STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345282**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 09/22/25 through 09/26/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D6E2D-H1. Due to QSO memo 26-01 ALL the posting of this 2567 will be delayed until the end of the federal government shutdown. Per CMS guidance the exit date of this survey was adjusted.	E0000		12/16/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 09/22/25 through 09/26/25. Event ID# 1D6E2D-H1. The following intakes were investigated: 793016, 793018, and 793027. 6 of the 6 complaint allegations did not result in deficiency. Due to QSO 26-01-All issued on 10/01/25 the posting of this 2467 will be delayed pending the resolution of the federal government shutdown. Per CMS guidance the exit date has been adjusted. On 1/8/26 the 2567 was amended as result of IDR.	F0000		12/16/2025
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to	F0607	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law Based on record review and staff interviews, the facility failed to complete a thorough investigation of an allegation of resident-to-resident abuse for 1 of 3 residents reviewed for abuse (Residents #9).	12/16/2025

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER: Cleveland Pines		STREET ADDRESS, CITY, STATE, ZIP CODE: 1404 N Lafayette Street , Shelby, North Carolina, 28150	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 1 investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to complete a thorough investigation of an allegation of resident-to-resident abuse for 1 of 3 residents reviewed for abuse (Residents #9). Findings included: The facility's "Prohibit and Prevent Violations of Resident Abuse, Neglect, Misappropriation of Resident Property and Exploitation" policy indicated in part, all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/ or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. All resident to resident altercations must be reported in accordance with the regulations to include any willful action that results in physical injury, mental anguish, or pain. Should an incident or suspected incident of resident abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the	F0607	Continued from page 1 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 11/24/25, the Social Worker contacted psych services for recommendations to address the resident's wandering behaviors. Any psych service recommendations will be provided to the Interdisciplinary Team for updates to Resident #9's care plan. On 11/24/25, the Social Worker evaluated Resident #9's adjustment utilizing the Patient Health Questionnaire-9 (PHQ-9) to determine if resident showed any signs of fear, anxiety, and/or depressed mood. No issues were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 11/20/25, the System Director of Nursing Services educated the Administrator, Director of Nursing, and Social Workers, on CMS Guidance for Resident-to-Resident Altercations to ensure compliance. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 11/20/25, a new Investigation Checklist was developed to ensure compliance with the Abuse Prohibition Policy/Procedure. The checklist will include the following elements to ensure alleged incidents are thoroughly investigated: Review 24-hour initial report form; Review the resident's medical record to determine events leading up to the incident; Interview the person reporting the incident; Interview the resident(s) involved in the allegation; Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; Interview staff members; Interviews with the resident's roommate, family members and visitors; Review events leading up to the alleged incident. On 11/20/25, the System Director of Nursing Services educated the Administrator, Director of Nursing, and Social Workers, on the new Investigation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 2 alleged incident. The following guidelines are used when performing the investigation: - Review “24-hour initial report” form - Review the resident’s medical record to determine events leading up to the incident - Interview the person reporting the incident. - Interview the resident(s) involved in the allegation - Interview the resident’s attending physician as needed to determine the resident’s current level of cognitive function and medical condition - Interview staff members - Interviews with the resident’s roommate, family members and visitors - Review events leading up to the alleged incident Resident #9 was admitted to the facility on 08/09/24 with diagnoses which included senile degeneration of brain, Parkinson’s disease, dementia, and schizophrenia. Resident #79 was admitted to the facility on 11/26/24 with diagnosis to include depression, anemia, and heart failure. Review of an emailed care event notification (a facility document used to report a care event) dated 9/23/25 read: the Nurse Aide (NA) overheard Resident #79 yelling. She opened the door and saw Resident #79 kicking Resident #9 in the legs telling her to get away. Staff separated them and notified the social worker. No injury noted. Handwritten at the bottom of the email was further information regarding the incident. The handwritten portion read: NA #2 separated residents immediately. Unit Manager (UM) #1 assessed residents, no injuries noted. Provider, Nurse Practitioner (NP) was notified. SW #1 and SW #2 spoke with Resident #79 about behavior and to call staff for assistance. Incident was isolated and did not happen again. The facility did not provide an author of the event care notification. Review of NA #2’s handwritten statement on 02/25/25 in	F0607	Continued from page 2 Checklist. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 12/1/25, the System Director of Nursing Services or designee will weekly review the new Investigation Checklist with all reportable of resident-to-resident altercations to assess compliance weekly for 12 weeks. Results of the monitoring will be shared with the System Director of Nursing Services on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 12/16/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 3 the “incident folder” read: as I was providing care to a resident, I overheard Resident #79 screaming in the hallway! I opened the door and saw Resident #79 kicking Resident #9, telling her to get away! I notified the charge nurse and moved residents! An interview on 9/25/25 at 2:15 PM with NA #2 revealed on 2/25/25 she was in a room providing care to another resident, behind closed doors, when she heard yelling outside the door. She reported she opened the door and saw Resident #79 kicking Resident #9 and yelling “get away from me”. NA #2 stated Resident #9 was trying to back up but was slow moving, she is also non-verbal except during rare occasions where she sings. NA#2 reported she immediately separated the two residents and notified the unit manager. NA #2 stated that she was not aware of Resident #9 ever being aggressive towards anyone but would grab the rail or any obstacle to help propel herself down the hall, even if it was another resident’s wheelchair. NA #2 reported that Resident #9 did not have the mental capacity to understand that grabbing other’s property was not appropriate. A second interview with NA #2 on 9/26/25 at 12:31 PM revealed on 2/25/25 she saw Resident #79 make contact several times with Resident #9’s lower legs. Resident #9 was trying to back away, but she was a slow mover. NA #2 reported Resident #79 usually wore gray slip-on type shoes with a medium-hard bottom. Resident #9 was nonverbal, but she was grimacing while the incident was happening. NA #2 did not remember telling anyone the residents did not make contact because she saw the incident very clearly. NA#2 stated she reported this to UM #1. Review of a nurses note in Resident #9’s medical chart written by UM #1 on 2/25/25 at 2:04 PM read: The NA overheard Resident #79 yelling. She opened the door and saw Resident #79 kicking Resident #9 in the legs telling her to get away. Staff separated them and notified the social worker. No injury noted. I notified the nurse practitioner (NP). Review of a nurse’s note in Resident #79’s medical chart written by UM #1 on 2/25/25 at 2:22 PM read: The NA overheard Resident #79 yelling. She opened the door and saw Resident #79 kicking Resident #9 in the legs telling her to get away. Staff separated them and notified the social worker. No injury noted. I notified	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 4 the nurse practitioner (NP). An interview on 09/25/25 at 2:05 PM with Unit Manager (UM) #1 indicated she had been made aware of the altercation between Resident #9 and Resident #79 by NA #2 on 2/25/25. NA #2 reported to her that she overheard Resident #9 and Resident #79 yelling, opened the door of the room she was in and saw Resident #79 kicking Resident #9. UM #1 reported she assessed resident #9 and she didn't remember any injuries. She reported Resident #9 is nonverbal and unable to communicate her feelings, but UM #1 felt that being kicked by someone would have hurt or at least made her feel scared, especially since she was unable to make her feelings known. UM #1 reported she did not complete any further assessments for physical injuries or mental anguish on Resident #9 or Resident #79 after the initial assessment. An interview with Social Worker (SW) #2 on 9/25/25 at 4:02 PM revealed the incident was reported to her by UM #1. SW #2 stated that it was reported to her that both resident #9 and #79 were in the hallway when Resident #9 got too close to Resident #79 and Resident #79 was seen kicking Resident #9. SW #2 reported that NA #2 was close by and separated them immediately. SW #2 reported she was notified the same day the incident occurred, and she and SW #1 spoke with Resident #79 and asked her what happened. SW #2 indicated that she didn't remember what Resident #79 said but both social workers let Resident #79 know to ask for help instead of acting out in those situations. SW #2 reported to her knowledge neither resident had a history of acting out. She stated she would report any incident to Director of Nursing (DON) or Administrator. Review of typed statement signed and dated on 2/25/25 by SW #2 read: SW #2 and SW #1 spoke with resident, Resident #79 about kicking another resident. Resident #79 yelled at social workers that she was in the doorway of her room, and the other resident kicked her and that she just kicked her back. SW explained that it is not appropriate to kick other people and to call staff when she needs help with another resident. A second interview with SW #2 on 9/25/25 at 5:00 PM revealed when asked who she reported the incident to she stated she believed she had reported it to the DON, but she couldn't be sure. She reported she thought she was told by a NA there was no actual physical contact	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 5 made, but she couldn’t remember exactly who told her. SW #2 reported she doesn’t remember if she told the administrator or the DON that or not. When SW #2 was asked why the incident was not further investigated, she indicated because it wasn’t abuse, no one was injured, they didn’t make contact. When asked why, when her statement revealed, Resident #79, who was alert and oriented, admitted to kicking and yelling at Resident #9 to get her away, an investigation was not started. SW #2 could not provide an answer. When asked if it was proven there was no contact between the residents why did she not amend her statement to reflect that she responded, “I just didn’t, the statements are what they are”. When asked if she felt that being kicked or even kicked at while being yelled at in your home could cause mental anguish, SW #2 stated, “yes, of course it would”. Interview with SW #1 on 9/25/25 at 4:20 PM revealed she thinks she remembered being told by someone that Resident #9 was rolling down 200 hall and got too close to Resident #79, who started shuffling her feet, a NA saw Resident #79 shuffling her feet at Resident #9 and separated them. SW #1indicated she became aware of the incident when SW#2 came to ask her to go see Resident #79 with her. When asked why she felt there was an inconsistency between SW #2’s statement and her understanding of what happened, SW #1 said she didn’t know. When asked why she felt an investigation did not occur after Resident #79 admitted to kicking Resident #9, SW #1 reported because it wasn’t abuse, no injuries were reported. SW #1 indicated she felt as a reasonable person if she were kicked or kicked at while being yelled at in her home it could cause mental anguish. An interview with Resident #79 on 9/26/25 at 1:10 PM revealed she remembered the lady who went up and down the hall in her wheelchair all the time grabbing things. She reported when she was over on the other hall, “she got right up on top of me”. She stated “I yelled at her and told her to move, she wouldn’t and so I kicked her and she was kicking me back, one of the aides come out and moved us away from one another." Resident #79 reported she kicked the resident several times and she was just defending herself because Resident #9 would not get away from her. An interview with the Director of Nursing on 9/25/25 at 6:05 PM indicated she had no firsthand knowledge of the allegation.	