consent. Resident #86 stated he would not touch or kiss Resident #14.Review of a nursing progress note by RN #205 dated 09/29/25 at 11:56 P.M. for Resident #14 revealed an aide alerted the nurse there was a male resident (Resident #86) inside Resident #14's room, on top of her bed. Resident #86 was escorted out of Resident #14's room and placed on one-on-one observation. Resident #14 was assessed and placed in a safe place. The nurse practitioner, manager and Resident #14's representative were updated. Review of SRI #265853 dated 09/29/25 revealed while Certified Nursing Assistant (CNA) #209 was doing rounds, she observed Resident #86 with his pants down laying on top of Resident #14 in her bed. RN #205 was alerted and went to the room and separated both residents. She performed assessments and spoke with each resident. Resident #14 denied sexual intercourse with Resident #86. She stated she wanted him to have sex with her. RN #205 then interviewed Resident #86. He stated Resident #14 wanted him in her room. He was reminded of the education he had been provided on 09/17/25 that he was to have no personal or private contact with Resident #14. Resident #86 stated nothing happened. The police were notified and a report was filed. The police report was not available in the SRI.Review of a nursing progress note dated 09/30/25 at 5:10 P.M. for Resident #14 revealed the nurse practitioner provided a new order to send her to the emergency room to complete a rape test kit.Review of the hospital history and physical dated 09/30/25 for Resident #14 revealed she was at the emergency room for suspected sexual assault. The emergency medical services had reported that Resident #14 was found by the facility staff with another resident on top of her with his pants down. Resident #14 stated her pants were still on. Resident #14 reported to the Sexual Assault Nurse Examiner (SANE) nurse that she felt safe around Resident #86. There was no record if the rape test kit was positive or negative.Interview on 10/06/25 at 9:41 A.M. with LPN #204 revealed she had observed Resident #14 and Resident #86 kissing on 09/17/25 and separated them. She stated staff were updated to keep them separated and nursing had educated all staff during shift change report. LPN #204 revealed after the incident on 09/30/25 where Resident #86 was found with his pants off lying on Resident #14 in her bed, the facility placed him on one-on-one supervision, which they were still doing. Interview on 10/06/25 at 10:23 A.M. with Resident #14's representative revealed he had been updated on 09/17/25 of