

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 21 residents (Resident #16, Resident #58, and Resident #62) who were reviewed for accuracy of assessments. 1. The facility failed to accurately complete the MDS assessment to indicate Resident #16 did not have a bedrail restraint. 2. The facility failed to accurately complete the MDS assessment to indicate Resident #58 did not have a bedrail restraint. 3. The facility failed to accurately complete the MDS assessment to indicate Resident #62's PASRR status was positive. These failures could place residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings include: 1. Record review of Resident #16's face sheet indicated an [AGE] year-old female originally admitted on [DATE] with diagnosis of vascular dementia (type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain), Type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar), and hypertensive heart disease (heart problems that arise due to prolonged high blood pressure) with heart failure (condition that develops when the heart doesn't pump enough blood for the body's needs). She resided in the memory care unit of the facility since 11/23/2025. Record review of Resident #16's quarterly MDS assessment, dated 05/14/2026, indicated a BIMS score of 06 indicating Resident #16 was severely cognitively impaired. Physical restraint (physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) assessment indicated Resident #16 used bedrails daily. She was independent with self-care and mobility tasks. Record review of Resident #16's care plan dated 11/26/2025 indicated resident utilized an enabling device of bed rails, to help with positioning, provide a sense of comfort/security, and/or promote independence. Interventions included Observe/document/report any changes regarding effectiveness of enabling device and possible reduction or discontinuation of its use. Record review of Resident #16's physician orders did not indicate the use of enabling device of bed rails. Record review of Resident #16's bed rail safety review dated 05/08/2026, authored by LVN D, indicated alternatives to bed rail use of adjusting height of bed (low bed) and education on turning and positioning in bed were recommended. (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: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 06/15/2026 at 9:56 a.m., Resident #16 was up ambulating with a walker independently within the memory care unit. Resident #16's assigned room revealed no bedrails noted on her bed. She said she gets up on her own and did not have or need bedrails. During an observation and interview on 06/15/2026 at 10:56 a.m., LVN D said she had worked at the facility for about 8 years and was routinely assigned to the memory care unit. She said Resident #16 independently ambulated with a walker within and outside the memory care unit with staff supervision. She said Resident #16 did not have bedrails or any type of restraint device on her bed, and she did not recall Resident #16 ever having any type of bedrails since she was admitted to the memory care unit. She observed Resident #16's room and bed and indicated she did not observe any bedrails or types of restraints on her assigned bed. LVN D was unsure why the MDS would be marked for restraints or bed rails. During an observation on 6/15/2026 at 1:56 p.m., Resident #16's room and assigned bed, no bedrails observed on bed. During an observation and interview on 06/16/2026 at 8:56 a.m., LVN E said he had worked at the facility for about 2 months and was routinely assigned to the memory care unit. He said Resident #16 independently ambulated with a walker within the memory care unit and outside the memory care unit with staff supervision. He said Resident #16 did not have bedrails or any type of restraint device on her bed, and he did not recall Resident #16 or any memory care unit residents ever having any type of bedrails. During an observation on 6/16/2026 at 10:00 a.m., Resident #16's room and assigned bed, no bedrails observed on bed. 2. Record review of Resident #58's face sheet dated 06/15/2026 indicated a [AGE] year-old female originally admitted on [DATE] with diagnosis of dementia (a decline in mental ability severe enough to interfere with daily life), schizoaffective disorder (chronic mental condition characterized by a combination of schizophrenia symptoms such as delusions and hallucinations and mood symptoms), chronic obstructive pulmonary disease (long term lung disease that blocks airflow and makes breathing difficult). Record review of Resident #58's quarterly MDS assessment, dated 04/30/2026, indicated a BIMS score of 03 indicating Resident #58 was severely cognitively impaired and diagnoses of dementia, schizoaffective disorder and chronic obstructive pulmonary disease. Physical restraint assessment indicated Resident #58 used bedrails daily. She was independent with self-care and mobility tasks. Record review of Resident #58's care plan with a target date of 07/02/2036 indicated Resident #58 had an ADL self-care performance deficit with interventions that included Bedrails: Bed rails to remain on the bed per resident's request for bed mobility. Date Initiated: 05/31/2016. Revision on: 06/08/2016 Record review of Resident #58's physician orders dated 06/15/2026 did not indicate the use of enabling device of bed rails. Record review of Resident #58's bed rail safety review dated 02/16/2026 indicated alternatives to bed rail use of adjusting height of bed (low bed) and education on turning and positioning in bed and continue current alternative measures was recommended. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/17/2026 at 9:20 a.m., Resident #58's assigned room revealed no bedrails noted on the bed. Resident #58 was up in her wheelchair and said she did not have side rails on her bed and was able to get out of bed without them. During an observation and interview on 06/17/2026 at 9:25 a.m., LVN A stated she had been there for 3 years. She said she was providing care for Resident #58 today (06/17/2026) and Resident #58 did not have bed rails on her bed. She said she did not remember her ever having bed rails on her bed. She said Resident #58 did not have restraints. LVN A was unsure why the MDS would be marked for restraints or bed rails. 3. Record review of Resident #62's face sheet indicated a [AGE] year-old female originally admitted on [DATE] with diagnosis of quadriplegia (a type of paralysis that results in the partial or total loss of use of all four limbs) and intellectual disability (significant limitations in intelligence/adaptive behavior). Record review of Resident #62's annual MDS assessment, dated 11/06/2025, indicated a BIMS score of 06 indicating Resident #62 was severely cognitively impaired. Preadmission Screening and Resident Review (PASRR) Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDS was coded 0 indicated No conditions related to ID/DD Status. Record review of Resident #62's care plan dated 08/17/2017 and revised on 05/11/2026 indicated she was positive PASRR with ID: Resident #62 has been Identified as having PASRR Positive Status related to Intellectual Disability. The goal indicated Resident #62 will maintain her highest level of practicable wellbeing. Interventions included: invite the LIDDA Representative and Responsible Party to the Quarterly Care Plan Meeting to Discuss Function Status. Coordination with a Representative from Behavioral Healthcare. Report any need to Evaluate for Habilitative Services and/or Durable Medical Equipment. Invite Member of Therapy Department to the Care Plan Meeting. Record review of Resident's #62 PASRR evaluation dated 04/30/2025 indicated Resident #62 was suspected of having an intellectual disability that manifested before [AGE] years old, and a developmental disability that manifested before [AGE] years old. During an interview and record review on 06/17/2026 at 9:40 a.m., MDS Coordinator said she would be employed for 1 year as of August 2026, and she was responsible for the resident MDS's in the facility. She said she was educated on the completion of MDSs by an outside consulting source and her Regional MDS Consultant. She said Resident #16's quarterly MDS, dated [DATE], and Resident #58's quarterly MDS, dated [DATE] were completed by her and she coded Resident #16 and Resident #58 with restraints from reviewing the EMR documentation focusing on the care plan, and the care plan identified they had bedrails, so she documented bedrail use in the restraint section of her MDS. She said Resident #16 and #58 should not have been coded for restraints on the MDSs because they did not have bedrails. She said the quarterly MDS and comprehensive care plan were not accurate and Residents #16 and #58 did not have bedrails. She said Resident #62 was PASRR positive and the MDS coding was incorrect. She said the Regional MDS Coordinator completed Resident #62's annual MDS dated [DATE]. The MDS Coordinator said the DON reviewed the MDS for accuracy and completion and the Regional MDS Consultant did random audits on the completed MDS's for accuracy. She said inaccurate assessments had low risk of harm and could lead to residents not receiving needed services. The MDS Coordinator said she follows the most recent RAI Manual for guidance for (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completing the MDSs. An attempted telephone interview on 06/17/2026 at 2:00 pm with the contracted MDS Coordinator completing Resident #62's annual MDS on 11/06/2025, was unsuccessful (with no answer and unable to leave message). During an interview on 06/17/2026 at 10:53 a.m. Regional MDS Consultant said the MDS Coordinator was responsible for all MDS in the facility. She said she did random reviews of MDSs for accuracy. She said