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345282**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 6 Review of the typed statement signed and dated 02/25/25 by the Administrator read, reported that Resident #79 was sitting in her room and Resident #9 was coming down the hallway. Resident #9 got to close to Resident #79 and Resident #79 started yelling at Resident #9 and kicking her feet at her. There was no contact made and social workers spoke to Resident #79 and told her to call for a staff member in the future if Resident #9 was bothering her because kicking her was not appropriate. Resident #79 is alert and oriented and understands what is being said to her. Review of the investigation folder revealed written statements from NA #2, SW #2, the Administrator, and two nurse’s notes written by UM #1. There were no statements from roommates or documentation about the conflicting statements between SW #2, NA#2, the nurses notes and the Administrator. There was no documentation of skin assessments done after the initial assessment to rule out injuries that may have taken longer to reveal themselves, such as bruising. There was also no documentation of any assessments that were carried out on either resident to determine if any mental anguish occurred after the incident An interview with the Administrator on 9/26/25 at 4:50 PM revealed the day this incident occurred Resident #79 had been agitated. The Administrator stated a NA, who she thought was NA #2, but couldn’t remember for sure, reported to her that Residents #79 and Resident #9 did not make contact. When the statements from the social worker, nurse aide and the nursing notes were reviewed with the Administrator she reported she understood the “kicking” between the residents to be just the word used, as the residents did not make contact. The Administrator did not reply with an answer when asked why the statements were not amended to show no contact was made. The Administrator reported she did not interview Resident #79 because the social workers had already talked to her about kicking not being appropriate. When asked why an investigation was not initiated when the Administrator learned that Resident #79 told the social workers that she and Resident #9 had in fact kicked one another she could not provide an answer, she continued to repeat, “We do not have abuse in this building”. She indicated she did not do an investigation because there was no injury, therefore it was not abuse. The Administrator explained the facility checked the residents when the incident occurred for any physical injury but denied any further assessments of the residents a because “abuse did not occur”. She	F0607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0607 SS = D	Continued from page 7 also reported the facility did not assess either resident for any mental anguish immediately following the incident or at any time since the incident occurred. She further stated that as a reasonable person, getting kicked or kicked at while being yelled at in her home would cause mental anguish. The Administrator reported she did not believe either of these resident's experienced any mental anguish because it was not reported to her and she continued to state, "We don't have abuse in this building".	F0607		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level II review was completed for residents with new mental health diagnoses for 2 of 4 residents (Resident #9 and Resident #43) reviewed for PASRR. The findings included: 1. Review of Resident #9's medical record revealed the resident was admitted to the facility on 9/09/17 with a readmission on 8/09/24. PASRR level I was completed on 9/07/17 prior to admission with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a	F0644	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 11/26/25, Resident #9, #43, and #15 Preadmission Screening and Resident Review (PASRR) was submitted by the Social Workers for further Level II review for resident's diagnosis including schizophrenia , post-traumatic stress disorder, and bipolar. The outcome of the requested rescreening process is pending. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Beginning 11/24/25, the Medical Records Coordinator audited 100% of residents with diagnosis of schizophrenia, post-traumatic stress disorder, and bipolar on the problem list. Any new diagnoses will be provided to the Social Workers, to submit further Level II screening requests. On 11/24/25, the Administrator provided education to staff submitting a PASRR, on submitting further Level II review requests, related to resident's diagnosis of schizophrenia, post-traumatic stress disorder, and bipolar. Any staff members who do not receive the training by 11/24/25 (due to FMLA, leave, etc.) will be	12/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0644 SS = D	Continued from page 8 significant change in the resident’s condition. The electronic medical record revealed Resident #9 was diagnosed with anxiety disorder on 9/09/17, mood affective disorder on 8/01/23, and schizophrenia on 10/24/24. No PASRR level II was completed. During an interview on 9/26/25 at 5:35 PM with the Administrator, she communicated her understanding that PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. 2. Review of Resident #43's medical record revealed the resident was admitted to the facility on 8/17/23 with a readmission on 9/11/25. PASRR level I was completed on 6/08/23 prior to admission to the facility with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident’s condition. The electronic medical record revealed Resident #43 was diagnosed with post-traumatic stress disorder (PTSD) on 7/11/23, bipolar disorder on 1/02/25, and major depressive disorder on 9/07/25. No PASRR level II was completed. An interview on 9/26/25 at 4:07 PM with Social Worker (SW) #1 revealed she was responsible for completing PASRR paperwork for residents. She stated she typically completed paperwork for PASRR level II when residents had a limited level II, and their paperwork required them to be reviewed every 30 or 60 days or had a change in behaviors. SW revealed she was not aware PASRR level II should be completed for residents with mental health diagnosis upon their admission or readmission or when they received a new mental health diagnosis as she was not always made aware of their new diagnosis. SW stated her understanding that based on Resident #43’s mental health diagnosis, PASRR level II should have been completed. During an interview on 9/26/25 at 5:35 PM with the Administrator, she communicated her understanding that PASRR level II should be completed in a timely manner	F0644	Continued from page 8 required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 12/1/25, the Social Workers will begin to submit Level II review requests for residents with diagnosis of schizophrenia, post-traumatic stress disorder, and bipolar. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 12/8/25, the Medical Records Coordinator or designee will weekly review 5 resident’s problem list with diagnosis of schizophrenia, post-traumatic stress disorder, and bipolar, to ensure submission for further Level II review, for 12 weeks. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 12/16/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0644 SS = D	Continued from page 9 upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis.	F0644		
F0687 SS = E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to ensure resident's toenails were trimmed and podiatry services were arranged for 3 of 7 residents reviewed for foot care (Resident #15, Resident #90, and Resident #24). The findings included: 1. Resident #15 was admitted to the facility on 1/14/25 and readmitted to the facility on 6/15/25 with diagnoses which included traumatic brain injury and contractures to bilateral upper and lower extremities. Review of revised care plan dated 6/15/25 revealed Resident #15 was care planned for activities of daily living (ADL) self-care performance deficits related to her disease process. Resident #15 was dependent on staff for all ADL care. Review of quarterly Minimum Data Set (MDS) assessment dated 7/24/25 revealed Resident #15 was severely cognitively impaired and had been assessed as requiring total care assistance from staff with all ADL care. Resident #15 was also coded as having no refusals	F0687	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/25/25, Resident #15, #90, and #24, received toenail care. Resident #24's resident representative was contacted to obtain consent for podiatry services. On 9/25, resident #24 received podiatry care. Resident #15 and #90 resident representatives were contacted to obtain consent for podiatry services. On 12/2/25, residents #15 and #90 received podiatry care. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 11/30/25, the Nurse Managers will conduct facility wide toenail care observations. Residents identified with toenail care needs will receive those services along with any necessary podiatry care referrals. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 12/1/25 the nurse educator and nurse managers began educating 100% of nurses on the new process that during weekly skin assessment include a targeted observation of each resident's toenails to ensure resident's toenails were trimmed, and podiatry services were arranged, as required. The new process will include, based on nursing judgement, having the nurse submit an Epic electronic medical record chat to Social Workers to alert the need	12/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0687 SS = E	Continued from page 10 with care. Review of Resident #15's weekly nursing assessments from 1/14/25 through 09/22/2025 revealed no notation that her toenails were long and thick and needed trimmed. Review of the facility's podiatry clinic schedule for 08/25/25, revealed Resident #15 was not seen by the podiatrist. Review of the facility's podiatry clinic schedule for 09/25/25 revealed Resident #15 was not scheduled to see the podiatrist. There were no consultation reports or notations in Resident #15's Electronic Medical Record (EMR) that she had been referred to or seen by a podiatrist since her admission to the facility. An observation of Resident #15's left foot was conducted on 09/24/25 at 4:05 PM. Resident #15's toes revealed thick, long toenails. Resident #15's left great toenail was thick and raised away from skin and left second toenail was black at bottom of nail. An interview was conducted with Nurse #1 on 09/24/2025 at 5:05 PM. Nurse #1 routinely cared for Resident #15 during the 3:00 to 11:00 PM shift. Nurse #1 stated that she could not recall the condition of Resident #15's toenails or if she had ever told anyone about her needing toenail care. Nurse #1 further explained that usually when she saw a resident who required more toenail care then she felt comfortable providing she would tell Social Worker (SW) #1 who would add the resident to the podiatry list. Nurse #1 further explained that if a resident's toenails were bad enough, they would arrange some type of emergency visit. An interview was conducted with NA #2 on 09/25/2025 at 10:35 AM. NA #2 stated that she had noticed Resident #15's toenails being a little long and very thick, but she could not remember if she had reported that to anyone or not. An interview was conducted with the Nurse Practitioner (NP) on 09/25/25 at 1:34 PM. The NP stated that she was not aware of the condition of Resident #15's toenails but given her disease process and contractures to her lower extremities she could see how her toenails may	F0687	Continued from page 10 to submit a podiatry care referral. Social workers will obtain consent and have podiatry scheduled. Any nurses not educated by 12/16/25 will receive education prior to working the next shift. All new hires will be educated in orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 12/16/25, the Wound Nurse or designee will conduct weekly toenail care observations with 10 residents for 4 weeks, and then 5 residents for 8 weeks, to ensure compliance. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 12/16/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0687 SS = E	Continued from page 11 require podiatry services. She revealed the nurses were supposed to complete weekly skin and nail assessments on each resident and if a resident had nail issues that required podiatry services they were supposed to notify SW #1 to have their name added to the podiatry list. An interview was conducted with the Director of Nursing (DON) on 09/25/2025 at 5:56 PM. The DON stated that nursing staff discussed nail care and toenail care daily during the nursing huddles. The DON further explained that she was not aware of any issues with Resident #15's toenail care. The DON also stated that podiatry clinic was held frequently and SW #1 scheduled residents for the podiatry clinic. The DON also stated that sometimes we don't follow up like we should, and some things fall through the cracks. An interview was conducted with Social Worker #1 on 09/26/2025 at 4:07 PM. SW #1 stated that she handled the podiatry clinic, and the podiatry clinic was held every other month or every month depending on how many residents needed to be seen. SW #1 further explained that the last podiatry clinic was held 08/25/2025 and the next podiatry clinic was scheduled for 09/26/2025. SW #1 stated that Resident #15 was not seen during the August podiatry clinic and was not scheduled to be seen on 09/26/2025 and to her knowledge a referral had never been made to add Resident #15 to the podiatry clinic list. An interview was conducted with the Administrator on 09/26/2025 at 5:31 PM. The Administrator stated that she understood the concerns with Resident #15's toenails. The Administrator stated that nursing staff should observe resident's toenails when they complete their skin assessments. 2. Resident #90 was admitted to the facility on 9/24/25 with diagnoses which included left above the knee amputation, hypertension, and peripheral vascular disease (PVD). Review of quarterly Minimum Data Set (MDS) assessment dated 8/01/25 revealed Resident #90 was moderately cognitively impaired and had been assessed as requiring partial staff assistance with eating, mobility, and personal hygiene, substantial staff assistance with dressing, and was dependent on staff assistance for showering, toileting, and transfers. Resident #90 was	F0687		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0687 SS = E	Continued from page 12 also coded as having no refusals with care and impairment on one side. Review of revised care plan dated 8/01/25 revealed Resident #90 was care planned for activities of daily living (ADL) self-care performance deficits related to his disease process and amputation. The goals included staff assistance in all aspects of daily care to ensure all needs were met. Interventions included staff to provide grooming and personal hygiene. Review of Resident #90’s weekly nursing assessments from 1/14/25 through 09/22/2025 revealed no notation that his toenails were long and thick and needed trimmed. Review of the facility’s podiatry clinic schedule for 08/25/25, revealed Resident #90 was not seen by the podiatrist. Review of the facility’s podiatry clinic schedule for 09/25/25 revealed Resident #90 was not scheduled to see the podiatrist. There were no consultation reports or notations in Resident #90’s Electronic Medical Record (EMR) that she had been referred to or seen by a podiatrist since her admission to the facility. An observation of Resident #90’s left foot was conducted on 09/24/25 at 5:05 PM. Resident #90’s toes revealed thick, long toenails. Resident #90’s right great toenail was thick and curling inward towards his skin. An interview and observation were conducted with Nurse #1 on 09/24/2025 at 5:05 PM. Nurse #1 routinely cared for Resident #90 during the 3:00 to 11:00 PM shift. After an observation of Resident #90’s toenails on his right foot, Nurse #1 stated that Resident #90’s toenails were too long and thick, and she would not feel comfortable trimming them. She revealed Resident #90 should have been seen by a podiatrist but could not recall if she had ever told anyone or referred him for podiatry services. Nurse #1 further explained that usually when she saw a resident who required more toenail care then she felt comfortable providing she would tell social worker (SW) #1 who would add the resident to the podiatry list. Nurse #1 further explained that if a resident’s toenails were bad enough, they would arrange some type of emergency visit.	F0687		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0687 SS = E	Continued from page 13 An interview was conducted with NA #2 on 09/25/2025 at 10:35 AM. NA #2 stated that she had noticed Resident #90’s toenails on his right foot being a little long and very thick, but she could not remember if she had reported that to anyone or not. An interview was conducted with the Nurse Practitioner (NP) on 09/25/25 at 1:34 PM. The NP stated that she was aware of the condition of Resident #90’s toenails on his right foot. She revealed she had previously been asked to assist nursing staff with trimming Resident #90’s toenails but due to them being so thick she was not able to trim them well. The NP stated she assumed Resident #90 had been referred to the podiatry clinic due to the thickness of his toenails and the facility not having the tools to assist with keeping his toenails trimmed. She revealed nursing staff were supposed to complete weekly skin and nail assessments on each resident and if a resident had nail issues that required podiatry services, they were supposed to notify SW #1 to have their name added to the podiatry list. An interview was conducted with the Director of Nursing (DON) on 09/25/2025 at 5:56 PM. The DON stated that nursing staff discussed nail care and toenail care daily during the nursing huddles. The DON further explained that she was not aware of any issues with Resident #90’s toenail care. The DON also stated that podiatry clinic was held frequently and SW #1 scheduled residents for the podiatry clinic. The DON also stated that sometimes we don’t follow up like we should, and some things fall through the cracks. An interview was conducted with Social Worker #1 on 09/26/2025 at 4:07 PM. SW #1 stated that she handled the podiatry clinic, and the podiatry clinic was held every other month or every month depending on how many residents needed to be seen. SW #1 further explained that the last podiatry clinic was held 08/25/2025 and the next podiatry clinic was scheduled for 09/26/2025. SW #1 stated that Resident #90 was not seen during the August podiatry clinic and was not scheduled to be seen on 09/26/2025 and to her knowledge a referral had never been made to add Resident #90 to the podiatry clinic list. An interview was conducted with the Administrator on	F0687		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0687 SS = E	Continued from page 14 09/26/2025 at 5:31 PM. The Administrator stated that she understood the concerns with Resident #90's toenails. The Administrator stated that nursing staff should observe resident's toenails when they complete their skin assessments. 3. Resident #24 was admitted to the facility on 12/04/2024 and readmitted to the facility on 01/27/2025 with diagnoses which included peripheral artery disease (PAD) and a left below the knee amputation (BKA). Resident #24's care plan dated 01/31/2025 revealed Resident #24 was care planned for activities of daily living (ADL) self-care performance deficits related to her disease processes and amputation. The care plan revealed Resident #24 was dependent on staff for putting on and taking off footwear. Resident #24 required maximal assistance with toileting, bathing, and dressing, moderate assistant with bed mobility and was dependent for transfers. Review of Resident #24's quarterly Minimum Data Set (MDS) assessment dated 07/25/2025 revealed Resident #24 was cognitively intact. The MDS also revealed Resident #24 required maximal assistance with toileting, bathing, and dressing, moderate assistant with bed mobility and was dependent for transfers. The MDS revealed Resident #24 had no rejections of care. Review of Resident #24's weekly nursing assessments from 12/04/2024 through 09/22/2025 revealed no notation that her toenails were long and thick and needed trimmed. Review of the facility's podiatry clinic schedule for 08/25/2025, revealed Resident #24 was not seen by the podiatrist. Review of the facility's podiatry clinic schedule for 09/25/2025 revealed Resident #24 was not scheduled to see the podiatrist. There were no consultation reports or notations in Resident #24's Electronic Medical Record (EMR) that she had been seen by a podiatrist. An observation of Resident #24's right foot was conducted on 09/23/2025 at 1:24 PM. Resident #24's toes revealed thick, long toenails. Resident #24's right great toenail was starting to curl inward into her skin. An interview was conducted with Resident #24 on 09/23/2025 at 1:26 PM. Resident #24 stated that she was no longer able to care for her toenails and that her toes on her right foot looked nasty and she would like to have them trimmed.	