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	05/08/2024

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38522 Based on interview, record review and facility policy review, the facility failed to provide spend-down letters for each month residents were approaching or over the resource limit. This affected two residents (#11 and #16) of five residents reviewed for resident funds. The facility census was 88. Findings include: 1. Review of Resident #11's medical record revealed an admitted [DATE] and diagnoses including paranoid schizophrenia, violent behavior, unspecified psychosis, impulse disorder, anxiety and hypertension. Review of a social service progress note dated 03/27/24 revealed the Business Office Manager (BOM) informed Resident #11's guardian that Resident #11 was in jeopardy of losing Medicaid due to an abundance of funds. Review of Resident #11's quarterly funds statement from 01/01/24 to 03/31/24 revealed an ending balance of $1832.49 on 01/31/24, an ending balance of $1872.59 on 02/29/24 and an ending balance of $1912.69 on 03/31/24. Review of attached documentation revealed a spend-down letter dated 03/27/24. No other spend-down letters were available for review. Interview on 05/06/24 at 10:52 A.M. with BOM #218 revealed she provided a spend-down letter when residents had a balance of $1800.00 or more every quarter with the quarterly financial statements. BOM #218 confirmed she did not have spend-down letters for January 2024 and February 2024 for Resident #11 during the interview. 2. Review of Resident #16's medical record revealed an admitted [DATE] and diagnoses including bipolar disorder, anxiety disorder, hypertension, dementia without behavioral disturbance and chronic hepatitis C. Review of Resident #16's quarterly funds statement from 01/01/24 to 03/31/24 revealed an ending balance of $1808.61 on 01/31/24, an ending balance of $1838.70 on 02/29/24 and an ending balance of $1868.79 on 03/31/24. Review of attached documentation revealed a spend-down letter dated 03/29/24. No other spend-down letters were available for review. (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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/06/24 at 10:52 A.M. with BOM #218 revealed she provided a spend-down letter when residents had a balance of $1800.00 or more every quarter with the quarterly financial statements. BOM #218 confirmed she did not have spend-down letters for January 2024 and February 2024 for Resident #16 during the interview. Review of the facility policy, Accounting and Records of Residents Funds, revised April 2017 revealed a representative of the business office would inform the resident if the balance in his/her personal funds account reached $200.00 less than the resident's supplemental security income (SSI) resource limit and that if the amount in the account reached the SSI resource limit for one person, the resident could lose eligibility for Medicaid or SSI.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32650 Based on record review and staff interview, the facility failed to accurately code comprehensive assessments for two residents (#54 and #88) of 24 residents reviewed for assessments. The facility census was 88. Findings Include: 1. Medical record review revealed Resident #88 was admitted to the facility on [DATE] with diagnoses including surgical aftercare following skin grafts to bilateral feet for burns, diabetes, stroke, end stage renal disease dependent on dialysis, and high blood pressure. Review of the physician's orders dated 02/13/24 revealed an order for oxycodone (an opioid pain medication) 5 milligrams (mg) orally every six hours as needed for pain. Review of the admission comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #88 was cognitively intact, received scheduled and as needed pain medication, and received non-medication alternatives for pain. On a scale of zero to ten with zero indicating no pain and ten indicating severe pain, the resident rated his pain level as a five. The pain occasionally interfered with therapy activities, daily activities, and sleep. The medications Resident #88 received during the assessment period included insulin, an anticoagulant, and a diuretic. The resident received no opioids during the assessment period per the assessment. Review of the progress notes for Resident #88 revealed on 02/12/24 Licensed Practical Nurse (LPN) #151 was performing the resident's dressing change to his feet which caused severe pain for the resident. LPN #151 administered oxycodone 5 mg orally for pain, waited 30 minutes, then resumed the dressing changed. Interview with MDS Coordinator #222 on 05/06/24 at 3:55 P.M. confirmed the Admission MDS assessment was incorrectly coded under Section N, Medications, and should have marked Resident #88 received opioids during the assessment period. 2. Review of the MDS discharge assessment for Resident #88, dated 02/15/24, revealed the resident was discharged to the hospital on 02/15/24. Review of the progress notes dated 02/15/24 revealed Resident #88 was discharged against medical advice and arranged for a ride home. Interview with MDS Coordinator #222 on 05/06/24 at 3:55 P.M. confirmed the discharge assessment as being transferred to the hospital was coded incorrectly. 