STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366458	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc of Landerhaven LLC	2108 Lander Road Mayfield Heights, OH 44124

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews, review of a Self-Reported Incident (SRI), interviews and review of facility policy, the facility failed to ensure nursing staff reported an allegation of abuse in a timely manner. This affected two residents (#51 and #52) of three residents reviewed for abuse reporting. The facility census was 41.Findings included: Review of the Self-Reported Incident (SRI) submitted by the facility on 08/12/25 at 9:43 A.M. and closed on 08/15/25 at 5:31 P.M. submitted for an allegation of sexual abuse revealed it involved Resident #51 and Resident #52. Review of the closed medical record for Resident #51 revealed an admission date of 07/31/25. Diagnoses included strain of right quadriceps muscle, spinal stenosis and chronic kidney disease. Resident #51 was moderately cognitively impaired.Review of the closed medical record for Resident #52 revealed an admission date of 08/09/25 and a discharge date of 08/12/25. Diagnoses included dementia, urinary tract infection, alcohol use, chronic kidney disease and contusion to head. Resident #52 was cognitively impaired and had wandering behavior one to three days a week and behavior towards others. Review of a progress note dated 08/12/25 at 5:29 A.M. and authored by Registered Nurse (RN) #100 revealed Resident #52 was found in another resident room. RN #52 directed this resident back to her room and educated her about where her room was located and she could not go into others' room unless ok. Further review of the SRI and related investigation revealed the incident occurred on 08/12/25 at 2:30 A.M. however in the first paragraph it indicated it occurred on 08/11/25. Resident #52 tried to touch Resident #51 under his clothing and climb on top of him so Resident #51 pushed her away. Review of a handwritten statement dated 08/12 (no year), no author, (later revealed by the DON to be written by RN #100) revealed Resident Resident #51 stated a patient was in his room and was touching him inappropriately, CNA removed Resident #52 from his room and put her in bed and informed nurse. Nurse checked on Resident #51 to make sure patient was okay. Review of the witness statement by CNA #150 emailed to the DON on 08/12/25 at 10:56 A.M. revealed Certified Nursing Assistant (CNA) #150 stated it was around 3:00 A.M. or 4:00 A.M. the morning of 08/12/25. She did her rounds. Resident #52 was still up and asked her if she wanted to go back to bed. She said no so CNA #150 stated she sat down for about 10 minutes when she heard Resident #51 yelling. When she went to the room the resident was in his doorway holding onto doorway and handle of bathroom. She grabbed a wheelchair for him to sit down. CNA #150 stated that was when she saw Resident #52 sitting on Resident #51's bed and told her she was in the wrong room, CNA #150 assisted Resident #52 back to her room.When she went back to Resident #51's he told her Resident #52 touched him sexually and made him uncomfortable. She stated she would tell the nurse. The nurse was on break but she told her immediately when she saw her. Review of questions for residents completed on during the facility investigation revealed the Administrator and DON asked them the following questions: 1)Do you fee safe in the building?; 2)Have you had any issues with the other patients entering your room?; 3) If so, when did that happen?; and 4) Have you had any issues with the care provided to you while in the building? There were no concerns needing followed up on in answers.Review of questions for staff completed within the facility investigation revealed the Administrator and DON asked them the following questions: 1) who is mandated reporter in the building?; 2) If a patient, family member or employee reports abuse to you, what should you do next?; 3) Who is the abuse coordinator in the building?; 4)What do you believe abuse is?; and 5) Have you ever witnessed abuse either by other patients or staff members while working here? The questions were answered by the staff who worked 08/12/25.Review of the Employee Separation Form dated 08/13/25 for CNA #150 revealed she was terminated for not following policy and procedures.Review of the Employee Separation Form dated 08/13/25 for RN #100 revealed she was terminated for not being compliant with rules and investigation.Interview on 09/19/25 at 1:20 P.M. with CNA #150 confirmed what she wrote in her statement about the incident involving Resident #51 and #52. She added it was her third week there and she could not remember everything in policy or how quickly she needed to report allegations of abuse. She stated she told the nurse, but did not recall what time. CNA #150 stated the DON called her at home asking for a statement which she emailed. She stated she was suspended during investigation and terminated a couple of days later.Interviews were attempted with RN #100 but were unsuccessful.Interview on 09/19/25 at 5:00 P.M. with the Administrator and DON revealed both RN #100 and CNA #150 were terminated for not reporting timely regarding the incident of allegation of sexual abuse involving Resident #51 and Resident #52. The DON stated RN #100 would not call back to clarify information in her witness statement so they were unclear on the time of events. The DON and Administrator verified the date of 08/11/25 listed in the SRI