the MDS Coordinator was educated by an outside consultant on completion of MDSs. She said the resident risk of an MDS coded as bedrail restraints and the resident did not have bed rails on their bed, was the care plan may be affected and the information would be transferred to the CNAs Kardex incorrectly. She said the bed rails were a problem that was care planned or ordered at some point to trigger the MDS Coordinator to code it on the MDS. She said they would complete a sweep of all MDSs in the facility today (06/17/2026) to ensure bed rails were documented accurately on the MDSs. She said the MDSs with the coding for bed rails as restraints was not a resident risk, just a coding inaccuracy. She said the PASRR not coded correctly on and MDS could make the care plan inaccurate. She said they had 14 days to modify MDS and modify care plans per the RAI. During an interview on 06/17/2026 at 1:45 p.m., the DON and the Regional Nurse said the MDS Coordinator was responsible for all MDS in the facility with the Regional MDS Consultant as the backup that double checked random MDSs. The DON said the MDS Coordinator was educated on the completion of MDSs. The DON said Resident #16's quarterly MDS dated [DATE], and Resident #58's quarterly MDS, dated [DATE], were marked incorrectly. She said Resident #16 was in the general population upon admission and initially had bedrails on her bed but had to be transferred to the memory care unit due to exit seeking behaviors and the bedrails were removed from the bed. She said after the transition to the memory care unit, the care plans and MDS should have been revised for accuracy. The DON said Resident #58 had fluctuating preference for bed rails. The DON said she reviewed the MDSs for completion. They said they are doing an observation audit with each resident, regarding bedrails, and if bedrails are in place, checking for appropriateness and MDS accuracy. They said they expected all MDSs in the facility to be correct and accurate. The DON said the resident risk of an MDS marked incorrectly was the MDS may not reflect the accurate residents care needed. They said they use the RAI Manual for guidance for completing the MDSs. During an interview on 06/17/2026 at 2:00 p.m., the Administrator said the MDS Coordinator was responsible for all MDSs in the facility and was educated on the completion of MDSs. She said the Regional MDS Consultant completed random MDS audits for accuracy. The Administrator said the resident risk of an MDS not marked correctly was the MDS may not be an accurate reflection of the resident and the resident's care. She said her expectation was all MDSs be correct and accurate. The Administrator said they did not have a policy regarding MDS completion, the facility utilized the RAI Manual for guidance for completing the MDSs. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, indicated .A1500: Preadmission Screening and Resident Review (PASRR). Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review (PASRR) Conditions. .P0100: Physical Restraints. Code 0, not used: if the item was not used during the 7-day look-back period or it was used but did not meet the definition. Code 1 used less than daily: if the item met the definition and was used less than daily during the observation period. Code 2 used daily: if the item met the definition and was used on a daily basis during the look-back period.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to properly store, prepare, distribute, and serve food in accordance with the professional standards for food service safety 1 of 3 dining rooms (the main dining room) reviewed for food and nutrition services. The facility failed to ensure the staff wore a hair net when plating the soup in the main dining room on 06/15/2026 at the lunch meal. This failure could place residents, who received food and beverages from the kitchen, at risk for health complications, foodborne illnesses, and decreased quality of life. Findings included: During an observation of the lunch meal on 06/15/2026 at 12:15 p.m., MA F was plating the soup from the electric soup warmer in the main dining room without a hair net. She filled 3 bowls with a ladle and gave the soup to 3 unidentified residents. During an interview on 06/16/26 at 2:45 p.m., MA F said she served the soup at lunch yesterday (06/15/2026). She said no one had ever trained her to wear a hair net while serving soup. During an interview on 06/17/2026 at 9:15 a.m., the Administrator said the CNAs served the soup out of the electric soup warmer. The Administrator said the CNAs were not behind the steam table, not in the kitchen and did not need to wear hair nets. During an interview on 06/17/2026 at 12:30 p.m., the DM said dietary staff cooked the soup, and gave the electric soup warmer to nursing, and the nurse aide or med aide served the soup into bowls. The DM said she never trained