F0687		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0687 SS = E	Continued from page 15 An interview and observation of Resident #24’s right foot was conducted with the Wound Nurse on 09/23/2025 at 1:50 PM. The Wound Nurse stated that she tried to file Resident #24’s toenails several days ago but she did not attempt to cut or trim them because of her PAD. The Wound Nurse also stated that she was not sure if Resident #24 was followed by the podiatrist, but it would be best if she was seen by the podiatrist due to Resident #24’s severe circulation problems. An interview was conducted with Social Worker #1 on 09/24/2025 at 3:41 PM. SW #1 stated that she handled the podiatry clinic, and the podiatry clinic was held every other month or every month depending on how many residents needed to be seen. SW #1 further explained that the last podiatry clinic was held 08/25/2025 and the next podiatry clinic was scheduled for 09/26/2025. SW #1 stated that Resident #24 was not seen during the August podiatry clinic and was not scheduled to be seen on 09/26/2025. SW #1 stated that she thought Resident #24 had been scheduled for podiatry services in May 2025, but Resident #24 had refused to see the podiatrist. SW #1 also stated that she kept a podiatry log in order to keep up with the residents who needed to be seen, had refused to be seen, and residents who were seen by the podiatrist. SW #1 also revealed that she was unsure if a follow up was made with Resident #24 to get her reschedule for podiatry services. SW #1 stated that the nursing staff would let her know if a resident needed to be added to the podiatry schedule. An interview was conducted with NA #1 on 09/25/2025 at 8:53 AM. NA #1 stated that he had noticed Resident #24’s toenails being a little long and very thick, but he could not remember if he had reported that to anyone or not. An interview was conducted with Nurse #1 on 09/25/2025 at 4:07 PM. Nurse #1 routinely cared for Resident #24 during the 3:00 to 11:00 PM shift. Nurse #1 stated that Resident #24’s “toenails were long and very thick but to be honest, I don’t remember if I told anyone about Resident #24’s toenails”. Nurse #1 further explained that she usually told SW #1, and SW#1 would add the resident to the podiatry list. Nurse #1 further explained that if a resident’s toenails were bad enough, they would arrange some type of emergency visit. An interview was conducted with the Director of Nursing (DON) on 09/25/2025 at 5:56 PM. The DON stated that nursing staff discussed nail care and toenail care daily during the nursing huddles. The DON further	F0687		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0687 SS = E	Continued from page 16 explained that Resident #24 had refused podiatry care in the past, but she was not sure if any follow up occurred. The DON also stated that podiatry clinic was held frequently and SW #1 scheduled residents for the podiatry clinic. The DON also stated that sometimes we don’t follow up like we should, and some things fall through the cracks. An interview was conducted with the Nurse Practitioner (NP) on 09/26/2025 at 11:54 AM. The NP stated that Resident #24 had severe circulatory issues, and the staff should not attempt to provide any type of toenail care for her. The NP stated that Resident #24’s toenails should be cared for by the podiatrist. An interview was conducted with the Administrator on 09/26/2025 at 5:31 PM. The Administrator stated that she understood the concerns with Resident #24’s toenails. The Administrator stated that nursing staff should observe resident’s toenails when they completed their skin assessments.	F0687		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow their infection control standards and procedures when Nurse #6 failed to sanitize her hands and change her gloves between replacing the new tracheostomy (a surgically created opening in the windpipe through the neck to provide an airway for breathing) ties and neck collar and before cleaning the stoma and outer cannula and applying new disposable inner cannula and when Nurse #7 failed to sanitize her hands and change her gloves after inserting the new inner cannula and before cleaning around the stoma and outer cannula and placing the stoma dressing and new neck collar and ties. The deficient practice occurred for 2 of 2 residents reviewed for respiratory care (Resident #15 and Resident #39).	F0695	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/25/25, the facility Infection Preventionist observed Nurse #6 and Nurse #7, providing tracheostomy care with Resident #15 and Resident #39 for compliance with the Lippincott Tracheostomy tube cannula and stoma care checklist. No issues were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Beginning 10/18/25, the facility Infection Preventionist provided clinical observations of nurses providing tracheostomy care, to ensure compliance with the Lippincott Tracheostomy tube cannula and stoma care checklist that includes	12/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER **Cleveland Pines**	STREET ADDRESS, CITY, STATE, ZIP CODE **1404 N Lafayette Street , Shelby, North Carolina, 28150**		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0695 SS = D	Continued from page 17 The findings included: 1. Resident #15 was admitted to the facility on 01/14/25 with diagnoses which included respiratory failure and tracheostomy status. Resident #15's quarterly Minimum Data Set (MDS) assessment dated 07/24/25 revealed she was severely cognitively impaired and was coded for tracheostomy care. Resident #15's comprehensive care plan revised on 06/15/25 revealed a focus area for being at risk for respiratory complications secondary tracheostomy. Interventions included tracheostomy care as ordered by physician. An observation was conducted on 09/24/25 at 12:44 PM of tracheostomy care being provided to Resident #15 by Nurse #6 and the Infection Preventionist (IP). Nurse #6 was providing tracheostomy care with the assistance of the IP. Nurse #6 and the IP were on either side of Resident #15's bed and had the tracheostomy supplies for care on a towel on the resident's overbed table next to Nurse #6. Nurse #6 and the IP had sanitized their hands and donned their gown and gloves and Nurse #6 began by removing the humidified oxygen trach collar (a piece that sits over the tracheostomy stoma and connects to an oxygen source with humidification to prevent airway drying). Nurse #6 and the IP then removed the ties on either side of the outer cannula (the main body of the tracheostomy tube that is inserted into the trachea to keep it open and serves as the primary structure into which the inner cannula fits) and removed the strap around the resident's neck and discarded it into the trash bag at the foot of the bed. The strap around the neck and ties were visibly soiled. Nurse #6 with the same gloves on proceeded to remove the inner cannula and discarded it in the trash bag at the foot of the bed touching the inside of the trash bag. With the same gloves on, Nurse #6 picked up the packaged inner cannula, opened the package, discarded the package in the trash bag and with the same gloves on inserted the new inner cannula and locked it into place. Nurse #6 replaced the trach collar after changing out the trach collar piece and she and the IP attached it on either side and placed the elastic connection behind the resident's neck. Nurse #6 then gathered her supplies and trash, doffed her gown and gloves, sanitized her hands and left the room. The IP with the same gloves on proceeded to clean the resident's mouth with a mouthwash-soaked oral swab. After completing oral care, the IP doffed her gown and	F0695	Continued from page 17 proper hand hygiene. Any staff members who do not receive the training by 12/10/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 10/25/25, the Facility Educator conducted in-services with nurses on following infection control standards and procedures during tracheostomy care. Any staff members who do not receive the training by 12/10/25 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 10/18/25, the facility Infection Preventionist implemented the Lippincott Tracheostomy tube cannula and stoma care checklist that includes proper hand hygiene to ensure nursing compliance with following infection control standards and procedures during tracheostomy care. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 12/10/25, the facility Infection Preventionist or designee will conduct weekly tracheostomy care observations with 2 observations for 12 weeks, to ensure compliance. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 12/16/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0695 SS = D	Continued from page 18 gloves, sanitized her hands and left the room. An interview was conducted on 09/25/25 at 5:30 PM with the Director of Nursing (DON). The DON stated she expected the nurses to follow all infection control procedures when providing tracheostomy care to residents. She further stated Nurse #6 had told her that she had changed her gloves during the procedure. An interview was conducted on 09/26/25 at 11:58 AM with Nurse #6. Nurse #6 stated she felt like the tracheostomy care on Resident #15 had gone “really well” yesterday. Nurse #6 stated she thought she had sanitized her hands and changed gloves during the trach care but said if she didn’t she knew she was supposed to and again said she was pretty sure she had sanitized her hands and changed gloves during the procedure. An interview was conducted on 09/26/25 at 12:30 PM with the Infection Preventionist (IP). The IP stated she was aware Nurse #6 should have changed her gloves during the trach care and said she started to say something to her but was not sure she could do so. She stated Nurse #6 should have doffed her gloves and sanitized her hands after replacing Resident #15’s ties and collar and before inserting her disposable inner cannula, especially since the collar around her neck was visibly soiled. The IP also stated she should have sanitized her hands and changed her gloves before providing mouth care to Resident #15. 2. Resident #39 was admitted to the facility on 04/17/23 with diagnoses which included respiratory failure and tracheostomy status. Resident #39’s quarterly Minimum Data Set (MDS) assessment dated 09/04/25 revealed she was severely cognitively impaired and was coded for tracheostomy care. Resident #39’s comprehensive care plan revised on 09/04/25 revealed a focus area for being at risk for respiratory complications secondary tracheostomy. Interventions included tracheostomy care as ordered by physician. An observation was conducted on 09/24/25 at 1:18 PM of tracheostomy care being provided to Resident #39 by Nurse #7. Nurse #7 was already in Resident #39’s room with her gown and gloves on and was providing the care with the assistance of the IP. Nurse #7 and the IP were on either side of Resident #39’s bed and had the tracheostomy supplies for care on a towel on the resident’s overbed table next to Nurse #7. Nurse #7 and	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0695 SS = D	Continued from page 19 the IP had sanitized their hands and donned their gown and gloves and Nurse #7 began by removing the humidified oxygen trach collar. Nurse #7 then removed the disposable inner cannula and placed it in the trash bag at the foot of the bed. Nurse #7 picked up the new inner cannula and placed it in the trach and locked it. Nurse #7 with the same gloves on and without sanitizing her hands and donning clean gloves removed the trach dressing around the stoma. Nurse #7 and the IP then removed the ties on either side of the outer cannula and removed the strap around the resident's neck and discarded it into the trash bag at the foot of the bed. The strap around the neck and ties were visibly soiled. Nurse #7 with the same gloves on proceeded to clean around the stoma of the trach, replaced the neck strap and ties around the outer cannula of the trach. Nurse #7 then replaced the trach collar after changing out the trach collar piece and she and the IP attached it on either side and placed the elastic connection behind the resident's neck. Nurse #7 then gathered her supplies and trash, doffed her gown and gloves, sanitized her hands and left the room. The IP with the same gloves on proceeded to clean the resident's mouth with a mouthwash-soaked oral swab. After completing oral care, the IP doffed her gown and gloves, sanitized her hands and left the room. An interview was conducted on 09/25/25 at 2:51 PM with Nurse #7. Nurse #7 stated she felt like the tracheostomy care on Resident #39 could have gone better. Nurse #7 stated she should have sanitized her hands and changed her gloves during the procedure but said she didn't see her extra gloves on the bedside table. Nurse #7 further stated she knew she should have sanitized her hands and changed her gloves during the procedure but said she didn't see another pair of gloves on her field and so she just kept going with the trach care. An interview was conducted on 09/25/25 at 5:30 PM with the Director of Nursing (DON). The DON stated she expected the nurses to follow all infection control procedures when providing tracheostomy care to residents. An interview was conducted on 09/26/25 at 12:30 PM with the Infection Preventionist (IP). The IP stated she was aware Nurse #7 should have changed her gloves during the trach care and said she started to say something to her but was not sure she could do so. She stated Nurse #7 should have doffed her gloves and sanitized her hands after inserting her disposable inner cannula, and before cleaning around the stoma and replacing the ties, neck strap, and trach collar. The IP also stated	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345282**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0695 SS = D	Continued from page 20 she should have sanitized her hands and changed her gloves before providing mouth care to Resident #39.	F0695		
