STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365731	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Park Care Center	8 East Park Circle Brook Park, OH 44142

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of Self-Reported Incidents (SRI), staff interview, and facility policy review, the facility failed to thoroughly investigate an allegation of abuse for Resident #51. This affected one resident (#51) of three residents reviewed for abuse. The facility census was 48.Findings include:Review of the medical record revealed Resident #51 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease, adjustment disorder with depressed mood, severe protein-calorie malnutrition, atrial fibrillation, abdominal aortic aneurysm, hypertension, benign prostatic hyperplasia, pacemaker, cystic disease of the liver, bradycardia, transient ischemic attack, and cognitive communication deficit. Review of the Discharge Minimum Data Set, dated [DATE] revealed Resident #10 had moderately impaired cognition with no behaviors. Review of the progress notes from 04/01/25 to 04/10/25 revealed no documentation of allegation of mistreatment being investigated. Review of the Self-Reported Incident dated 04/09/25 revealed Resident #51 told the social worker at the hospital he felt mistreated at the facility. The resident was currently at the hospital. Summary of the incident revealed the Administrator interviewed the resident when he returned from the hospital and felt safe at the facility and did not feel mistreated. Further review of the SRI revealed no facility investigation was completed. There were no interviews with staff or residents and no skin assessments completed. On 10/08/25 at 3:15 P.M. an interview with Regional Director of Clinical Services #262 verified there was no investigation found for the SRI dated 04/09/25. She stated it was the former Administrator who completed the investigation and they could not find the investigation anywhere. Review of the undated facility policy titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Residents Property, revealed residents had the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This included, but was not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint that was not required to treat the resident's medical symptoms. It was the Facility's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source, in accordance with this policy and to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident.This deficiency represents non-compliance investigated under Complaint Number 1387795.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, staff interview, and facility policy review, the facility failed to ensure a treatment was timely initiated for treatment of Resident #36's yeast infection. This affected one resident (#36) of three residents reviewed prompt and adequate care. The facility census was 48. Findings include:Review of the medical record revealed Resident #36 was admitted to the facility on [DATE]. Diagnoses included infection of the skin, cognitive communication deficit, personality disorder, Parkinson's disease, chronic obstructive pulmonary disease, hyperlipidemia, anemia, major depressive disorder, disorder of adult personality and behavior, hypothyroidism, and dementia.Review of the Health Status note dated 03/12/25 at 5:54 A.M. revealed Resident #36 was awake most of the night complaining about a pain and burning sensation in her vaginal area. There was no further documentation or evidence the physician being notified. Review of the Nursing Note dated 03/24/25 at 10:51 A.M revealed the facility's Nurse Practitioner (NP) was in at around 10:00 A.M. and was notified of residents' concerns and she went to visit the resident. The NP ordered doxycycline (an antibiotic) 100 milligrams twice daily for redness in her right leg, consult an endocrinologist for hyperthyroidism, vitamin D 50, 000 units once a week for vitamin D deficiency, and miconazole (an antifungal) cream for seven days for vaginal itching. Resident #36 was recorded as being her own responsible party. Review of the Medication Administration Record dated March 2025 revealed Resident #36 was not administered her miconazole vaginal cream on 03/24/35, 03/26/25, 03/27/25 and 03/29/25 because it was not available. Review of the pharmacy delivery sheets dated from 03/01/25 through 03/31/25 revealed no evidence that the miconazole vaginal cream for Resident #36 was delivered to the facility. Review of the Health Status note dated 04/04/25 at 10:40 A.M. revealed Resident #36 complained of vaginal discomfort, she stated she had a yeast infection. The NP ordered for her to receive one dose of Diflucan (an oral antifungal medication) and Monistat vaginal cream daily for seven days. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #36 had intact cognition. On 10/08/25 at 10:07 A.M., an interview with Resident #36 revealed she had told the nurses several times she had vaginal itching and it was from the antibiotic. She stated she got a yeast infection every time she was on an antibiotic, but they did not do anything so she called her doctor and that was when they had the doctor at the facility to see her. Resident #36 stated she never got the cream because the staff could never find it. On 10/08/25 at 3:33 P.M. an interview with Licensed Practical Nurse (LPN) #300 revealed she was not sure why Resident #36 did not get her vaginal cream but she would investigate it. LPN #300 verified the documentation indicated she had first complained about itching on 03/12/25 and the physician was not notified until 03/24/25 by the resident herself. She stated she would have to find out why the cream was not delivered. On 10/09/25 at 1:25 P.M. an interview with the Administrator revealed the medication for Resident #36 was over the counter so they went out and purchased it for her use. She stated the previous Administrator went out and purchased it. On 10/09/25 at 1:48 P.M. an interview with the Administrator verified there was no documentation the medication was given on 03/24/35, 03/26/25, 03/27/25, and 03/29/25. Review of the facility policy titled, Administering Medications, dated 04/28/25 revealed medications would be administered in a safe and timely manner and as prescribed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the medical record, review of manufacturer's instructions, and staff interview, the facility failed to ensure the air mattress for Resident #10 was set at the appropriate weight for him. This affected one resident (Resident #10) of three residents reviewed for preventative interventions in place. The facility census was 48.Findings include:Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, systemic inflammatory response syndrome (SIRS), diabetes, hemiplegia of the left side, anoxic brain damage, aphasia, dysphagia, anemia, osteoarthritis, traumatic brain injury, anxiety disorder, neuromuscular disfunction of the bladder, adult failure to thrive, peripheral vascular disease and bed confinement. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #10 had severely impaired cognition, was dependent on staff for all activities of daily living (ADLs) and had an indwelling urinary catheter. Resident #10 received a mechanically altered diet and had a feeding tube. Review of Resident #10's physician's orders for October 2025 revealed Resident #10 had an order dated 05/08/25 for an air mattress with bolsters dated 05/08/25 and an order for wound care dated 10/02/25 which stated to cleanse the sacrum with normal saline, pat dry, apply barrier cream and dry dressing for pad and protection every three days and as needed.Observation with the Director of Nursing (DON) on 10/07/25 at 1:55 P.M. revealed the air mattress was set at 610 pounds. The DON verified at the time of observation the mattress was set at 610 pounds but stated the resident was comfortable. Observation on 10/08/25 at 11:30 A.M. revealed the air mattress for Resident #10 was still set at 610 pounds. Observation with Licensed Practical Nurse (LPN) #226 on 10/08/25 at 2:00 P.M. revealed the air mattress for Resident #10 was set at 610 pounds. An interview at the time of observation with LPN #226 revealed Resident #10 only weighted 165 pounds. She stated she was told he was care planned for it to be at 610 pounds so he could elevated higher to see the television. On 10/08/25 at 4:15 P. M. an interview with the DON verified there was no documentation in the plan of care for Resident #10 to have his air mattress at 610 pounds per his preference. Review of the operation manual for the Proactive Protek Aire Mattress revealed the Press Pressure Range was 20-65 millimeters of mercury adjustable by the residents weight. The mattress weight settings were adjustable between 90 and 650 pounds.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the hospital records, staff interview, and facility policy review, the facility failed to properly care for the feeding tube for Resident #10 to prevent mold from forming within the tube. This affected one resident (#10) of three residents reviewed for feeding tubes. The facility census was 48.Findings include: Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, systemic inflammatory response syndrome (SIRS), diabetes, hemiplegia of the left side, anoxic brain damage, aphasia, dysphagia, anemia, osteoarthritis, traumatic brain injury, anxiety disorder, neuromuscular disfunction of the bladder, adult failure to thrive, peripheral vascular disease, and bed confinement.Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #10 had severely impaired cognition, was dependent on staff for all activities of daily living (ADLs) and had an indwelling urinary catheter. Resident #10 received a mechanically altered diet and had a feeding tube. Review of Resident #10's physician's orders for August 2025 revealed Resident #10 had an order dated 04/20/24 for hydration flushes every four hours with 300 milliliters of water, an order dated 08/27/25 for bolus tube feedings using IsoSource 1.5 (tube feeding formula) 237 milliliters routinely at 12:00 A.M., 3:00 A.M., 6:00 A.M., and 9:00 P.M., an order dated 04/03/24 to cleanse Resident #10's Percutaneous Endoscopic Gastrostomy (PEG) tube site daily with soap and water, apply a T-drain (split dry gauze) dressing daily and as needed, and an order dated 04/05/24 noting that Resident #10 was ordered a regular diet with pureed texture with small portions and was able to be administered his medication by mouth.Review of the Health Status notes dated 08/25/25 at 3:11 P.M. revealed Resident #10 was sent out to the hospital for evaluation of a discolored PEG tube. Upon initial assessment, the PEG tube site appeared intact but with dark discoloration of the tubing, with no visible leakage or bleeding from the insertion site. The site surrounding the PEG tube was clean and dry with minimal erythema (redness), however, the tubing showed brownish discoloration internally, which raised concerns for possible infection or internal bleeding. Resident #10 denied abdominal pain, nausea, or vomiting but reported mild discomfort at the peg tube site. Resident #10 had no sign of fever or hemodynamic instability noted. His vital signs were within normal limits at time of assessment. The physician was notified and gave order to send him to the hospital for further evaluation and possible replacement. Resident #10 was transported via ambulance in stable condition. The family was notified of his change in condition and transfer to hospital. The PEG tube site was lightly dressed prior to transport. Review of the Case Management report from the hospital dated 08/25/25 revealed Resident #10 presented to the emergency room (ER) for tube feed assessment. It was reported by an unnamed Registered Nurse that the resident had a moldy peg tube with a large black and budging (moving) spots. Review of the Physician's emergency room report dated 08/26/25 at 12:33 A.M. revealed Resident #10 was in the ER with mold around his PEG tube which was replaced in the ER and he was discharged back to the facility. On 10/08/25 at 3:33 P.M. an interview with Nurse #300 verified there was mold in the PEG tube of Resident #10. She stated they sent him out to the hospital because she did not want to flush the tubing with the mold in the tube. She stated she interviewed the (unnamed) certified nursing assistants (CNA) about it and they all stated it had been like that for a while, however, they were not nurses and did not know what it was. Nurse #300 also stated none of the nurses remembered seeing discoloration or mold in the tubing and confirmed if they had been flushing the PEG tube as ordered they would have seen it.Review of the facility policy titled, G Tube/J Tube Care, dated 09/2021 revealed the licensed nurse would provide routine care to the gastrostomy and jejunostomy tubes to maintain patency of the tube and good skin integrity.This deficiency represents non-compliance investigated under Complaint Number 2603716.

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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. Based on observation, staff interview, and facility policy review, the facility failed to maintain the shower on the [NAME] hallway in good working condition. This had the potential to affect 11 residents (#7, #15, #22, #24, #33, #35, #38, #40, #43, #45, and #47) who used the [NAME] Hallway shower. The facility census was 48. Findings include: On 10/08/25 at 8:55 A.M., an interview with Family Member #263 revealed the shower on the [NAME] Hallway had several titles falling off the wall and they have been like that for about a year now. Observation of the [NAME] hallway shower room with Licensed Practical Nurse (LPN) #300 on 10/08/25 at 9:17 A.M. revealed the toilet broken off the seal in the floor, there was feces smeared on the outside of the toilet, there were six tiles pulled off the shower stall wall around the floor exposing a very large hole in the wall. There were two tiles missing from the bottom corner of the shower stall with a hole in the wall exposed. There was a pile of broken tile in the corner of the shower stall. An interview at this with LPN #300 confirmed the tiles were off the wall and were lying on the floor in a pile. She also verified the toilet was broken and there was feces on the toilet. On 10/08/25 at 9:31 A.M., an interview with Certified Nursing Assistant (CNA) #249 stated the tiles in the [NAME] Hallway bathroom have been broken for a while but she was not sure for how long. Review of the facility policy titled, Resident Environmental Quality, dated 08/23 revealed it was the policy of the facility to be designed, constructed, equipped and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.