that the CNAs or MAs needed hair nets in the dining room to serve the soup. She said she was trained for the staff to wear the hair nets while in the kitchen and behind the steam table in the dining room. She said the dietary staff wear hair nets to prevent hair falling in the food and prevent food born illnesses. Record review of the Food Safety Requirements dated 2024 indicated Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, disturbed and served in accordance with professional standards for food services' safety. d. Dietary staff must wear hair restraints . to prevent hair from contacting food. e. Hairnets should be worn when cooking, preparing or assembling food. Record review of the Food and Drug Administration Food Code 2022 indicated . (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints. 2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from Chapter 2. Management and Personnel Chapter 2 - 22 contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (B) This section does not apply to FOOD EMPLOYEES such as counter staff who only serve BEVERAGES and wrapped or PACKAGED FOODS, hostesses, and wait staff if they present a minimal RISK of contaminating exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to make sure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 2 of 31 residents (Resident #16 and Resident #58) reviewed for care plans. 1. The facility failed to ensure Resident #16's comprehensive care plan was reviewed and revised when her bedrails were removed from her bed.2. The facility failed to ensure Resident #58's comprehensive care plan was reviewed and revised when her bedrails were removed from her bed. This failure could place residents at risk of not receiving the care and services to meet their needs. Findings included: 1. Record review of Resident #16's face sheet indicated an [AGE] year-old female originally admitted on [DATE] with diagnosis of vascular dementia (type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain), Type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar), and hypertensive heart disease (heart problems that arise due to prolonged high blood pressure) with heart failure (condition that develops when the heart doesn't pump enough blood for the body's needs). She has resided in the memory care unit of the facility since 11/23/2025. Record review of Resident #16's quarterly MDS assessment, dated 05/14/2026, indicated a BIMS score of 06 indicating Resident #16 was severely cognitively impaired. Physical restraint (physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body) assessment indicated Resident #16 used bedrail daily. She was independent with self-care and mobility tasks. Record review of Resident #16's care plan dated 11/26/2025 indicated resident utilized an enabling device of bed rails, to help with positioning, provide a sense of comfort/security, and/or promote independence. Interventions included Observe/document/report any changes regarding effectiveness of enabling device and possible reduction or discontinuation of its use. Record review of Resident #16's physician orders did not indicate the use of enabling device of bed rails. Record review of Resident #16's bed rail safety review dated 05/08/2026, authored by LVN D, indicated alternatives to bed rail use of adjusting height of bed (low bed) and education on turning and positioning in bed were recommended. During observation and interview on 06/15/2026 at 9:56 a.m., Resident #16 was up ambulating with a walker independently within the memory care unit. Resident #16's assigned room revealed no bedrails noted on her bed. She said she gets up on her own and did not have or need bedrails. During an observation and interview on 06/15/2026 at 10:56 a.m., LVN D said she had worked at the facility for about 8 years and was routinely assigned to the memory care unit. She said Resident #16 independently ambulated with a walker within and outside the memory care unit with staff supervision. She said Resident #16 did not have bedrails or any type of restraint device on her bed, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and she did not recall Resident #16 ever having any type of bedrails since she was admitted to the memory care unit. She observed Resident #16's room and bed and indicated she did not observe any bedrails or types of restraints on her assigned bed. LVN D was unsure why the MDS would be marked for restraints or bed rails. During an observation on 6/15/2026 at 1:56 p.m., Resident #16's room and assigned bed, no bedrails observed on bed. During an observation and interview on 06/16/2026 at 8:56 a.m., LVN E said he had worked at the facility for about 2 months and was routinely assigned to the memory care unit. He said Resident #16 independently ambulated with a walker within the memory care unit and outside the memory care unit with staff supervision. He said Resident #16 did