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	04/30/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan to meet each resident's medical, nursing, mental, and psychosocial needs for 1 of 18 residents reviewed for care plans. (Resident #57) The facility did not have a care plan to address Resident #57's use of polymyxin b-trimethoprim ophthalmic solution (antibiotic eye drops to treat eye infections). This failure could place residents at risk of not having their individual needs met and not receiving needed services. Findings included: Record review of a face sheet dated 04/30/25 indicated Resident #57 was a [AGE] year-old female admitted on [DATE] and readmitted [DATE]. Her diagnoses included dementia (a group of thinking and social symptoms that interfere with daily functioning). Record review of the most recent annual MDS assessment dated [DATE] indicated Resident #57 had a BIMS score of 0 indicating severely impaired cognition and had adequate vision. Record review of physician's orders dated 04/30/25 indicated Resident #57 was prescribed polymyxin b-trimethoprim ophthalmic solution 10,000 units per 1ml to instill 1 drop in both eyes three times a day for an eye infection with a start date of 04/24/2025 for 7 Days. Record review of Resident #57's care plans printed on 04/30/25 indicated the care plan did not address Resident #57's use of polymyxin b-trimethoprim ophthalmic solution for an eye infection. Record review of Resident #57's MAR printed 04/30/25 indicated she received polymyxin b-trimethoprim ophthalmic solution three times a day for 7 days with a start day of 04/24/25. During an observation on 04/28/25 at 12:10 p.m., Resident #57 was up in her wheelchair, and her eyes and the skin around her eyes appeared pink and irritated. Resident #57 denied pain but was confused and did not respond when asked if she received eye drops. (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

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	04/30/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/25 at 2:11 p.m., LVN A said she was providing care for Resident #57 today and Resident #57 received antibiotic eye drops. She said the nurses did not complete care plans, and the MDS nurse was responsible for care plans. She said the antibiotic eye drops were not care planned and should be. She said it was possibly missed. LVN A said the resident risk of antibiotic eye drops not care planned was the staff may not be made aware to complete assessments of the resident during antibiotic administration or doing a follow up of the antibiotic after completion. During an interview on 04/30/25 at 2:16 p.m., MDS nurse B said she was responsible for updating care plans with the quarterly and comprehensive MDS assessments. She said the ADON was responsible for acute care plans involving antibiotics. She said she was educated on completion of care plans. She said it was possibly missed. MDS nurse B said the resident risk of antibiotic eye drops not care planned was possibly the antibiotic not being reevaluated after 7 days or the medication given too long. During an interview on 04/30/25 at 2:21 p.m., the ADON said she was responsible for acute care plans for antibiotics. She said she was the infection preventionist. She said the IDT double checks all the new antibiotic orders in the morning meeting to ensure they were all care planned and met antibiotic stewardship qualifications. The ADON said she was off Friday 04/25/25 and HHS entered the building Monday, 04/28/25 morning and she just she missed it. She said every morning she generated a report of new antibiotics prescribed by physicians for morning meeting to review and care plan. The ADON said she was educated to care plan all new antibiotics. She said the resident risk of antibiotic eye drops not care planned was staff may not be aware of interventions to be implemented, and the interventions may not be added to the nursing Kardex (a nursing tool that summarizes patient information). During an interview on 04/30/25 at 2:40 p.m., the DON said Resident #57's antibiotic eye drops should have been care planned. She said the ADON was responsible for initiation of the infection control program and care planning all new antibiotics. She said the IDT was the back up with weekly meetings to address all new antibiotics prescribed. The DON said the ADON initiated the antibiotic stewardship program, updated the IDT, and ensured all antibiotics were care planned. She said when the ADON was not in the building she was the back up. She said Resident #57's antibiotic eye drops not care planned was overlooked. The DON said the ADON was educated to care plan all acute care plans. She said the resident risk of an antibiotic not care planned was after the infection resolved it would be hard to identify if an infection was a repeat infection or a new infection and could be overlooked. The DON said her expectation was the antibiotic stewardship program be followed, all new antibiotics care planned and in the IDT meetings the staff ensure all new antibiotics were care planned. During an interview on 04/30/25 at 2:46 p.m., the Administrator said the ADON was responsible for acute care plans for antibiotics. She said the IDT was the backup, including the DON and MDS nurses to care plan all new medication and orders after morning meetings. The Administrator said Resident #57's antibiotic eye drops were ordered on a Friday, HHS entered on Monday, and the facility did not have their usual meeting Monday morning, 04/28/25 and it was missed. She said the facility got out of their routine. The Administrator said the resident risk was not following regulations by the antibiotic eye drops not care planned. She said the physician order ensured the nurses gave the medication and it had a stop date ordered so there was no resident risk. She said the risk was not following the regulations of care planning. The Administrator said her expectation was all care plans completed accurately and timely. (continued on next page)

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	04/30/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled, Comprehensive Care Plans dated 2025, indicated, . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs and {ALL} services that are identified in the resident's comprehensive assessment and meet professional standards of quality.