

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2024
NAME OF PROVIDER OR SUPPLIER Eastbrook Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 17322 Euclid Ave Cleveland, OH 44112	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on interview, record review, facility investigation review, and facility policy review the facility failed to ensure Resident #73 was transferred safely resulting in a fall. This affected one resident (#73) of three residents reviewed for accidents. Facility census was 83.</p> <p>Findings include:</p> <p>Review of Resident #73's medical record revealed an admitted [DATE] with diagnoses included but not limited to systolic congestive heart failure, acute respiratory failure, acute kidney failure, and artificial opening of urinary tract status and need for assistance with personal care.</p> <p>Review of the care plan dated 05/10/19 revealed Resident #73 had an ADL self-care performance deficit related to activity intolerance and impaired balance. Interventions included toileting dependent with assist of two persons and mechanical lift with two person assist for transfers.</p> <p>Review of Resident #73's quarterly Minimum Data Set assessment dated [DATE] revealed the resident required substantial/maximal assistance with toileting hygiene and was dependent on staff for mobility.</p> <p>Review of the progress noted dated 06/14/24 at 4:49 P.M. authored by Licensed Practical Nurse (LPN) # 223 revealed she was notified by State tested Nurse Aide (STNA) #305 regarding Resident #73 fell out of bed while being provided care with one assist for peri care. LPN #223 did an assessment, notifications, and started neurological (neuro) checks. LPN #223 and STNA #305 lifted resident back to bed with two-staff assistance without mechanical lift.</p> <p>Review of the investigation report dated 06/14/24 revealed Resident #73 received care by one staff and fell out of bed. LPN #223 assessed Resident #73, and she was lifted from floor mat back into bed with two staff assist manually. Resident #73 sustained no injuries or complaints of pain.</p> <p>Interview on 08/19/24 at 11:06 A.M. with Nurse Practitioner (NP) #326 revealed she was notified of the fall and reported the STNA #305 was new and was only using one assist for care and there should have been two assisting with peri care/toileting.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 08/19/24 at 11:53 A.M. with LPN #223 revealed STNA #305 reported Resident #73 had fallen out of bed during peri care/toileting. LPN #223 reported she believed Resident #73 was a two person assist for peri care/toileting.</p> <p>Interview on 08/19/24 at 12:39 P.M. with LPN #212 revealed Resident #73 was a two person assist for peri care/toileting.</p> <p>Interview on 08/19/24 at 12:41 P.M. with STNA #297 revealed Resident #73 was a two person assist for peri care/toileting.</p> <p>Interview on 08/19/24 at 12:49 P.M. with STNA #305 revealed at the time of Resident #73's fall, the resident was supposed to be a two person assist for peri care and he only had himself assist because he didn't check the Kardex to see what assistance was required. STNA #305 reported he received education after the incident to include she was two person assist with peri care.</p> <p>Interview on 08/20/24 at 7:30 A.M. with the Director of Nursing (DON) confirmed Resident #73 had a fall during peri care with only one staff present, and Resident #73 required two staff per the care plan and Kardex.</p> <p>Review of the facility policy, Falls and Fall Risk, Managing, revised March 2018, revealed staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with history of falls.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00156029.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061</p> <p>Based on observation and interview, the facility failed to ensure medications were administered with an error rate of less than 5%. A total of two errors out of 29 opportunities observed resulting in a 6.9% medication error rate. This affected two resident (#36 and #73) out of four observed for medication administration.</p> <p>Findings include:</p> <p>1. Review of Resident #36's medical records revealed an admitted [DATE]. Diagnosis included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed resident had intact cognition.</p> <p>Review of physician orders for 07/07/23, revealed resident was ordered Aspirin 81 milligram (mg) chewable to give one tablet by mouth (PO) in the morning.</p> <p>Observation of medication administration on 08/15/24 at 8:29 A.M. with Licensed Practical Nurse (LPN) #266 for Resident #36 revealed the LPN administered Aspirin 81 mg enteric coated (EC), not chewable.</p> <p>Interview on 08/15/24 at 10:08 A.M. with LPN #266 verified she gave the wrong medication. LPN #266 reported she didn't look to see it was Aspirin 81 mg chewable and administered Aspirin 81 mg EC.</p> <p>2. Review of Resident #73's medical records revealed an admitted [DATE]. Diagnosis included but not limited to systolic congestive heart failure, acute respiratory failure, acute kidney failure, artificial opening of urinary tract status and need for assistance with personal care.</p> <p>Review of Minimum Data Set (MDS) assessment dated [DATE] revealed resident had intact cognition.</p> <p>Review of physician orders for 12/29/23 revealed resident was ordered Senna 8.6 mg give 50 mg PO (by mouth), one tablet, two times a day for constipation.</p> <p>Observation of medication administration on 08/15/24 at 8:01 A.M. with LPN #249 for Resident #73 revealed LPN administered Senna 8.6 mg, one tablet PO.</p> <p>Interview on 08/15/24 at 10:13 A.M. with LPN #249 verified she gave incorrect medication. LPN #249 verified it should have been Senna 8.6-50 mg 1 tablet PO.</p> <p>Interview on 08/15/24 at 12:30 P.M. with Regional [NAME] President of Clinical Services (RVPCS) # 329 verified the wrong medication was administered and education provided to the nurse.</p> <p>Review of facility policy, Administering Mediations, revised April 2019, revealed medications are administered in accordance with prescriber orders and the individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route of administration before giving the medication).</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This deficiency represents non-compliance investigation Complaint Number OH00155885.</p>