

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Cleveland Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 N Division St Cleveland, OK 74020	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46703</p> <p>Based on record review and interview, the facility failed to ensure a resident and/or resident's representative the right to participate in the development and implementation of their person-centered plan of care for 1 (#5) of 1 sampled resident reviewed for care plan meetings.</p> <p>The DON identified 52 residents resided in the facility.</p> <p>Findings:</p> <p>A Comprehensive Person-Centered Care Plan policy, dated 01/23/19, read in part, 3. The Interdisciplinary Team, along with the Resident and/or Resident Representative, will identify resident problems, needs, strengths, life history, preferences, and goals. 6. The Comprehensive Person Centered Care Plan can be revised at quarterly intervals in conjunction with the completion of MDS quarterly, significant change and annual assessments per the RAI manual.</p> <p>Resident #5 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease and kidney failure.</p> <p>Resident #5's clinical record was reviewed July 2024 through March 2025. There was no documentation to show Resident #5 and/or their representative participated in the development and implementation of their care plan.</p> <p>An annual MDS assessment, dated 01/29/25, showed Resident #5's cognition was intact with a brief interview for mental status score of 15.</p> <p>On 03/17/25 at 1:00 p.m., Resident #5 stated they had not had a care plan meeting, but would like to. They stated no one had discussed their plan of care with them.</p> <p>On 03/18/25 at 1:00 p.m., the director of nursing stated they depended on the MDS coordinator to tell them when care plan meetings were done, but they did not have a certain way they follow up on the meetings.</p> <p>On 03/18/25 at 1:30 p.m., the MDS coordinator stated they have not been doing care plan meetings because everyone says they are too busy, but they should be done quarterly.</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
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