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	10/28/2025

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interview and medical record review, the facility failed to ensure residents were notified in writing of a room move. This affected three residents (#110, #115, #117) of three residents reviewed for room moves. The facility census was 50.Findings include:1. Review of the medical record for Resident #110 revealed an admission date of 06/07/24 and diagnoses including dementia, congestive heart failure (CHF), and hypertension.Review of the clinical census revealed Resident #110 had a room move on 12/31/24.Review of the progress note dated 12/31/24 revealed Resident #110 requested a room move.Review of the medical record revealed no evidence of a written room move notification was issued.2. Review of the medical record for Resident #115 revealed an admission date of 03/11/25 and diagnoses including Parkinson's disease, chronic obstructive pulmonary disease (COPD), and dementia.Review of the clinical census revealed Resident #115 had a room move on 04/22/25.Review of the progress note dated 04/22/25 revealed social services discussed a room move with Resident #115. Resident #115 was agreeable to move rooms.Review of the medical record revealed no evidence of a written room move notification was issued.3. Review of the medical record for Resident #117 revealed an admission date of 07/09/21 and diagnoses including chronic kidney disease (CKD), osteoporosis, and atrial fibrillation.Review of the clinical census revealed Resident #117 had a room move on 05/13/25.Review of the progress note dated 05/13/25 revealed social services contacted Resident #117's emergency contact. The facility needed a private room for another resident who required isolation. Resident #117's emergency contact agreed to the room move.Review of the medical record revealed no evidence of a written room move notification was issued.Interview on 10/22/25 at 10:12 A. M. with Social Service Designee (SSD) #860 revealed when a resident was set to move rooms, they had a verbal discussion to get confirmation. SSD #860 confirmed there was no written notice for room moves for Residents #110, #115, or #117.Interview on 10/22/25 at 2:57 P.M. with Regional Nurse #703 revealed the facility did not have a policy on room moves.This deficiency represents non-compliance investigated under Complaint Number 2642458.

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

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	10/28/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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	10/28/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of staff statements, medical record review, and review of facility policy, the facility failed to develop and implement a comprehensive and effective pressure ulcer program to ensure wound care was provided to prevent a decline Resident #150's wound status. Actual Harm occurred beginning on 07/24/25 when Resident #150 returned from a hospitalization and wound care orders to treat a chronic right heel wound were not transcribed into the facility's electronic health record (EHR) for implementation. Between 07/24/25 and 08/20/25, Resident #150 had no wound care orders in place and had no documented wound dressing changes recorded. Resident #150 was seen by Wound Nurse Practitioner (NP) #706 on 08/20/25 who noted the wound had deteriorated and had an increase in wound exudate. Resident #150 was hospitalized on [DATE] and required a debridement (a medical procedure to remove dead, infected, or damaged tissue from a wound) for gas gangrene (bacterial infection that destroys muscle tissue) of the right foot and osteomyelitis (infection of the bone) of the right heel. The debridement procedure resulted in significant exposure of the plantar calcaneus (bottom part of the heel). Resident #150 was admitted to the hospital for eight days and required intravenous antibiotics to treat his wound infection. On 09/07/25 staff identified the presence of maggots in Resident #150's right heel wound. The resident was transferred to the hospital for treatment of infection of the area. This affected one resident (#150) of three residents reviewed for wound care. The facility census was 50.Findings include:Review of the medical record for Resident #150 revealed an initial admission date of 02/14/24 with diagnoses including Stage IV (a full-thickness wound involving muscle, tendon, and/or bone) pressure ulcer of right heel, local infection of skin and subcutaneous tissue, chronic osteomyelitis with draining sinus of left ankle and foot, non-pressure chronic ulcer of left heel and mid foot with necrosis of bone, congestive heart failure, diabetes mellitus, myiasis (parasitic infection of fly larvae in human tissue), and epilepsy. Record review revealed Resident #150 had multiple hospitalizations while residing in the facility.Review of the plan of care initiated 02/29/24 revealed Resident #150 was at risk for pressure ulcer development related to history of pressure ulcers, decline in activities of daily living and mobility, and incontinence status. Interventions included administer treatments as ordered, monitor for effectiveness of treatments, educate on causes of skin breakdown, inform of any new areas of skin breakdown, monitor dressing to ensure it is intact, monitor nutritional status, obtain labs as ordered, and treat pain as ordered. The plan of care was cancelled on 09/01/25. An additional plan of care was initiated on 09/03/25 and revised on 09/08/25 to include the resident had an alteration to his skin to include osteomyelitis affecting bilateral heels. Listed interventions included administer treatments as ordered and monitor for effectiveness, assess, record, and monitor wound leaking as ordered, pressure reducing mattress to the bed, and assist the resident to turn and reposition as needed. The care plan did not mention any offloading of the heels or heel boots that Resident #150 should wear. Review of the census list for Resident #150 revealed the resident was hospitalized from [DATE] to 07/03/25. Review of the Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 07/04/25 revealed Resident #150 was at moderate risk for developing pressure injuries. Review of a wound assessment report dated 07/09/25 authored by Wound Nurse Practitioner (NP) #706 revealed Resident #150 had an unstageable (indicating a wound bed and depth of a wound is unable to be visualized) diabetic ulcer of the right heel measuring 5.0 centimeters (cm) in length by 5.5 cm in width with 0.1 cm depth. (This ulcer was subsequently assessed during a July 2025 hospitalization to be a pressure ulcer.) The report revealed the wound was acquired on 11/14/24. There was 90 percent (%) eschar (layer of dead tissue that forms over wound) and 10% epithelial tissue (thin layer of new tissue). There was no exudate (fluid that leaks out of blood vessels into surrounding tissue in response to inflammation or injury) noted. The recommended wound treatment was to cleanse the right heel with normal saline, apply Betadine (antiseptic solution), and abdominal (ABD) pad, and rolled gauze, change daily and as needed. The wound was noted to be stalled. Review of a wound assessment report dated 07/16/25 authored by Wound NP #706 revealed Resident #150's right heel wound measured 5.0 cm in length, 5.5 cm in width, and 0.1 cm depth. The wound was 90% eschar and 10% epithelial tissue. There was no noted exudate. The wound remained stalled. The recommended treatment remained to cleanse with normal saline, apply Betadine, and ABD pad, and rolled gauze with frequency of daily and as needed. Review of a progress note dated 07/19/25 timed 11:15 P.M. revealed Resident #150 was having difficulty managing his blood glucose levels and the physician recommended to send the resident to the hospital for evaluation. An additional progress note dated