38522 3. Review of Resident #54's medical record revealed an admitted [DATE] and diagnoses including vascular dementia without behavioral disturbance, adult failure to thrive, hyperlipidemia, chronic kidney disease and hypertension. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an annual minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 was cognitively impaired. The assessment indicated that no falls had occurred since the prior assessment. Review of a fall report dated 09/19/23 revealed Resident #54 fell on [DATE] at 8:00 P.M. with no injuries noted. Interview on 05/06/24 at 3:54 P.M. with MDS Registered Nurse (RN) #222 revealed Resident #54 had a fall on 09/19/23. MDS RN #222 stated the annual MDS assessment dated [DATE] was coded to reflect Resident #54 having no falls, when in fact he did have a fall and verified the assessment was coded incorrectly.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48567 Based on observation, interview, medical record review, and policy review, the facility failed to ensure a medication error rate of less than five percent (%). Six medication errors occurred within 31 observed opportunities for error resulting in an error rate of 19.35% . This affected three residents (Residents # 241, #41, and #58) of nine residents observed during medication administration. The facility census was 88. Findings include: 1. Review of the medical record for Resident #241 revealed an admitted [DATE] with diagnoses including sepsis due to other specified staphylococcus, chronic obstructive pulmonary disease (COPD), type two diabetes mellitus, depression, dependence on renal dialysis, and anemia. Review of the Minimum Data Set (MDS) 3.0 assessment completed on 04/27/24 revealed Resident #241 had intact cognition. Further review of the MDS revealed Resident #241 had no insulin-related order changes and had received an insulin injection seven of the seven days during the look-back period. Review of the physician orders revealed an order dated 04/22/24 for nystatin mouth/throat suspension, 100, 000 units per milliliter (ml), five ml by mouth every six hours with instructions for the resident to swish and then swallow the nystatin. Review of the physician orders further revealed an order dated 04/20/24 for Humulin N KwikPen 100 unit/ml, four units subcutaneously before meals and at bedtime for type two diabetes mellitus. Observation on 05/06/24 at 12:13 P.M. of Resident #241's medication administration by licensed practical nurse (LPN) #140 revealed Resident #241 took the nystatin suspension and was instructed to swish but not swallow the medication. LPN#140 then placed a plastic cup under Resident #241's mouth and instructed him to spit the nystatin into the cup. Further observation Resident #241's medication administration revealed LPN #241 dialed the Humalog N KwikPen to the ordered dose of four units, carried the pen and injection supplies into the resident's room, applied the needle at the bedside, and injected the insulin subcutaneously into the back of Resident #241's left upper arm before first priming the needle. Interview on 05/06/24 at 12:15 P.M. with LPN #140 confirmed she administered the Humalog KwikPen to Resident #241 without first priming the needle. She further confirmed it was her typical practice to dial the dose knob to the ordered dose, take the injection pen into the residents' rooms, apply the needle to the injection pen at the bedside, and administer the insulin without first priming the needle and re-dialing the dose knob to the ordered insulin dose. Another interview with LPN #140 on 05/06/24 at 12:58 P.M. confirmed she instructed Resident #241 to spit and not swallow the nystatin and confirmed the written order contained instructions to swish and swallow the nystatin. Review of the policy titled Administering Medications, revised April 2019 revealed medications were to be administered in accordance with prescriber orders and the staff administering the ordered medications should check the label three times to verify the administration rights, which included the right method of administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Instructions for Use Humulin (R)N KwikPen(R) revealed the injection needle must be primed prior to each injection. The instructions further revealed once the new needle is placed, the dose knob should be turned to two units and then depressed until a 0 is seen in the dose window and insulin could be seen at the tip of the needle before resetting the dose knob to the ordered dose. 2. Review of the medical record for Resident #41 revealed an admitted [DATE] with diagnoses including unspecified dementia, late onset Alzheimer's disease, psychotic disorder with delusions, restlessness and agitation, hypertension, type two diabetes mellitus, moderate protein-calorie malnutrition, and encounter for fitting and adjustment of gastrointestinal appliance and device. Review of the Minimum Data Set (MDS) 3.0 assessment completed on 02/18/24 revealed Resident #41 had severely impaired cognition and had a feeding tube. Review of the care plan dated 02/08/24 revealed Resident #41 had the potential for an alteration in comfort secondary to deconditioning and decreased mobility. Interventions included anticipating Resident #41's need for pain relief, responding immediately to complaints of pain, and reviewing pain medication dosing schedules and pain interventions for effectiveness. Review of the physician orders revealed an order dated 04/22/24 