F0700 SS = E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and Nurse Practitioner and staff interviews, the facility failed to review risks and benefit of side rails use with the resident or resident representative prior to installation, failed to obtain informed consent, and failed to accurately assess 5 of 8 severely cognitively impaired residents for the use of bilateral half side rails on their beds (Resident #3, Resident #9, and Resident #15, Resident #39, Resident #35). Findings included: 1. Resident #3 was readmitted to the facility on 07/01/25 with diagnoses which included bilateral above knee amputation, cerebrovascular accident (stroke), tonic-clonic seizure disorder, chronic anticoagulation, and altered mental status.	F0700	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. On 11/26/25, the Nurse Manager or designee, will conduct side rail assessments, and review risks and benefits of side rails use and obtain informed consent with residents and/or resident representatives with continued use of side rails, for Resident #3, #9, #15, #39, and #35. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Beginning on 12/4/25 nurse managers or designee, will conduct facility wide side rail assessments, and review risks and benefits of side rails use and obtain informed consent with residents and/or resident representatives with continued use of the side rails. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/4/25, the facility Educator or designee will provide in-services to nursing on conducting accurate side rail assessments, reviewing risks and benefits of side rail use, and obtaining informed consent with residents and/or resident representatives with continued use of side rails. Any staff members who do not receive the training by 12/16/25 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 12/16/25, the Unit Coordinator or designee will audit monthly, completion of side rail assessment,	12/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 21 Resident #3’s annual Minimum Data Set (MDS) assessment dated 07/08/25 revealed she was severely cognitively impaired, unable to make her needs known and staff had to anticipate her needs daily. The assessment also revealed she required extensive assistance of 2 staff members for bed mobility, and she was on a turning and repositioning program. Resident #3 was not coded for side rails. Review of Resident #3’s care plan dated 09/04/25 revealed a focus area for activities of daily living (ADL) deficits related to altered mental status, atrial fibrillation, and stroke with hemiplegia (paralysis on one side of body). The goal was for the resident to have all Activities of Daily Living needs met through staff to keep her safe, clean and appropriately dressed. Review of Resident #3’s medical record revealed the resident did not have consent for the use of bed rails. Further review of Resident #3’s medical record revealed no documentation of risks and benefits of side rail use. Review of Resident #3’s physician orders revealed no order for bilateral half or quarter side rails to bed to assist in bed mobility. Review of Resident #3’s medical record revealed she had side rail assessments completed on: - 3/21/25 completed by Unit Manager (UM #1) - side rails – does the assist rail restrict voluntary movement– no; at risk for going over/under assist rail- no; reason for device use- bed controls on upper rail to assist resident with manipulating physical environment; family member name- family of Resident #3; family reason for side rail-sense of security; medical symptoms- seizure disorder; were the risks and benefits explained to the resident and/or family-yes; will the side rail assist the resident in being transferred-yes; will the side rails assist the resident in bed mobility-yes; Care Area Assessment used to determine need for side rails-no; identify all the contributes to the resident’s need to use assist rails-weakness, pain, balance deficit, knees buckle; assist rail type-quarter length; alternative to assist rails-n/a; resident understands the use and operation of assist rails- yes; resident successfully demonstrated the use of side rails-yes. - 04/8/25 completed by Nurse #2 - side rails – does the assist rail restrict voluntary movement– no; at risk for going over/under assist rail- no; reason for device	F0700	Continued from page 21 the accuracy of the assessment, risks and benefits were reviewed, and informed consents were obtained, 20 for one month, and then 10 for 2 months. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 12/16/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER: Cleveland Pines	STREET ADDRESS, CITY, STATE, ZIP CODE: 1404 N Lafayette Street , Shelby, North Carolina, 28150		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 22 use- sense of security; family member name- n/a; family reason for side rail-n/a; medical symptoms- weakness; were the risks and benefits explained to the resident and/or family-yes; will the side rail assist the resident in being transferred-yes; will the side rails assist the resident in bed mobility-yes; Care Area Assessment used to determine need for side rails-yes; identify all the contributes to the resident's need to use assist rails-weakness, awareness of safety, balance deficit; assist rail type-half length; alternative to assist rails-none; resident understands the use and operation of assist rials- yes; resident successfully demonstrated the use of side rails-yes. An interview on 9/25/25 at 3:32 PM with Nurse #2 who frequently cared for Resident #3 revealed Resident #3 was dependent with all care, she did not make purposeful movements, and she would not have been able to reach and pull herself in the bed if you asked her. Nurse #2 reported side rail assessments were done with a form that was checked off on the computer. She stated that if the resident could not communicate, we just check the boxes based on the last assessment. She reported she did not go into the room and actually assess if the resident could use the side rails. Nurse #2 reported the side rails kept the residents from rolling off the bed when NAs were performing care. She stated everyone here had bed rails, they came with the bed. - 07/01/25 completed by Unit Manager (UM) #2 - side rails – does the assist rail restrict voluntary movement– no; at risk for going over/under assist rail- no; reason for device use- sense of security; family member name- self; family reason for side rail-security; medical symptoms- weakness; were the risks and benefits explained to the resident and/or family-yes; will the side rail assist the resident in being transferred-yes; will the side rails assist the resident in bed mobility-yes; Care Area Assessment used to determine need for side rails-no; identify all the contributes to the resident's need to use assist rails-weakness, pain, balance deficit; assist rail type-quarter length; alternative to assist rails-none; resident understands the use and operation of assist rials- yes; resident successfully demonstrated the use of side rails-yes. An interview with UM #2 on 09/26/25 at 11:15 AM revealed that side rail assessments were done on all residents on admission and quarterly. She reported that all beds came with side rails on them and there was a standing order for side rail assessments but not for the actual side rail. UM #2 stated when she completed	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 23 the assessment she assessed for safety, and if the resident could hold the rail but reported the rails were ultimately there for security, for example, if rolling the resident from side to side the side rails were there to stop the resident from falling out of bed. She reported that the facility did not have signed consents for side rails. She reported when doing the assessments, if she answered yes to understanding, it was the family she was speaking about. She reported she guessed she didn't completely understand how to do the assessments for side rails. She stated she assumed if the staff could put the resident's hand on the rail and it stayed there then the resident was ok to have the side rail. Observation of Resident #3 on 09/23/25 at 9:45 AM revealed her lying in bed in her room with side rails up on either side of her bed. The side rails were gray metal that extended from the head of the bed to halfway down the bed. The resident was asleep in bed; bilaterally contracted hands were noted. Observation of Resident #3 on 09/24/25 at 8:45 AM revealed her lying in bed in her room with half side rails up on either side of her bed. The side rails were gray metal that extended from the head of the bed to halfway down the bed. The resident was asleep in bed; bilaterally contracted hands were noted. Observation of patient care for Resident #3 on 09/24/25 at 10:15 AM revealed Resident #3 lying in bed in her room with her side rails up on either side of her bed. Two nurse aides assisted in care for this resident. The resident was observed to have bilateral above knee amputations and bilateral hand contracture. No voluntary movement was observed during care. Turning of the resident side to side required both nurse aides. The resident did not participate in her care. She was unable to make eye contact with nurses' aides and unable to make her needs known. An interview on 09/24/25 at 10:15 AM with Nurse Aide (NA) #2 who was frequently assigned to Resident #3 revealed Resident #3 was unable to participate in any of her care. She reported she had been unable to participate in her care since she came back to the facility on 07/01/25. She reported that Resident #3 could sometimes smile and would often scream out if she is in pain but was otherwise nonverbal. She reported she rarely made eye contact any more. An interview with Nurse #6, on 9/26/25 11:58 AM revealed she had not been trained to do side rail assessments. She reported she just knew how to do them	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 24 from her old job but had always been told if the residents couldn't use the rails, they shouldn't have them. She stated all the residents at this facility had them because they came with the beds. She reported she felt like it was a sense of security for the staff to keep the residents from rolling off the bed. She reported she did the assessment when she was prompted to by the computer software and used the information from the prior assessment. Nurse #6 indicated she shouldn't be using the prior assessment's information for the new assessment but that is what everyone did. An interview on 09/24/25 at 10:45 AM with the Nurse Practitioner (NP) revealed all residents got side rails at admission. She reported that the side rails helped the staff with providing care and for bed mobility. She stated she had never signed an order for side rails but there was a standing order for side rail assessments on all residents, and she believed that was completed on admission and then quarterly, because it was protocol. She reported everyone who was admitted had side rails on their bed because she didn't think the side rails could be removed. She stated "if the resident was not moving then the side rail was just going to be there, it did not matter if they could use it or not". Resident #3's side rails were on her bed because they help staff provide care and they couldn't be removed. Resident #3 was not able to use the side rails. An interview with Director of Nursing (DON) on 09/25/25 at 6:04 PM revealed Resident #3 was a bilateral above knee amputee and had contractures in both her hands. She was total care since she returned from the hospital on 07/01/25. DON stated she would have expected the nurses to actually assess the resident to determine if the side rails were beneficial, not just check boxes. She reported there were not signed orders or consents for bed rails. An interview with the Administrator on 09/26/25 at 4:50 PM indicated she realized when it was called to her attention during the annual survey that bed rail assessments and use was not being executed correctly and there was an opportunity to improve. 