STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365129	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastbrook Healthcare Center	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)
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 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. 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. 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. 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. 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. 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 (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the observation with the Administrator confirmed the findings. 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. 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. 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. 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. 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. 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. 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. 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. 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. This deficiency represents non-compliance investigated under Complaint Number 2570903.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to provide restorative services to prevent a decline of the residents' functional abilities in the facility. This affected three residents (#10, #14 and #54) out of four residents reviewed for rehabilitation services. The facility census was 103.Findings include:1. A review of Resident #14's clinical record revealed an admission date of 06/11/26 with diagnoses including diabetes mellitus type two, high blood pressure and cholesterol, centrilobular emphysema, segmental and somatic dysfunction of the sacral region, myalgia, pulmonary fibrosis, adult failure to thrive, gastroesophageal reflux disease, dementia with agitation, dysphagia (trouble swallowing), tachycardia, depression and pain. Resident #14 had medical conditions including muscle weakness, abnormal gait and mobility and other signs and symptoms of cognitive functions and awareness, and long-term drug therapy. A review of Resident #14's plan of care revealed no restorative services to prevent a decline in his functional ability to balance during walking and transitions. A review of Resident #14's Restorative assessment dated [DATE] indicated Resident #14 was unsteady when moving from seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet, and surface to surface transfers between the bed and chair/wheelchair. Resident #14 used a wheelchair for mobility. Resident #14 needed limited assistance of one staff member for transfers, walking, dressing, toilet use, personal hygiene, and bathing. The assessment indicated Resident #14 was currently receiving occupational and physical therapy services. An interview with Resident #14 on 01/12/26 at 11:00 A.M. revealed Resident #14 was not receiving therapy services to increase his strength for his ability to independently perform his activities of daily living needs. An interview with Therapy Director of Rehabilitation (DOR) #520 on 01/13/25 at 4:10 P.M. revealed Resident #14 received physical therapy services with an evaluation completed on 01/11/25 and the first physical therapy session was scheduled on 01/13/25. DOR #520 stated the facility did not provide restorative therapy services. DOR #520 stated the Director of Nursing (DON) informed her the facility did not provide restorative therapy to maintain the residents' functional abilities. DOR #520 stated that when a resident had a decline in activities of daily living, therapy would evaluate the resident to determine their need for therapy services. DOR #520 stated the facility would routinely recertify a resident for therapy services when they exhibited a decline in their functional abilities and physical/occupational therapy did not provide recommendations for restorative services because the facility did have a restorative therapy system in place. DOR #520 agreed that the residents who had therapy services were at risk for declining after their therapy services were discontinued because there was no restorative services implemented after discontinuation of the therapy services. DOR #520 stated the facility would have the physician order an evaluation for the need for therapy services when a resident had a decline in their functional abilities. An interview with DON on 01/15/26 at 10:00 A.M. revealed the facility did not offer restorative services to prevent a functional decline in a resident's ability to perform activities of daily living. DON stated the facility provided quarterly restorative assessments and when a resident had a decline in their functional abilities, the resident was referred to therapy for an evaluation to provide therapy services. DON stated the facility did not have a policy and procedure for restorative care in the facility. DON verified the above findings at the time of the interview. An interview with Certified Nursing Assistant (CNA) #577 on 01/15/26 at 10:18 A.M. revealed the residents were not provided with routine restorative therapy services. If a resident required range of motion exercises, occupational and physical therapy services were provided to address range of motion needs. 