not have bedrails or any type of restraint device on her bed, and he did not recall Resident #16 or any memory care unit residents ever having any type of bedrails. During an observation on 6/16/2026 at 10:00 a.m., Resident #16's room and assigned bed, no bedrails observed on bed. 2. Record review of Resident #58's face sheet dated 06/15/2026 indicated a [AGE] year-old female originally admitted on [DATE] with diagnosis of dementia (a decline in mental ability severe enough to interfere with daily life), schizoaffective disorder (chronic mental condition characterized by a combination of schizophrenia symptoms such as delusions and hallucinations and mood symptoms), chronic obstructive pulmonary disease (long term lung disease that blocks airflow and makes breathing difficult). Record review of Resident #58's quarterly MDS assessment, dated 04/30/2026, indicated a BIMS score of 03 indicating Resident #58 was severely cognitively impaired and diagnoses of dementia, schizoaffective disorder and chronic obstructive pulmonary disease. Physical restraint assessment indicated Resident #58 used bedrail daily. She was independent with self-care and mobility tasks. Record review of Resident #58's care plan with a target date of 07/02/2036 indicated resident #58 had an ADL self-care performance deficit with interventions included Bedrails: Bed rails to remain on the bed per resident's request for bed mobility. Date Initiated: 05/31/2016. Revision on: 06/08/2016 Record review of Resident #58's physician orders dated 06/15/2026 did not indicate the use of enabling device of bed rails. Record review of Resident #58's bed rail safety review dated 02/16/2026 indicated alternatives to bed rail use of adjusting height of bed (low bed) and education on turning and positioning in bed and continue current alternative measures was recommended. During an observation and interview on 06/17/2026 at 9:20 a.m., Resident #58's assigned room observed no bedrails noted on the bed. Resident #58 was up in wheelchair and said she did not have side rails on her bed and was able to get out of bed without them. During an observation and interview on 06/17/2026 at 9:25 a.m., LVN A here 3 years Said she was providing care for Resident #58 today (06/17/2026) and Resident #58 did not have bed rails on her bed. She said she did not remember her ever having bed rails on her bed. She said Resident #58 did not have restraints. LVN A was unsure why the MDS would be marked for restraints or bed rails. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 06/17/2026 at 9:45 a.m., MDS Coordinator said she was responsible for entering the MDS assessments as well as reviewing and revising the care plan with each assessment along with the IDT collaboration. She said when a resident had bedrails the MDS and care plan should reflect the use of bedrails, and if they were removed, the bedrails should have been removed from the MDS and care plan. She said Resident #16 should not have been coded for restraints on the MDS because she did not have bedrails. She said the quarterly MDS and comprehensive care plan was not accurate, and Resident #16 did not have bedrails. She said the MDS and care plan should have been revised when the bedrails were removed or discontinued. The MDS Coordinator said Resident #58 should not have been coded for restraints on the care plan. The MDS Coordinator said Resident #58 should not have been coded for bed rails on the care plan since she did not have bedrails on her bed. She said if a care plan was not reviewed and updated with changes, it could affect resident care. During an interview on 06/17/2026 at 12:50 p.m., the ADON said the floor nurses started the baseline care plans, and the DON reviewed the baseline care plans. She said she was responsible for antibiotic care plans and updates. She said she had been addressing different systems since she started and had planned to go room to room this week, and address the bedrails and bedrail care plans. The ADON said the MDS Coordinator reviewed care plans quarterly for accuracy. She said the staff were all educated on the completion of care plans. She said the DON, and herself, reviewed random care plans for accuracy. She said the bedrail care plans were overlooked for Residents #18 and #58. She said the risk of a resident with no bed rails care planned for bed rails was that the care plan was not individualized. During an interview on 06/17/2026 at 1:50 p.m., the DON and the Regional Nurse said the MDS Coordinator was responsible for the revision of the resident's care plan at the time of the assessment. The DON said the inaccurate care plans should have been identified and revised during the IDT care plan meeting. She said inaccurate care plans could result in affecting resident care needs. The DON said Resident #58 had fluctuating preferences related to Schizophrenia and periodically changed her