2. Resident #9 was admitted to the facility on 08/09/24 with diagnoses which included senile degeneration of brain, Parkinson's disease, dementia, and schizophrenia. Resident #9's quarterly Minimum Data Set (MDS) assessment dated 05/08/25 revealed resident #9 was severely cognitively impaired, and dependent with all activities of daily living. Resident #9 was not coded	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 25 for side rails on her MDS. Review of Resident #9's medical record revealed the resident did not have a consent for the use of bed rails. Further review of Resident #9's medical record revealed no documentation of risks and benefits of side rail use. Review of Resident #9's physician orders dated 09/25/25 revealed no order for bilateral half side rails. Review of Resident #9's care plan 03/08/25 revealed a focus area for activities of daily living (ADL) deficits related to dementia, Parkinson's disease and Chronic obstructive pulmonary disease (COPD). The goal was for the resident to have all Activities of Daily Living needs met through staff to keep her safe, clean and appropriately dressed. Review of Resident #9's medical record revealed she had only two side rail assessments completed on: - 05/06/25 completed by Nurse #7- side rails - does the assist rail restrict voluntary movement-no; is resident at risk for going over/under the assist rail-no; why is the use of assist rails being considered- sense of security; family member-self; family reason for side rail- sense of security; medical symptoms-weakness; were risks and benefits explained to the resident and/or family-yes; will side rails assist the resident in bed mobility-yes; did the facility use a care area assessment to determine the need for side rails-yes; will side rails assist the resident in transfers- yes; additional reasons why the assist rails assist the resident-yes; assist rail assistance details-assist with mobility; Identify all the contributes to the resident's need to use assist rails-awareness of safety needs, balance deficit, weakness; assist rail type-quarter length; alternative to rails-no; resident understands the use and operation of assist rails-yes; resident height and weight operation of assist rails-yes; resident successfully demonstrated the use of side rails-yes; use of assist rails can be eliminated or reduced-no; elimination of reduction of assist rails details-not applicable. - 08/04/25 completed by UM #2- side rails – does the assist rail restrict voluntary movement-no; is resident at risk for going over/under the assist rail-no; why is the use of assist rails being considered- sense of security; family member-self; family reason for side rail- sense of security; medical symptoms-weakness; were risks and benefits explained to the resident and/or family-yes; will side rails assist the resident	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 26 in bed mobility-yes; did the facility use a care area assessment to determine the need for side rails-yes; will side rails assist the resident in transfers- yes; additional reasons why the assist rails assist the resident-yes; assist rail assistance details-assist with mobility; Identify all the contributes to the resident's need to use assist rails-awareness of safety needs, balance deficit, weakness; assist rail type-quarter length; alternative to rails-no; resident understands the use and operation of assist rails-yes; resident height and weight operation of assist rails-yes; resident successfully demonstrated the use of side rails-yes; use of assist rails can be eliminated or reduced-no; elimination of reduction of assist rails details-not applicable. An interview with Unit Manager (UM) #2 on 09/26/25 at 11:15 AM revealed that side rail assessments were done on all residents on admission and quarterly. She reported that all beds came with side rails on them and there was a standing order for side rail assessments but not for the actual side rail. UM #2 stated when she completed the assessment she assessed for safety, and if the resident could hold the rail but reports the rails were ultimately there for security, for example, if rolling the resident the side rails were there to stop the resident from falling out of bed. She reported that the facility did not have signed consents for side rails. She reported when doing the assessments, if she answered yes to understanding, it was the family that she was speaking about. She reported she guessed she didn't completely understand how to do the assessments for side rails. She stated she assumed if the staff could put the resident's hand on the rail and it stayed there then the resident was ok to have the side rail. An interview on 09/24/25 at 10:15 AM with Nurse Aide (NA) #2 who was frequently assigned to Resident #9 revealed Resident #9 was unable to participate in any of her care. She reported she had been unable to participate after a decline earlier in the year. She reported that Resident #9 had also been nonverbal since admission but had recently started singing occasionally. NA #2 reported Resident #9 was not able to follow directions and NA #2 had not seen Resident #9 use the side rails since her decline earlier this year. Observation of Resident #9 on 09/24/25 at 10:33 AM revealed her lying in bed in her room with side rails up on either side of her bed. The rails were gray metal that extended from the head of the bed to halfway down the bed. The resident was alert but unable to communicate, she had her left leg thrown off the bed over her right leg, her right leg was bent and pressing	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 27 on the side of the bed rail. An interview on 9/25/25 at 3:32 PM with Nurse #2 who frequently cared for Resident #9 revealed Resident #9 was dependent with all care. Nurse #2 reported side rail assessments were done with a form that was checked off on the computer. She stated that if the resident could not communicate, staff just checked the boxes based on the last assessment. She reported she did not go into the room and actually assess if the resident could use the side rails. Nurse #2 reported the side rails kept the residents from rolling off the bed when the NAs were performing care. She stated everyone here had bed rails, they came with the bed. An interview with Nurse #6, on 9/26/25 11:58 AM revealed she had not been trained to do side rail assessments. She reported she just knew how to do them from her old job but had always been told if the residents couldn’t use the rails, they shouldn’t have them. She stated all the residents at this facility had them because they came with the beds. She reported she felt like it was a sense of security for the staff to keep the residents from rolling off the bed. She reported she did the assessment when she was prompted to by the computer software and used the information from the prior assessment. Nurse #6 indicated she shouldn’t be using the prior assessment’s information for the new assessment but that is what everyone did. An interview on 09/24/25 at 10:45 AM with the Nurse Practitioner (NP) revealed all residents got side rails at admission. She reported that the side rails helped the staff with providing care and for bed mobility. She stated she had never signed an order for side rails but there was a standing order for side rail assessments on all residents, and she believed that was completed on admission and then quarterly, because it was protocol. She reported everyone who was admitted had side rails on their bed because she didn’t think the side rails could be removed. She stated, “if the resident was not moving then the side rail was just going to be there, it did not matter if they could use it or not”. Resident #9’s side rails were on her bed because they helped staff provide care and they couldn’t be removed. Resident #9 was not able to use them. Observation of Resident #9 on 09/25/25 at 8:15 AM revealed her lying in bed in her room with side rails up on either side of her bed. The resident was asleep. An interview with Director of Nursing (DON) on 09/25/25 at 6:04 PM revealed Resident #9 had Parkinson’s and dementia and was dependent with all care since a	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 28 decline around the first of the year. DON stated she would have expected the nurses to actually assess the resident to determine if the side rail was beneficial, not just check boxes. She reported there were not signed orders or informed consent for bed rails. An interview with the Administrator on 09/26/25 at 4:50 PM indicated she realized when it was called to her attention during the annual survey that bed rail assessments and use was not being executed correctly and there was an opportunity to improve. 3. Resident #15 was admitted to the facility on 1/14/25 with a readmission on 6/15/25. Diagnoses that included traumatic brain injury, tracheostomy (surgical procedure to provide opening in windpipe to provide airway for breathing), bilateral contractures (restricted joint mobility) of upper and lower extremities, and gastrostomy tube (a tube surgically placed in the stomach to provide nutrition, hydration, and medications). Review of revised care plan dated 6/15/25 revealed Resident #15 was care planned for activities of daily living (ADL) deficits related to disease processes. Resident #15 was dependent on staff for all ADL care, bed mobility, transfers, and upper side rails used for assistance with bed mobility. The care plan also revealed Resident #15 had impaired physical mobility and decreased range of motion related to her bilateral contractions of her upper and lower extremities. Review of the quarterly Minimum Data Set (MDS) assessment dated 07/24/25 revealed Resident #15 was rarely/never understood and was severely cognitively impaired. Resident #15 was dependent on staff for all ADL care, bed mobility, and transfers. In addition, the assessment indicated bed rails were not used under Restraints and Alarms. Resident #15's Electronic Medical Record (EMR) revealed Resident #15's side rail assessments were completed on 1/14/25, 4/14/25, and 7/13/25. The side rail assessments included the following: 1. Does the Assist Rail Restrict Voluntary Movement? No 2. Is Resident at Risk for Going Over/Under the Assist Rail? No 3. Why is the use of assist rail being considered?	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 29	F0700		

