

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 01/15/2026
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed ensure there was accurate documentation. This affected two residents (#31 and #42) out of 24 medical records reviewed for accuracy of medical records. The facility census was 103. Findings include: 1. Review of medical record for Resident #42 revealed an admission date of 05/23/24 and his diagnoses included morbid obesity, diabetes with diabetic neuropathy, chronic kidney disease, and chronic obstructive pulmonary disease (COPD). Review of care plan dated 05/24/24 revealed Resident #42 had potential for hypoglycemia and/or hyperglycemia related to diabetes. Interventions included checking glucose levels, administering insulin and monitoring labs as ordered. Review of care plan dated 05/24/24 revealed Resident #42 had a nutritional problem related to morbid obesity, history of binge eating, congestive heart failure (CHF), and excessive consumption of highly processed snacks and beverages. Interventions included administering medication as ordered, monitoring and documenting side effects and effectiveness, monitoring weights and providing and serving diet as ordered. Review of September 2025 Medication Administration Record (MAR) revealed Resident #42 had an order for Mounjaro (an injectable medication used to treat diabetes and obesity) subcutaneous (SQ) solution auto-injector 2.5 milligrams (mg) per 0.5 milliliter (ml), inject one application SQ in the afternoon every Wednesday for diabetes. The MAR indicated on 09/17/25 to see the nursing notes as it was not administered. Review of nursing note dated 09/17/25 at 6:12 P.M. revealed Resident #42's Mounjaro was not given as it was reordered. There was no documentation Primary Care Physician (PCP) #900 was notified regarding Resident #42 missing his dose and Resident #42 did not receive the medication until the next time that it was scheduled on 09/24/25. Review of November 2025 MAR revealed Resident #42 had an order for Mounjaro SQ solution auto-injector 2.5 mg per 0.5 ml, inject one application SQ in the afternoon every Thursday for diabetes. The MAR was blank on 11/06/25. Review of nursing notes dated 11/01/25 to 12/31/25 for Resident #42 revealed no documentation PCP #900 was notified regarding Resident #42 not receiving his Mounjaro on 11/06/25 and 12/11/25. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #42 was cognitively intact. Review of Physician Progress Note dated 11/10/25 at 8:11 A.M. and completed by PCP #900 revealed Resident #42 had the following diagnoses: morbid obesity, diabetes, and COPD. He recommended to continue Mounjaro for diabetes and morbid obesity. Review of December 2025 MAR revealed Resident #42 had an order for Mounjaro SQ solution auto-injector 2.5 mg per 0.5 ml, inject one application SQ in the afternoon every Thursday for diabetes. The MAR was blank on 12/11/25. Interview on 01/12/26 at 9:40 A.M. and 01/15/26 at 8:43 A.M. with Resident #42 revealed he was supposed to receive Mounjaro once a week mainly to assist him in weight loss. He revealed at times he did not receive this medication but could not remember details of when he did not or how often. Interview on 01/14/26 at 2:22 P.M. with Director of Nursing (DON) verified on Resident #42's MAR it indicated on 09/17/25 his Mounjaro was not given as it was not available, and on 11/06/25 and</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365129	Facility ID: 365129 If continuation sheet Page 1 of 4

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/11/25 the MAR was blank. She verified there was nothing in the nursing notes regarding the physician being notified that the medication was not given. She revealed she felt the medication possibly was given but the nurse did not document it. 2. Review of medical record for Resident #31 revealed an admission date of 09/11/25 and diagnoses included paraplegia, hypertension and neuromuscular dysfunction of the bladder. Review of care plan dated 10/01/25 revealed under resident care Resident #31 required catheter care per policy, always keep catheter bag below level of bladder, and keep catheter bag always covered. Review of quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #31 had intact cognition and had an indwelling catheter (a flexible tube inserted into the bladder for continuous urine drainage). He was dependent on staff assistance with toileting hygiene. Review of Treatment Administration Record (TAR) for December 2025 and January 2026 revealed there was no documentation catheter care was completed for Resident #31. Review of task bar from 12/14/26 to 01/14/26 revealed there was no order and/or documentation Resident #31's catheter care was completed. Review of January 2026 physician orders revealed Resident #31 had a urinary indwelling catheter to continuous drainage and there were no orders for catheter care. Interview on 01/12/26 at 10:10 A.M. with Resident #31 revealed he was unsure how often staff provided catheter care as it was something he did not keep track of. Review of Kardex for Resident #31 dated 01/14/26 revealed staff were to complete catheter care per policy and after each incontinent episode of bowel. There was no frequency identified regarding catheter care. Interview on 01/14/26 at 1:30 P.M. with the DON verified there was no physician order for catheter care or evidence of documentation that catheter care was completed. She revealed she felt it was completed every shift but that it was not documented. She verified there should have been a physician order for catheter care to be completed every shift and that staff should have documented the completion. Review of facility policy labeled, Administering Medications dated April 2019 revealed medications were to be administered in a safe and timely manner as prescribed. If the drug was withheld, refused or given at a time other than scheduled the nurse administering the medication shall initial and circle the MAR space provided. The nurse administering the medication initialed the MAR after giving the medication. Review of facility policy labeled, Catheter Care dated September 2024 revealed the purpose of the policy was to prevent catheter-associated urinary tract infections. There was nothing in the policy regarding documenting the completion of catheter care and/or how often catheter care should be completed. This deficiency represents non-compliance investigated under Complaint Number 2585985 and Complaint Number 2560614.