for Resident #41 to receive acetaminophen 1,000 milligrams (mg) through her percutaneous endoscopic gastrostomy (PEG) tube (a tube that is surgically placed into the stomach for nutrition, hydration, and medication) three times a day for pain. Review of the physician orders revealed no additional instructions related to water flushes with medications. Observation on 05/06/24 at 12:50 P.M. of licensed practical nurse (LPN) #143 administering acetaminophen to Resident #41 revealed LPN #143 crushed the 1,000 mg of acetaminophen, mixed the granule with water in a plastic cup, withdrew the water mixture from the cup, paused the tube feeding, attached the syringe with the water and medication onto the port of the PEG tube, pushed the medication through the tubing by depressing the plunger of the syringe, then reconnected and restarted the tube feeding. At the time of the medication administration, no flush was observed before of after the medication administration and the plastic cup used to mix the acetaminophen still contained a moderate amount of white medication granules settled at the bottom of the cup with a small amount of cloudy water. Interview on 05/06/24 at 12:50 P.M. with LPN #143 at the time the medication administration observation, once she resumed the tube feeding, confirmed she was finished with the administration of the ordered acetaminophen, restarted the tube feeding without flushing the PEG tube, and then confirmed there was left over medication settled on the bottom of the cup that was not given to Resident #41 at the time of the medication administration. Review of the policy titled Administering Medications, revised April 2019 revealed medications were to be administered in accordance with prescriber orders. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Administering Medications through an Enteral Tube revised in November 2018 revealed if the tube feeding was running at the time medication was to be administered, staff were to stop the feeding, flush with at least 15 milliliters (ml) of warm purified water, unless a different amount or fluid was prescribed for flushing, administer the diluted medication into the syringe (without the plunger) by gravity flow, flush the tube with 15 ml of warm purified water, clamp the tubing, remove syringe, and then restart the feeding. 32650 3. Observation of medication administration on 05/07/24 at 8:45 A.M. for Resident #58 revealed Licensed Practical Nurse (LPN) #155 administering Miralax (a medication used to prevent constipation) 17 grams (gm) mixed in four ounces of water, Eliquis (an anticoagulant) 5 milligrams (mg), a multi-vitamin, omeprazole (used to treat gastric reflux) 20 mg, and Colace (a medication used to prevent constipation) 100 mg. All medications were given orally. Review of Resident #58's May 2024 recapitulation of physician's orders revealed an order dated 08/29/23 for Breo Ellipta Aerosol Powder Breath (an inhaler used to treat asthma or chronic obstructive pulmonary disease) 200-25 micrograms (mcg) one puff every morning. Rinse mouth thoroughly and spit, and orders dated 07/11/22 for magnesium 100 mg administer two tablets every morning, and Flonase nasal spray (a medication used to treat environmental allergies) 50 mcg/AT one spray in each nostril. Review of the Medication Administration Record dated 05/07/14 revealed the Breo Ellipta inhaler, Flonase nasal spray and magnesium were not signed off by LPN #155 as being administered. Interview with LPN #155 on 05/07/24 at 1:30 P.M. regarding the omitted medications revealed the magnesium was not available, she thought she administered the Flonase nasal spray and she did not remember if she administered the Breo Ellipta inhaler. The Director of Nursing (DON) was present during the interview.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38522 Based on observation, interview and facility policy review, the facility failed to ensure food items were appropriately labeled, dated and contained. This had the potential to affect 85 residents receiving meals from the kitchen as three residents (#41, #71 and #77) were ordered nothing-by-mouth (NPO). The facility census was 88. Findings include: Observation of the kitchen on 05/05/24 starting at 9:15 A.M. with [NAME] #116 revealed the following: In the beverage cooler, there were four desserts in styrofoam bowls with lids that lacked labels or dates. In the walk-in cooler, a case of bacon slices was open to air with no other covering and there was a pan of fried chicken in a hotel pan uncovered and open to air. There was a bag of lettuce that was not re-sealed, a pack of sliced cheese and a bag of shredded cheese and all lacked labels and dates. In the dry storage room, there was a sanitizer pail and the bin of sugar was open to air. Interviews with [NAME] #116 verified the findings at the time of observation. [NAME] #116 indicated food items should be covered, labeled and dated before placed in the coolers. [NAME] #116 was not sure why there was a sanitizer pail in the dry storage room. Review of the undated facility policy, Food Storage, revealed food items should be stored, thawed and prepared in accordance with good sanitary practice. All products should be dated upon receipt, when open and when prepared. Remember to cover, label and date. Review of a diet list as of 05/05/24 revealed three residents (#41, #71 and #77) were NPO.