Sense of security

4. Family Member Name? No Answer

5. Family Reason for Side Rail? No Answer

6. Medical Symptoms? No Answer

7. Were the Risk/Benefits explained to Resident/Family? Yes

8. Will Side Rail assist the Resident in bed mobility? Yes

9. Did Facility use a Care Area Assessment to determine the need for side rails? No

10. Will side rails assist with transfers? Yes

11. Additional Reasons why the Assist Rails assist the resident? No

12. Assist Rail Assistance Details? N/A

13. Identify all the contributes to the Resident’s need to use Assist Rails? Weakness/ Pain

14. Assist Rail Type? Quarter Rail

15. Alternative to Assist Rail? None

16. Resident understand the use and operation of assist rail? None

17. Resident height/weight considered in the use of side rail? No

18. Resident successfully demonstrated the use of side rails? Yes

19. Use of Assist Rails can be eliminated or reduced? No

20. Elimination or Reduction of Assist Rail details? Not applicable

An interview on 09/26/2025 at 11:58 AM with Nurse #6 who frequently took care of Resident #15 and completed Resident #15’s side rails assessments. She stated Resident #15 had involuntary muscle spasms sometimes but could not move voluntarily and had bilateral contractures of the upper and lower extremities. Nurse #6 further explained that Resident #15 could not use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 30 her side rails for anything including positioning or bed mobility and was dependent on staff for all care needs. Nurse #6 further stated that Resident #15 was safer with the side rails up so she would not fall out of bed, and the side rails also helped the nursing assistants because it kept Resident #15 from rolling out of bed during care. Nurse #6 also revealed that the facility does not have physician orders for side rails, side rails are just standard practice, and all the beds in the facility have side rails. An observation was conducted of Resident #15 on 9/22/25 at 11:45 AM. Resident #15 was observed lying in bed in her room with side rails that extended from the head of the bed to the middle of the bed. The side rails were up on the right and left side of her bed. The side rails were of metal construction. Resident #15's legs and arms were contracted; she was non-verbal and did not respond when asked questions. An additional observation of Resident #15 was conducted on 9/23/25 at 2:45 PM. Resident #35 was lying in bed in her room with her side rails up on both sides of her bed. Resident #15's legs and arms were contracted; she was non-verbal and unable to answer any questions or follow any directions. Observation of Resident #15 on 9/24/25 at 4:05 PM revealed her lying in bed in her room with side rails up on both sides of her bed. Resident #15 legs and arms were contracted; she was non-verbal and unable to answer any questions or follow any directions. An interview on 09/25/2025 at 1:34 PM with the Nurse Practitioner (NP) about side rails revealed that any resident who was admitted was assessed for side rails. The side rails helped with repositioning and were used for mobility. The NP further explained that for dependent residents, the side rails helped the staff provide resident care. The NP revealed the facility did not have side rails orders and all the beds have side rails, and the bed rails were not removable. The NP stated that she had not seen a bed in the facility without side rails. The NP further stated that all residents in the facility had side rails on their beds. An observation was conducted on 9/25/25 at 3:55 PM. Resident #15 was lying in bed in her room with her side rails up on both sides of her bed.	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 31 An interview was conducted with the Director of Nursing (DON) on 09/25/2025 at 5:56 PM. The DON stated the nurses reported the side rails helped the aides and prevented Resident #15 from falling out of bed during care. Resident #15 was total care and dependent on staff for all care needs. The DON stated that she was not sure if the facility obtained side rail consents and she was unsure if there were physician orders for bed rails, but the nursing staff did complete quarterly side rail assessments on all residents in the facility. An interview was conducted with the Administrator on 09/26/2025 at 5:22 PM. The Administrator stated that the facility had an opportunity for improvement related to side rails assessments and the use of side rails. She declined to discuss side rail usage or specific resident information regarding side rails. 4. Resident #39 was admitted to the facility on 04/17/23 with diagnoses which included respiratory failure with tracheostomy status, left upper extremity contracture, aphasia, and quadriplegia. Review of Resident #39's Care Area Assessment (CAA) summaries dated 05/01/25 revealed no CAA summary addressing the use of bed rails. Review of a Side Rail assessment dated 07/22/25 completed by Nurse #2 revealed the following: 1. Does the assist rail restrict voluntary movement? No. 2. Is resident at risk for going over/under the assist rail? No. 3. Why is the use of assist rail(s) being considered? Bed controls on upper rail. 4. Family member name? None. 5. Family reason for side rails? Bed controllers. 6. Medical symptoms? Weakness. 7. Were the risks and benefits explained to the Resident and/or family? Yes. 8. Will side rails assist the resident in bed mobility? No. 9. Did the facility use a Care Area Assessment to	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345282**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 32 determine the need for side rails? Yes. 10. Will side rail(s) assist the Resident in transfers? No. 11. Additional reasons why the assist rail(s) assist the Resident? No. 12. Assist rail assistance details? Help with mobility. 13. Identify the contributes to the Resident's need to use assist rails. Unable to support trunk in upright position. 14. Assist rail type? Quarter length. 15. Alternative to assist rails? Not applicable An interview was conducted on 09/25/25 at 3:27 PM with Nurse #2. Nurse #2 explained she had completed the Side Rail Assessment for Resident #39 and the side rail assessments were to be completed every 3 to 6 months. The nurse stated the electronic medical record (EMR) alerted staff of when the Side Rail Assessment was due to be completed. Nurse #2 stated if a resident was able to talk, she would go in the room and talk with them to complete their Side Rail Assessment but said if they were unable to talk, like Resident #39, she checked off the assessment based on the answers provided on the last assessment completed. Regarding the answer Nurse #2 provided for question #12 in the Side Rail Assessment, Assist rail assistance details? Help with mobility, Nurse #2 stated she guessed she meant it would help the Nurse Aides (NAs) because it would keep Resident #39 from rolling off the bed, out of the bed, and the side rails, "keep her in the bed." Nurse #2 stated Resident #39 did not move at all on her own and was unable to provide any additional information regarding how the side rail benefited Resident #39. Nurse #2 further stated the side rails came standard with all the beds at the facility but said she had worked at other facilities that didn't have bed rails and said they had to have a specific order for side rails. Review of Resident #39's physician orders dated 09/01/25 revealed no orders for bed rails. Review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated 09/04/25 revealed Resident #39 was rarely/never understood and the brief interview for mental status (a cognitive screening tool used to assess a resident's memory and orientation) (BIMS) assessment was unable to be conducted. Resident #39's	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 33 cognitive skills for daily decision making were severely impaired and Resident #39 was dependent on staff to anticipate and provide activities of daily living (ADL). The assessment also revealed she required extensive assistance of 2 staff members for bed mobility and she was on a turning and repositioning program. In addition, the assessment indicated bed rails were not used under Restraints and Alarms. Review of Resident #39's care plan dated 09/04/25 revealed no care plan for the use of bed rails. Observation of Resident #39 on 09/22/25 at 11:31 AM revealed her lying in bed in her room with side rails that extended from the head of the bed to the middle of the bed. The side rails were up on the right and left side of her bed. The side rails were of metal construction and Resident #39 was non-verbal and did not respond when asked questions. Observation of Resident #39 on 09/23/25 at 9:26 AM revealed her lying in bed in her room with her side rails up on the right and left sides of her bed. The resident was turned onto her left side with her head of bed elevated and had earphones on and was watching a program on her electronic tablet attached to the top of her bed rail. Observation of Resident #39 on 09/24/25 at 2:41 PM revealed her lying in bed in her room with the side rails up on the right and left sides of her bed. The resident was turned onto her left side with her head of bed elevated and had earphones on and was watching a program on her electronic tablet attached to the top of her bed rail. An interview on 09/25/25 with Nurse Aide (NA) #1 revealed Resident #39 was total care and unable to do anything for herself and unable to ask for assistance with care. NA #1 stated Resident #39 was non-verbal and only able to blink to some simple yes/no questions. NA #1 further stated she provided total care for Resident #39 which included feeding, changing, bathing, and positioning her in bed. NA #1 stated Resident #39 could not move on her own and was unable to use the side rails for mobility due to her contracture and not being able to move her upper or lower extremities on her own. An interview on 09/25/25 at 2:51 PM with Nurse #7 revealed she usually took care of Resident #39 and said sometimes she could get a response from the resident by the resident blinking her eyes to simple yes/no questions and sometimes she didn't respond at all. Nurse #4 stated Resident #39 was non-verbal, required	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 34	F0700		

Continued from page 34
total care and could not move at all on her own and could not use her side rails to help move herself in the bed.

An interview on 09/26/25 at 3:30 PM with the Nurse Practitioner (NP) about side rails revealed that any resident who was admitted to the facility was assessed for side rails, the side rails helped with repositioning and were used for mobility. The NP stated that for dependent residents, the side rails helped the staff provide resident care. The NP further explained that the facility did not have side rail orders, the beds came with side rails, and the side rails were not removable. The NP stated she had not seen a bed in the facility without side rails and explained Resident #39's side rails were used for positioning the resident in the bed and preventing the resident from falling out of the bed when turned.

An interview was conducted with the Director of Nursing (DON) on 09/25/25 at 5:56 PM. The DON stated she thought Resident #39's side rails were used to hold her tablet; to allow her to be positioned on her left side so she could watch the tablet and provide trunk support. She further stated the rails served to support the pillows used to position her in the bed. The DON also stated the nurses reported to her the side rails helped the Nurse Aides (NAs) when turning the resident and prevented Resident #39 from falling out of bed during care. The DON stated Resident #39 was total care and dependent on staff for all her care needs and could not move at all on her own. The DON explained she was not sure if the facility obtained side rail consents and said she was unsure if there were physician orders for bed rails, but the nursing staff did complete quarterly side rail assessments on all residents in the facility.

An interview was conducted with the Director of Nursing Services (a corporate nursing representative) and Administrator on 09/26/25 at 5:22 PM. The Director of Nursing Services stated the facility had an opportunity for improvement related to side rail assessments and the facility's use of side rails. The Administrator added that side rails had always been on their beds.

