

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 04/04/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30267</p> <p>Based on observation, record review, and interview, the facility failed to provide a resident with a bed wide enough to allow the resident to reposition themselves and side rails/trapeze bar for the resident to use in positioning for 1 (#2) of 3 residents sampled for accommodation of needs.</p> <p>The alphabetical resident roster identified 56 residents resided in the facility.</p> <p>Findings:</p> <p>On 03/28/25 at 11:45 a.m., Resident #2 was observed in bed with the head of the bed up approximately 45 degrees. The resident was on an air mattress with approximately 4 inches from their hip to the edge of the air mattress on either side. There were no side rails or a trapeze bar present.</p> <p>A facility policy titled Quality of Life - Accommodation of Needs, dated 02/01/16, read in part, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well-being .The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility.</p> <p>Resident #2 was admitted on [DATE] with diagnoses which included paraplegia, anxiety, depression, and pressure ulcers.</p> <p>An admission assessment, dated 03/12/25, showed the resident was cognitively intact (BIMS 15), felt down, depressed, or hopeless, and was dependent on staff to roll left/right when lying on back or moving to/from sitting on the side of the bed. The assessment showed the resident was dependent on personal hygiene, lower body dressing, bathing, and toileting hygiene. The assessment showed the resident had four Stage 4 pressure ulcers.</p> <p>A care plan, dated 03/18/25, read in part, The resident has paraplegia r/t Spinal injury d/t MVA .Assist with ADLs [activities of daily living] and locomotion as required. Encourage resident to perform as much as possible of these activities .limited physical mobility d/t paraplegia r/t past MVA .Encourage resident to perform as much of upper body tasks as possible.</p> <p>(continued on next page)</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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/28/25 at 11:45 a.m., Resident #2 stated their bed mobility was limited without side rails and a trapeze bar to grab. The resident stated they were accustomed to using side rails and a trapeze bar for bed mobility, but when they asked for side rails, the facility informed them the facility did not use side rails because they were a restraint. The resident stated they felt claustrophobic and restrained due to the bed's size and their lack of independent bed mobility. The resident stated without anything to hold onto, they were completely dependent on staff for bed mobility and feared falling from the edge of the bed every time they were repositioned.</p> <p>On 03/28/25 at 2:30 p.m., the DON stated the resident had requested full side rails on admission, but the facility policy did not allow for the use of full side rails. The DON stated the resident requested a trapeze bar a few days before, but they had not provided one yet.</p> <p>On 03/31/25 at 11:30 a.m., the DON stated they relied on their nursing staff and therapy department to inform them when an accommodation was needed. The DON stated they were unaware the resident's bed did not comfortably accommodate the resident.</p>		