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to maintain resident rooms in a safe and sanitary condition. This affected 14 residents (#1, #3, #36, #39, #52, #60, #63, #64, #65, #72, #84, #94, #100 and #101) out of 24 residents reviewed for environment. The facility census was 103. Findings include: Interview on 01/12/26 at 9:39 A.M. with Resident #72 revealed his shared bathroom toilet for Rooms #112 and #114 had been plugged up and unusable since 01/10/25 for two days. Resident #72 stated he notified nursing of the issue on 01/10/26 and was informed they would notify maintenance and place a work order. The nurses provided the residents (#36, #39, #72 and #101) who shared the bathroom with urinals; however, there was no place to empty the urinals since the toilet was broken. So, they were told to use the communal bathroom out on the floor, but Resident #72 complained there was no toilet paper in the bathroom. Observation at the time of the interview of the shared bathroom revealed the toilet appeared plugged up and had old urine and feces inside the toilet.</p> <p>Interview with the Director of Nursing (DON) on 01/12/26 at 10:00 A.M. revealed she was unaware of the problem and verified there was no work order placed on 01/10/25.</p> <p>Observation on 01/12/26 at 10:35 A.M. of Resident #60's and #94's room revealed red and brown stains on both residents' privacy curtains. Resident #94's fall mat was stained and had various debris on it. Crushed chocolate candies were scattered all over the floor. Heavy dust build-up was underneath the air conditioner unit. The wall between the bathroom and the sink had numerous stains of what appeared to be blood and feces. The bathroom had an empty hanger and various pieces of trash on the ground with brown stains on the wall behind the toilet. The floor was very sticky. Interview at the time of the observation with Housekeeping Director (HD) #573 confirmed the findings.</p> <p>Observation on 01/12/26 at 10:50 A.M. of Resident #1's and #64's room revealed dust build-up on the portable fan and a sticky floor. Resident #64 had tracheostomy tubing, a cookie wrapper, alcohol pads, gloves, a napkin, and numerous crumbs around and underneath his bed. Numerous stains and splatters were on the wall between the sink and the bathroom. Resident #1 had numerous food crumbs, wipes and a dirty urinal on the floor. Interview at the time of the observation with HD #573 confirmed the findings.</p> <p>Observation on 01/12/26 at 11:06 A.M. of Resident #65's room revealed the floor was sticky and there were two gloves on the ground underneath the floor air vents. Interview at the time of the observation with the DON confirmed the findings.</p> <p>Observation on 01/12/26 at 11:09 A.M. of the second-floor shower room located near room [ROOM NUMBER] revealed the floor was dirty, and tissue paper was on the floor. There was an estimated three-inch stain of what appeared to be feces on the top inside of the toilet. Interview at the time of the observation with the Administrator confirmed the findings.</p> <p>Observation on 01/12/26 at 11:18 A.M. of Resident #100's room revealed a banana on the floor with numerous foam cups and plastic food containers around room. There was cluttered items on the floor. Interview at the time of the observation with Resident #100 revealed he had asked staff numerous times to clean up the room and assist with arranging items, so he was able to reach them. Interview at the time of the observation with Licensed Practical Nurse (LPN) #528 confirmed the findings.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 01/12/26 at 12:05 P.M. of Resident #63's room revealed numerous items of trash on the floor including a pillowcase, a pillow, a bowl, a napkin, numerous crumbs and an incontinence brief. The mini refrigerator in the room had visible dust build-up. Interview at the time of the observation with the Assistant Director of Nursing (ADON) #596 confirmed the findings.</p> <p>Observation on 01/12/26 at 4:18 P.M. of Resident #3's and #84's room revealed visible dust build-up and splatter along the floor vents and wall by Resident #3's bed. Resident #3 had various shoes, incontinent briefs and wedges behind the bed on the floor. Interview at the time of the observation with Housekeeper #507 confirmed the findings.</p> <p>Observation on 01/12/26 at 4:46 P.M. of Resident #52's room revealed numerous stains, splatter and a napkin on the wall by the bed. Interview at the time of the observation with Certified Nursing Assistant (CNA) #577 confirmed the findings.</p> <p>Observation on 01/15/26 at 10:19 A.M. of the first-floor shower and bathroom located across from room [ROOM NUMBER] revealed dirty footprints and two toilet paper rolls on the floor. The toilet had dried urine splatter on the seat. There was a used disposable razor on the sink, shaved hair clippings in the sink, and the facet seal was dirty and brown. The floor around the toilet had brown debris and stains. The non-skid strips across from the toilet were coming unattached from the floor. The floor vents were visibly dusty. The vent on ceiling had thick dust build-up. The shower had the appearance of mold in the corner, orange build-up along the tile grout, and soap build-up on the soap dispenser. Interview at the time of the observation with Housekeeper #525 confirmed the findings.</p> <p>Observation on 01/15/26 at 10:32 A.M. of the second-floor shower and bathroom revealed a one inch by one-inch dried stain which appeared to be feces on the toilet seat. Interview at the time of the observation with DON confirmed the findings.</p> <p>Observation on 01/15/26 at 10:36 A.M. of the findings in the first-floor shower and bathroom with DON confirmed the above findings.</p> <p>Observation on 01/15/26 at 11:01 A.M. with HD #573 of the entry way for room [ROOM NUMBER] revealed the vinyl flooring was cracked, raised up above floor and had a hole in it. Interview at the time of the observation with HD #573 confirmed the findings.</p> <p>Review of facility policy labeled, Quality of Life - Homelike Environment, revised May 2017, revealed residents were provided with a safe, clean, comfortable and homelike environment, and encouraged to use their personal belongings to the extent possible,. The facility staff and management maximized to the extent possible the characteristics of the facility that reflected a personalized, homelike setting. This included a clean and orderly environment.</p> <p>This deficiency represents non-compliance investigated under Complaint Number 2570903.</p>		