mind wanting bed rails and then not wanting bed rails. The DON said Resident #58's bedrail care plan was not an error. She said the verbiage did not accurately describe Resident #58's current preferences. She said the expectations were for all residents' care plans to be completed accurately and completely. During an interview on 06/17/2026 at 2:10 p.m., the Administrator said comprehensive care plans should be reviewed and revised with significant changes, quarterly, annually, and as needed with resident care changes. She said the MDS Coordinator and IDT should be reviewing the care plan and making sure all the care need areas were addressed. The Administrator said Resident #58's preferences fluctuated, and the bed rail care plan was not an error. She said the verbiage did not accurately describe the resident's fluctuating preferences. She said not having an accurate care plan could affect resident care needs and expected each resident's comprehensive care to be reviewed, revised and accurate. Record reviews of the facility's policy titled Care Plan Revisions Upon Status Change indicated, . Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs. 3. The MDS Coordinator will determine whether a Significant Change in Status assessment is warranted. If so, the assessment will be completed according to established procedures.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455952	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER Cleveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all medications were properly secured and stored in locked compartments for 1 of 7 medication carts (Nurse Hall 100) reviewed for pharmacy services. The facility failed to keep unattended medications secured by leaving it on top of a medication cart. This failure could place residents at risk of misappropriation of medications, adverse reactions by ingesting medication that did not belong to them, and not receiving therapeutic effects of medication. Findings included: During an observation and interview on 06/16/26 at 8:08 a.m., LVN G pulled the medication cart to the doorway of a resident's room, locked the cart, locked the electronic medical record and proceeded to walk away, going into the nurse station room located (approximately 25 feet away from the medication cart); leaving an intravenous medication on top of the cart and out of her visual sight. The medication cart was unattended during this time and a resident in a wheelchair was self-propelling his wheelchair next to the cart. Multiple staff members walked past the cart and attended to the resident. At 8:09 a.m., LVN G returned to the medication cart and said she left the cart to get a black marker from the nurse station room to continue her medication pass. LVN G said she would use the marker to write the date and time on the outside of the intravenous bag of medication. During an interview on 06/16/26 at 8:45 a.m., LVN G stated she should not have left the intravenous medication on the cart. LVN G said she should have kept the intravenous medication she planned to administer in the locked medication cart while she went to get a black marker. LVN G said the intravenous bag of medication was not in her view when she left to go to the nurse station room. LVN G verified that the intravenous medication was Rocephin 2 grams in 100 ml of normal saline (an antibiotic for infection). LVN G said she should not have left the medication on top of the medication cart unattended because someone could have taken the medication and it could have caused them to become sick. LVN G said she had been trained on medication storage, use of medication carts, and to keep medications locked up when not in use. LVN G said she just got nervous and forgot. During an interview on 06/17/26 at 3:20 p.m., the DON said the nurses and MAs needed to always maintain a view of the medication cart and never walk away from the cart with medications left on top for the safety of the residents, because it risked contamination and someone could come and take the medication off the cart. The DON said she was not sure why this occurred. The DON said she and the Administrator made rounds in the morning and several times a day and checked to see if the medication carts were locked if not in use and if meds are secured. The DON stated nurses and medication aides were trained on hire and PRN, on the use of medication carts, medication storage and security. During an interview on 06/17/26 at 3:30 p.m., the Administrator said she expected the staff to be compliant with the policies regarding proper medication storage. The Administrator said medications should never be left on top of a medication cart unattended because from a safety perspective, someone could come along and take it. A review of the facility's undated Policy, titled Medication Storage included that: .Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.		