

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 12/08/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review and interview, the facility failed to ensure medication was administered as ordered by the physician for 1 (#44) of 1 resident sampled reviewed for medication administration. The regional director identified 58 residents resided in the facility. Findings: A physician order, dated 07/09/24, showed Nystatin Powder was to be applied to folds, abdomen, and neck topically every shift. A significant change assessment, dated 11/17/25, showed Resident #44 had diagnosis which included candidiasis of the skin and nails. The assessment showed Resident #44 had a BIMS of 15 and was cognitively intact for daily decision making. A review of the November 2025 medication administration record for the night shift, showed Resident #44 had not received Nystatin Powder on November 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 25, 26, 27 and 28. On 12/08/25 at 10:14 a.m., the ADON stated if the check box on the medication administration record was not checked the task had been completed then they assumed it was not done.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to evaluate a resident for vaping/e-cigarette use safely for 1 (#44) of 2 sampled residents reviewed for safe smoking. The regional director identified 58 residents resided in the facility. Findings: On 12/02/25 at 2:53 p.m., Resident #44 was observed in bed wearing oxygen with a nasal canula attached to an oxygen concentrator. There were three pink vape-e-cigarettes smoking devices observed on the resident's bedside table. On 12/04/25 at 11:02 a.m., Resident #44 was observed in bed wearing oxygen with a nasal canula attached to an oxygen concentrator. There were three pink vape-e-cigarettes smoking devices observed on the resident's bedside table. A facility policy titled Smoking Protocol, dated 10/25/22, did not show vaping/e-cigarettes was addressed in the policy to prevent accidents and hazards. Resident #44's Smoking Safety Evaluation, dated 11/05/25, showed the resident did not smoke. Resident #44's comprehensive assessment, dated 11/17/25, showed the resident was admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease and hypoventilation syndrome. The assessment showed Resident #44's cognition was intact with a BIMS score of 15. The assessment showed Resident #44 required substantial to maximum assistance with bed mobility and was dependent for a bed transfers. The assessment showed the resident used supplemental oxygen and was not a tobacco user. On 12/02/25 at 2:23 p.m., Resident #44 stated they were bed bound and used supplemental oxygen continuously. Resident #44 stated they vaped e-cigarettes in their room and everybody, but the DON knew they vaped in their room. Resident #44 stated facility staff turned their heads because they could not go outside. On 12/04/25 at 11:02 a.m., Resident #44 stated the ADON told them they should not smoke in their room, but understood because the resident did not get out of bed. On 12/04/25 at 11:22 a.m., CNA #1 was asked to discuss Resident #44's smoking. CNA #1 stated Resident #44 used e-cigarette/vapes, had vapes/e-cigarettes on their bedside table, and did not like to get out of bed unless it was for a shower. CNA #1 stated Resident #44 had confided in them they vaped e-cigarettes in their room when nurses had asked them not to. On 12/04/25 at 11:34 a.m., the ADON was asked about Resident #44. The ADON stated Resident #44 was bed bound, used continuous supplemental oxygen, and was on hospice services. The ADON stated Resident #44 got out of bed for showers only and was a three to four person assist. The ADON stated Resident #44 used e-cigarettes/ vapes the resident had in their possession. The ADON stated Resident #44 hid under their blanket and used the e-cigarette/vape in their room. The ADON stated they did not include vaping/e-cigarettes on smoking assessments. On 12/04/25 at 11:43 a.m., the administrator stated vaping/e-cigarettes were not included in smoking assessment and smoking policy. The administrator stated residents were not allowed to use vapes/e-cigarettes inside the facility.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the head of bed was elevated for 1 (#5) of 1 resident reviewed for continuous tube feeding. The ADON identified two residents received tube feeding. Findings: On 12/03/25 at 8:43 a.m., Resident #5 was observed to receive continuous tube feeding without the head of their bed elevated. On 12/04/25 at 8:51 a.m., the head of bed for Resident #5 was observed to be flat and without elevation. On 12/04/25 at 12:25 p.m., the head of bed for Resident #5 was observed to be flat and without elevation. On 12/08/25 at 11:00 a.m., the head of bed for Resident #5 was observed to be flat and without elevation. A care plan, dated 08/08/25, showed Resident #5 had diagnoses which included severe protein calorie malnutrition and gastro-esophageal reflux disease. A significant change assessment, dated 11/21/25, showed Resident #5 had moderate cognitive impairment with a BIMS of 10. On 12/08/25 at 11:00 a.m., LPN #1 stated they had worked at the facility for one week and had not observed the head of Resident #5's bed to be elevated. On 12/08/25 at 11:15 a.m., Resident #5 stated they do not want the head of the bed elevated because they like to sleep a lot and cannot sleep if the head of the bed is elevated. On 12/08/25 at 2:22 p.m., the ADON stated Resident #5 should have the head of their bed elevated 45 degrees. They stated the resident could aspirate if it was not elevated. They stated the resident would put the head of the bed down if it were elevated. The ADON stated the resident had not been educated on the possible complications of not having the head of their bed elevated.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a resident's nebulizer and oxygen mask were bagged when not in use to prevent cross contamination for 1 (#4) of 16 sampled residents reviewed for infection control practices. The regional director identified 58 residents resided in the facility. Findings: On 12/03/25 at 2:47 p.m., Resident #4 was not in their room. Resident #4's nasal cannula was observed laying bedside in a recliner loose and not in a bag. Resident #4 nebulizers mask was bedside with a hose attached laying on a cart under the window and not in a bag. Resident #4's physician orders, dated 01/10/25, showed Resident #4 had orders for albuterol sulfate inhalation solution 2.5 milligrams/3 milliliter orally via a nebulizer. Resident #4's physician orders, dated 07/04/25, showed Resident #4 had orders for continuous oxygen at two liters via an oxygen concentrator. The orders showed to store tubing and mask in a dry protective cover when not in use. Resident #4's significant change assessment, dated 11/17/25, showed they were admitted on [DATE] with diagnoses which included congestive heart failure and anemia. The assessment showed Resident #4's cognition was moderately impaired with a BIMS score of 11. The assessment showed Resident #4 was dependent for transfers, used a wheelchair to ambulate, and used oxygen therapy. On 12/03/25 at 2:55 p.m., LPN #2 was asked about Resident #4's respiratory needs and orders. LPN #2 stated Resident #4 had orders for continuous oxygen and had routine breathing treatments. LPN #2 stated the nasal cannula was laying on the chair and should be hung on the machine. On 12/03/25 at 3:02 p.m., the ADON was asked to look in Resident #4's room and discuss the concern. The ADON stated the nasal cannula was laying on the recliner not in a bag and the nebulizer mask was laying bedside on a cart not in a bag. The ADON stated the nasal canula and nebulizer mask should be bagged when not in use. The ADON stated Resident #4 required staff assistance to transfer the resident and put on portable oxygen. The ADON stated staff should have bagged the nasal canula and the nebulizer mask for infection control to keep germs away.</p>		