STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455952	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Health Care Center	903 E Houston St Cleveland, TX 77327

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare for 1 of 3 residents (Resident #1) reviewed for discharge requirements. The facility failed to ensure Resident #1 remained in the facility and not transferred when not ordered. This failure could place discharged residents and residents residing in the facility at risk of being inappropriately discharged and causing a disruption in their care and/or services.Findings included: Record review of the Resident #1 face sheet dated 12/31/25 indicated he was a [AGE] year-old male admitted on [DATE] with diagnoses of high blood pressure, dementia, anxiety, heart disease and chronic kidney disease for respite care. Record review of Resident #1‘s physicians orders dated November 2025 indicated Resident #1 was admitted for hospice respite care and did not include active discharge orders. Record review of Resident #1's current care plan dated 11/26/25 reflected a plan for discharge with intervention to establish a pre-discharge plan with family. Record review of nurse notes dated 11/28/25 at 1:00 p.m., Resident #1 was transferred in error by ambulance. LVN B had given report then went to the room and realized the ambulance took the wrong resident. Record review of nurse note dated 11/28/25 at 1:32 p.m., LVN B assessed Resident #1 when ambulance returned Resident #1 to his bed. LVN B indicated no apparent injuries or bruises were noted. During attempted interviews on 12/30/25 at 10:00 a.m. and 2:00 p.m., Family members of Resident #1 did not answer the phone call and left detailed message for a return call. During attempted interviews on 12/30/25 at 11:00 a.m. and 3:00 p.m., the agency nursing services did not answer or return calls for interview with LVN B. During attempted interview on 12/31/25 at 8:30 a.m., the agency nursing services did not answer or return calls for interview with LVN B. A detailed message was left for request of interview with LVN B. During attempted interviews on 12/31/25 at 10:00 a.m. and 1:00 p.m., Family members of Resident #1 did not answer the phone call and left detailed message for a return call. During an interview on 12/31/25 at 11:00 a.m., The administrator said when the Resident #1 was mistakenly transferred. She said LVN B had notified her of the incident of Resident #1 being transferred instead of his roommate. She said she immediately called the hospice service and told them to return Resident #1 to the facility. She said Resident #1 was never taken out of the ambulance and returned to the facility within 30 to 35 minutes. She said LVN B assessed Resident #1 when he was returned, and no apparent injuries and the physician was notified, and family were at bedside when Resident #1 returned to this facility. She said her expectation was for the correct resident to be transferred. During an interview on 12/31/25 at 11:45 a.m., Hospice nurse C said she was not the nurse for the 11/28/25 and that nurse was on maternity leave, however she was aware of the event of 11/28/25. She said the wrong resident had been transferred and the ambulance service brought Resident #1 back to the facility after hospice was notified by the Administrator of the incident. Record review of the undated policy titled Transfer and Discharge indicated . It is the policy of this facility to permit each resident to remain in the facility, and not transferred or discharged from the facility .