2. A review of Resident #10's clinical record revealed an admission date of 05/11/23 with diagnoses including dementia, kidney failure, anemia, malnutrition, high blood pressure and cholesterol, depression, stroke, arteriovenous malformation of the digestive system, dysphagia, altered mental (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status, alcohol abuse, diabetes mellitus type two, peripheral vascular disease, nicotine dependence, high potassium level, insomnia, metabolic encephalopathy, hemiplegia and hemiparesis, melena, liver disease, gastroesophageal hemorrhage, and high magnesium level. A review of Resident #10's care plan initiated on 01/13/24 indicated a self-care deficit related to stroke, cognitive communication deficits, impaired mobility and weakness. The goal of the care plan was to maintain current ability with activities of daily living through the next review. There were no interventions to address this goal. Interventions included the amount of assistance Resident #10 needed to perform activities of daily living and to refer to therapy to evaluate and treat as needed. An interview with Resident #10 on 01/13/25 at 7:54 A.M. revealed Resident #10 stated he was unsure if he was receiving exercises for his contracted right hand or other exercises to assist him with maintaining his current level of function to perform his activities of daily living. An observation of Resident #10 revealed his right hand was contracted. An interview with DOR #520 on 01/13/25 at 4:19 P.M. revealed there was no restorative program recommended to address Resident #10's contracted right hand because the facility did not offer restorative services to the residents. An interview with DON on 01/15/26 at 10:00 A.M. revealed the facility did not offer restorative services to prevent a functional decline in a resident's ability to perform activities of daily living. DON stated the facility provided quarterly restorative assessments and when a resident had a decline in their functional abilities, the resident was referred to therapy for an evaluation to provide therapy services. DON stated the facility did not have a policy and procedure for restorative care in the facility. DON verified the above findings at the time of the interview. 3. A review of Resident #54's clinical record revealed an admission date of 04/16/25 with diagnoses including nontraumatic cerebral hemorrhage, hemiplegia and hemiparesis, dysphagia, facial weakness, dysarthria (a motor speech disorder caused by muscle weakness, paralysis, or poor coordination due to brain or nerve damage), post-traumatic stress disorder, restlessness, agitation, high cholesterol and blood pressure, contracted left hand, and high potassium.Resident #54's care plan initiated on 04/19/25 indicated a self-care deficit related to failure to thrive, stroke with left sided paralysis, facial weakness with speech dysfunction and communication deficit, contracture of left hand, restlessness, agitation and chairbound. A review of Resident #54's care plan revealed no interventions to address the left-hand contracture or other restorative interventions to prevent further decline in his functional ability. Interventions on the plan of care included assisting with activities of daily living as needed and report improvement or decline in resident's participation with activities of daily living, assess functional level and refer to therapy/Registered Nurses and/or physician orders. There were no interventions to address the left-hand contracture, range of motion or exercises to prevent loss of functional ability.An observation of Resident #54 on 01/13/25 at 1:30 P.M. revealed Resident #54 was unable to answer questions regarding his care in the facility. Resident 54 had a contracted left hand with the fingers clenched tightly in his left palm.An interview with DOR #520 on 01/13/25 at 4:23 P.M. revealed Resident #54 developed a wound on his left palm due to his contracted fingernails digging into his palm causing a wound. The wound had healed and now therapy could work on his range of motion for his left-hand contracture to assist in loosening up the left-hand contracture to prevent wound development.An interview with DON on 01/14/25 at 7:42 A.M. revealed Resident #54 did not have restorative exercises to address his left-hand contracture and if he had a decline in his functional ability, the facility would have therapy evaluate him for physical and/or occupational therapy to address his specific decline in his functional ability. DON verified the above findings and agreed the facility did not have a restorative therapy system in place to prevent a decline in a residents' functional ability.An interview with CNA #577 on 01/15/26 at 10:18 A.M. stated the residents should have range of motion exercises performed by the aides but the residents do not routinely receive range of motion services because therapy performs the range of motion exercises.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 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 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to post the most recent survey results readily accessible to residents and family members. This had the potential to affect all 103 residents residing in the facility. Findings include: Observation on 01/15/26 at 10:34 A.M. of the public survey binder located on the bottom shelf of a table by the facility entrance door with no signage related to binder or its access. The last survey included in the binder was dated 01/27/22. There were no recent surveys conducted after 01/27/22 contained within the survey binder. Interview on 01/15/26 at 11:00 A.M. with the Administrator verified the most recent survey results were not included in the survey binder making it readily accessible to residents and family members.