5. Resident #35 was admitted to the facility 02/15/2019 with diagnoses that included spino- cerebellar ataxia (condition characterized by impaired coordination and balance due to damage to the cerebellum (a part of the brain that controls muscle coordination) and spinal cord, and gastrostomy tube (a tube surgically placed in the stomach to provide nutrition, hydration, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345282**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 35 medications) status. Resident #35's care plan dated 12/28/2024 and revised on 03/28/2025 revealed Resident #35 was care planned for activities of daily living (ADL) deficits related to disease processes. Resident #35 was dependent for all ADL. The care plan also revealed Resident #35 had aphagia (a language disorder that affects a person's ability to communicate and can impact various aspects of language including speaking and understanding) due to spino-cerebellar ataxia and received 100% of his nutrition via the gastrostomy tube. Resident #35's Electronic Medical Record (EMR) revealed he had side rail assessments completed on 04/01/2025 and 06/20/2025. The side rail assessments revealed the following: 1. Does the assist rail restrict voluntary movement? No. 2. Is resident at risk for going over/under the assist rail? No. 3. Why is the use of assist rail(s) being considered? Sense of security. 4. Family member name? Self. 5. Family reason for side rails? Sense of security. 6. Medical symptoms? N/A. 7. Were the risks and benefits explained to the Resident and/or family? Yes. 8. Will side rails assist the resident in bed mobility? No. 9. Did the facility use a Care Area Assessment to determine the need for side rails? Yes.10. Will side rail(s) assist the Resident in transfers? No. 10. Additional reasons why the assist rail(s) assist the Resident. No. 12. Assist rail assistance details? Safety. 13. Identify what contributes to the Resident's need to use assist rails? Unable to support trunk in upright position. 14. Assist rail type? Quarter length.	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 36 15. Alternative to assist rails? Not applicable An interview on 09/25/2025 at 3:41 PM with Nurse #2 who frequently took care of Resident #35 and completed Resident #35's side rails assessments stated Resident #35 had involuntary muscle spasms and movement and the side rail padding kept him from smacking his arms and his legs on the side rails. Nurse #2 further explained that Resident #35 could not use his side rails for anything including positioning or bed mobility and he was dependent for all care needs. Nurse #2 further stated that Resident #35 was safer with the side rails up so he would not fall out of bed, and the side rails also help the nursing assistants because it kept Resident #35 from rolling out of the bed during care. Nurse #2 also revealed the facility did not have physician orders for side rails, side rails were just standard practice, and all of the beds in the facility had side rails. Resident #35's significant change Minimum Data Set (MDS) assessment dated 07/02/2025 revealed Resident #35 was rarely/never understood and the Brief Interview for Mental Status (a cognitive screening tool used to assess a resident's memory and orientation) (BIMS) assessment was unable to be conducted. Resident #35's cognitive skills for daily decision making were severely impaired and Resident #35 was dependent for all ADL. In addition, the assessment indicated bed rails were not used under Restraints and Alarms. Observation of Resident #35 on 09/22/2025 at 11:58 AM and 09/23/2025 at 1:54 PM. Resident #35 was observed in his room lying in bed with side rails that extended from the head of the bed to the middle of the bed. The side rails were up on the right and left side of his bed and both rails had blue side rail padding. Resident #35's arms were contracted. Resident #35 was mumbling incoherently, and he was unable to answer questions or follow any directions. An additional observation of Resident #35 was conducted on 09/24/2025 at 7:30 AM. Resident #35 was observed in his room lying in bed with side rails that extended from the head of the bed to the middle of the bed. The side rails were up on the right and left side of his bed and both rails had blue side rail padding. Resident #35 was mumbling incoherently, and he was unable to answer questions or follow any directions. Observation of Resident #35 on 09/24/2025 at 7:30 AM revealed him lying in bed with side rails that extended from the head of the bed to the middle of the bed. The side rails were up on the right and left side of his	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	1404 N Lafayette Street , Shelby, North Carolina, 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 37 bed and both rails had blue side rail padding. Observation of Resident #35 on 09/25/2025 at 3:55 PM revealed him lying in bed in his room with side rails that extended from the head of the bed to the middle of the bed. The side rails were up on the right and left side of his bed and both rails had blue side rail padding. Resident #35 was mumbling incoherently, and he was unable to answer questions or follow any directions. An interview on 09/26/2025 at 3:30 PM with the Nurse Practitioner (NP) about side rails revealed that any resident who was admitted was assessed for side rails. The side rails helped with repositioning and were used for mobility. The NP further explained that for dependent residents, the side rails helped the staff provide resident care. The NP revealed the facility did not have side rails orders and all the beds have side rails, and the bed rails were not removable. The NP stated that she had not seen a bed in the facility without side rails. The NP also explained that Resident #35's padded side rails were used for protection because Resident #35 has spastic involuntary movements and the padded side rails kept him from hitting himself on the side rails and having an injury. The NP further stated that all residents in the facility had side rails on their beds. An interview was conducted with the Director of Nursing (DON) on 09/25/2025 at 5:56 PM. The DON stated that she thought a positioning wedge was used with Resident #35 for trunk support and the side rails kept the wedges from falling off the bed. Resident #35 used to thrash around in bed and had a lot of involuntary movements but now he just leaned to the side of the bed, and he does not thrash as much as he used to. The padding was probably there to keep him from hurting himself, but the side rails were for trunk support. The side rails support the pillows and cushions to position him. The DON also stated the nurses reported to her that the side rails helped the aides and prevented Resident #35 from falling out of bed during care. Resident #35 was total care and dependent on staff for all care needs. The DON stated that she was not sure if the facility obtained side rail consents and she was unsure if there were physician orders for bed rails, but the nursing staff did complete quarterly side rail assessments on all residents in the facility. An interview was conducted with the Director of Nursing Services (a corporate nursing representative) and the Administrator on 09/26/2025 at 5:22 PM. The Director of Nursing Services stated that the facility had an	F0700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345282**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/18/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0700 SS = E	Continued from page 38 opportunity for improvement related to side rails assessments and the use of side rails. The Administrator added that side rails had always been on their beds.	F0700		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews with staff, the facility failed to have effective systems in place for accurate reconciliation of controlled medications and maintaining accurate records of a resident's controlled medication declining count sheet for 1 of 6 residents reviewed for pharmacy services (Resident #46).	F0755	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F755 Based on record reviews and interviews with staff, the facility failed to have effective systems in place for accurate reconciliation of controlled medications and maintaining accurate records of a resident's-controlled medication declining count sheet for 1 of 6 residents reviewed for pharmacy services (Resident #46). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 12/17/25, Resident #46 was credited for the missing controlled medications and was not charged. The missing controlled declining inventory sheet was not located. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 11/25/25, 100% audit of all active controlled medications was conducted by the Pharmacy Director. The missing controlled declining inventory sheet was compared to the resident specific controlled medication to ensure they were all accounted for based on the orders. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 12/2/25, Pharmacy will provide the Director	12/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 39 The findings included: Review of the facility's Controlled Substances Distribution and Control Policy read in part: PROCEDURES D. A separate record will be maintained on each controlled substance in the form of a declining inventory record (Controlled Substance Sign-Out Sheet). Such record will be accurately maintained and will include: 6) The quantity of the controlled substance currently on hand. 10) Such records will be reconciled to a physical count of the remaining doses at each shift change by two licensed nurses including the nurse taking charge of these controlled substances 11) Such record will be retained by the facility for a period of not less than three (3) years. Resident #46 was admitted to the facility on 8/17/2022 with diagnoses that included generalized anxiety disorder. Review of a physician order dated 2/7/2023 last modified on 12/15/2024 read, lorazepam (Ativan) tablet 0.5mg by mouth twice daily. Review of the Controlled substance delivery manifest dated 12/9/2024 revealed receipt of 25 tabs of Ativan 0.5 mg for Resident #46 and was signed by Nurse #1 and Nurse #8. The controlled declining inventory sheet dated 12/9/2024 for Resident #46's Ativan 0.5mg tablets was not available for review, the facility was unable to locate the sheet. Review of the incident report dated 12/17/2024 revealed an event description that read: "Resident's card of Ativan is missing. There were 10 tablets left on the card. The narcotic sheet was still in the nurse's book." The incident report indicated the missing tablets belonged to Resident #46. During an interview on 9/25/2025 at 2:20 PM Nurse #2 stated she worked from 7:00 AM to 3:00 PM on 12/17/2024 and thought the card that contained 10 Ativan 0.5mg tablets was present in the locked controlled substance drawer when she counted on the morning of 12/17/2024	F0755	Continued from page 39 of Nursing (DON) with a new weekly report that captures all the controlled medications that were dispensed that week. The new weekly report will include the prescription number, date filled, drug name, and quantity. The DON will provide the new weekly report to Unit Coordinators to ensure medication has been administered, discontinued, or sent home with the resident upon discharge. Following the review, Medical Records will be notified by Unit Coordinators to scan the controlled declining inventory sheet into the required electronic medical record. On or before 12/1/25, the Director of Nursing will provide in-services to Unit Coordinators and Medical Records, on the new weekly controlled medication process. Any staff members who do not receive the training by 12/1/25 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 12/8/25, the Unit Coordinator or designee will audit 10 dispensed controlled medications weekly for 4 weeks, and then 5 a week for 8 weeks, for compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 12/16/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345282	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Pines	**1404 N Lafayette Street , Shelby, North Carolina, 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0755 SS = D	Continued from page 40 and in the afternoon Resident #46's Ativan tablets were not in the drawer. Nurse #2 stated it was toward the end of the shift when she realized the card with Resident #46's 10 Ativan tablets was missing from the locked controlled substance drawer, and the controlled declining countdown sheet was still in the book. Nurse #2 indicated she reported this to the Director of Nursing (DON) and the DON called whoever she needed to call and contacted the pharmacy to see if Resident #46's card that contained 10 Ativan 0.5mg tablets had accidentally been sent back to the pharmacy. Review of Omnicell log dated 12/17/2024 revealed Nurse #3 obtained Ativan 0.5mg for Resident #46 on 12/17/2024 at 9:59 PM. Review of the Medication Administration Record (MAR) for 12/17/2024 revealed Resident #46 received Ativan 0.5mg at 9:30 AM and 9:00 PM. During an interview on 9/26/2025 at 9:00 AM Resident #46 stated she thought she received all her medications because she took a lot. Resident #46 stated she did not have any concerns about her Ativan and did not recall going without her medication. Resident #46 stated she did not remember any of her medications going missing. During an interview on 9/25/2025 at 1:54 PM the Director of Nursing stated on 12/17/2024 it was discovered by Nurse #2 that Resident #46's Ativan 0.5mg card that contained 10 tablets was missing. The DON stated the controlled declining inventory sheet for Resident #46's Ativan 0.5mg was in the controlled declining inventory book on 12/17/2024. The DON stated the controlled declining inventory sheet for Resident #46's Ativan 0.5mg dispensed 12/9/2024 could not be found. The DON stated she knew the controlled declining count sheets were supposed to be maintained for three years and stated it must have been put in the investigation folder that was unable to be located. The DON stated Resident #46's missing 10 Ativan 0.5mg tablets were never found, but she believed it was human error and not misappropriation. Review of Resident #46's pharmacy charges revealed the 25 tablets of Ativan 0.5mg dispensed on 12/17/2024 were provided to Resident #46 at no charge. During an interview on 9/26/2025 at 4:54 PM the Administrator stated she expected the controlled medications to be accurately maintained and for controlled declining inventory sheets to be kept per the policy.	F0755		