STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255114	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cleveland Community Care Center	4036 Highway 8 East Cleveland, MS 38732

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to develop a communication care plan for (Resident #46), failed to implement a Behavioral care plan for (Resident #22), failed to implement an activities of daily living (ADL) care plan for (Resident #29, #64, and #105), and failed to implement a range of motion (ROM) care plan for (Resident # 105) for six (6) of 27 care plans reviewed.Findings include: Review of the facility policy titled, Care Plans, Comprehensive Person Centered, last revised March 2022, revealed the policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Resident #22 Review of the Behavior Management care plan, last revised 12/06/25, revealed the intervention: 1 on 1 (one-on-one) precautions. During an observation and interview with Resident #22 on 1/05/2026 at 11:40 AM, the resident stated he wanted to go back to where he came from, and this conversation with the resident continued for approximately five minutes. When asked if the gentleman asleep in a chair in his room was his family member, Resident #22 stated, No, he is supposed to be watching me but just look at him sleeping. The gentleman asleep in the chair did not awaken during the observation and interview. During the continued observation and interview on 1/05/26 at 11:48 AM, Certified Nurse Assistant (CNA) #3 stepped into the room and she identified the gentleman asleep in the chair as the Transporter assigned to sit with Resident #22 due to one-on-one supervision related to the resident's behaviors. The CNA loudly called the Transporter's name three times, and he did not awaken. An interview with the Minimum Data Set (MDS) nurse on 1/06/26 at 2:50 PM she stated that upon review of the resident's Behavior Management care plan, staff did not implement the one-on-one supervision when the assigned staff member was observed sleeping in the room and not observing the resident. She stated the purpose of the care plan is to direct the specific care each individual resident requires. Record review of the admission Record revealed Resident #22 was admitted on [DATE] with diagnoses including paranoid schizophrenia and bipolar disorder. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Brief Interview for Mental Status (BIMS) for Resident #22 dated 12/12/25 revealed a score of 15, indicating the resident was cognitively intact. Resident #29 Resident #29's Care plan revealed, I require assistance with my adls related to my history of cerebrovascular accident (cva) with left sided weakness/hemiplegia, right hand contracture, incontinent bowel/bladder, diagnosis of liver and colon cancer along with my history of Crohn's disease with small bowel obstruction. Under approaches: Shower every other day and PRN (as needed). On 1/05/2026 at 11:30 AM, an observation and interview revealed that Resident #29 was lying in bed, with her hair disheveled, and was wearing a white gown with dried liquid in various circles, visible on her gown. The resident revealed that she is supposed to get a shower each Tuesday, Thursday, and Saturday. She confirmed that she did not get a shower on Saturday and was not offered one. She revealed that the last time I had a shower was last Thursday, and that was the last time I had my clothes changed, so I have been wearing the same outfit for four (4) days. The resident revealed she had not had her hair combed since two days before Thanksgiving. In an interview and observation on 1/06/2026 at 11:05 AM, CNA #1 confirmed the resident's hair was disheveled and unkempt. On 1/06/2026 at 5:15 PM, during an interview and observation with the Director of Nurses (DON) present, Resident #29 reiterated her hair had not been combed since two days before Thanksgiving. The resident's hair remains disheveled and unkempt. The DON confirmed that the resident's hair needed attention and that she would ensure it was addressed. The DON revealed that each of our residents should always be adequately groomed and presentable, and with Resident #29 not adequately showered and her hair not attended to, then her plan of care was not being followed. An interview on 1/7/26 at 4:10 PM the MDS nurse revealed according to Resident #28's care plan she is supposed to receive a shower every other day and as needed. She revealed if her last shower was last Thursday then her plan of care was not being followed. She revealed hair care falls under the approach of having a shower. She revealed that the staff know that when a resident has a shower, they should also have their hair brushed. She confirmed that the resident's care plan was not implemented and revealed that we could do a better job by being more specific in developing each resident's individual plan of care. A record review of Resident #29's admission Record revealed the facility admitted the resident on 6/11/24 with diagnoses that included Crohn's Disease, Hemiplegia and Hemiparesis, and Malignant Neoplasm of Colon. A record review of Resident #29's MDS with an ARD of 11/14/26 revealed, under section C, a BIMS score of 15, which indicated the resident is cognitively intact. Resident #46 An observation and attempted interview with Resident #46 on 1/06/26 at 8:32 AM revealed he was lying in bed and unable to communicate. He shook his head back and forth as if he did not understand the questions. The resident's roommate verbalized that Resident #46 did not speak English. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #46's Care Plan Report revealed a care plan was not developed for his language/communication barrier. An interview with the MDS Nurse on 1/07/26 at 11:07 AM revealed the purpose of a care plan was for staff to know how to care for the residents. She stated Resident #46 used a phone as a translator to communicate with staff and confirmed a care plan was not developed because they were behind. Record review of the admission Record revealed the facility admitted Resident #46 on 12/11/25 with a diagnosis of Insomnia. Record review of the MDS with an ARD of 12/18/25 revealed under section A1110, What is your preferred language? Spanish was indicated. Section C revealed a BIMS summary score of 15, which indicated Resident #46 was cognitively intact. Resident #64 Record review of the resident's Care Plan identified that he required assistance with ADLs, with approaches including oral care daily and as needed (PRN). An observation and interview conducted on 01/05/2026 at 11:00 AM and 01/06/2026 at 4:35 PM revealed that Resident #64 was observed lying in bed receiving nutrition through a Percutaneous Endoscopic Gastrostomy (PEG) tube. The resident revealed he was unable to take anything by mouth due to difficulty swallowing. Upon observation, the resident's lower teeth exhibited a yellowish-tan substance along the gum line and between the teeth. Resident #64 revealed that staff did not brush his teeth. He stated he would feel cleaner if his teeth were brushed and stated that staff didn't have time, but they need to take time to do it. An observation and interview conducted on 01/06/2026 at 4:50 PM with the DON confirmed that Resident #64's teeth were visibly dirty and needed brushing. The DON stated that CNAs were responsible for providing oral care and that this intervention was included in the resident's care plan. The DON further stated that failure to provide appropriate oral hygiene could result in tooth decay, mouth sores, foul odors, and possible infection, and indicated that staff would address the issue immediately. She also confirmed that by not receiving the proper mouth care, his care plan was not followed. Record review of the admission Record indicated that Resident #64 was admitted on [DATE] with diagnoses including Dysphagia, Hemiplegia, and Hemiparesis. Record review of the MDS with an ARD of 12/23/2025 showed a BIMS score of 9, indicating moderate cognitive impairment. Under Section GG, the MDS documented that the resident was dependent on staff for oral hygiene. Resident #105 Review of a care plan for Resident #105 titled, Resident is at risk for ADLs related to decreased mobility, muscle weakness, and type two diabetes, revealed the following approaches: Nail care per nurse and ROM to upper and lower extremities with AM and PM care. During an observation on 1/05/26 at 11:30 AM revealed the resident's bilateral hands appeared contracted in appearance with no positioning devices in place, and the resident's fingernails were (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately one inch in length. During an observation of Resident #105's hands with CNA #2 on 1/06/26 at 2:18 PM, he confirmed the resident's bilateral hands were contracted and that the fingernails were very long and needed to be trimmed. He confirmed he did not perform any type of range of motion (ROM) to the resident's hands due to the severity of the contractures and stated the nurses were responsible for trimming the resident's fingernails. An interview with the MDS nurse on 1/06/26 at 3:10 PM revealed she stated that if staff failed to trim the resident's fingernails or provide ROM services as outlined, staff failed to implement the resident's care plan as instructed. She stated the purpose of the care plan is to direct resident-specific care for each individual resident. Record review of the admission Record revealed Resident #105 was admitted on [DATE] with diagnoses including type two diabetes and contracture of the right hand. Record review of the BIMS for Resident #105 dated 11/20/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interview, record review, and facility policy review, the facility failed to provide activities of daily living (ADL) care for three (3) of 113 residents residing in the facility. Resident # 29, #64, and # 105 Findings Include: Review of the facility policy titled, ADLs Supporting undated, revealed .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . Review of the facility policy titled, Fingernail Care, Foot Care, and Podiatry Referral, effective date 4/18/2017, revealed the stated purpose was to provide guidelines for the delivery of safe, evidence-based nail and foot care which promote good personal hygiene, prevent hand, foot, and nail infections, soft tissue injury, and foot ulcers . Resident #29 An observation and interview on 1/05/2026 at 11:30 AM revealed that Resident #29 was lying in bed, with her hair disheveled, and was wearing a white gown with dried liquid in various circles, visible on her gown. The resident revealed that she is supposed to get a shower each Tuesday, Thursday, and Saturday. She confirmed that she did not get a shower on Saturday and was not offered one. She revealed that the last time I had a shower was last Thursday, and that was the last time I had my clothes changed, so I have been wearing the same outfit for four (4) days. The resident revealed she had not had her hair combed since two days before Thanksgiving. During an observation and interview on 1/06/2026 at 8:28 AM, Resident #29 was again observed lying in bed with disheveled hair and unchanged appearance from the previous day, wearing the same gown. The resident stated, Today is Tuesday, so I'm supposed to get my shower today. In an interview and observation on 1/06/2026 at 11:05 AM, with Certified Nursing Assistant (CNA) #1 confirmed that the resident gets her showers on Tuesday, Thursday and Saturday and stated, The resident does not refuse care. CNA #1 revealed I'm not sure what happened with her not getting a shower this past weekend, but she is supposed to get a shower today. She confirmed the resident's hair was disheveled and unkempt. Observation and interview on 1/06/2026 at 3:10 PM revealed Resident #29's clothing had changed; however, her hair remained disheveled and unkempt. Resident #29 revealed, I got my shower today, but the girl didn't comb my hair. She said she doesn't know how to braid my hair. During an interview and observation on 1/06/2026 at 5:15 PM, with the Director of Nurses (DON) present, Resident #29 reiterated her hair had not been combed since two days before Thanksgiving. The resident's hair remains disheveled and unkempt. The DON confirmed that the resident's hair required attention and that she would ensure it was taken care of. The DON revealed that each of our residents should always be adequately groomed and presentable. A record review of Resident #29's admission Record revealed the facility admitted the resident on 6/11/24 with diagnoses that included Crohn's Disease, Hemiplegia and Hemiparesis, and Malignant Neoplasm of Colon. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #29's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/25 revealed, under section C, a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Resident #64 Review of the facility policy titled Mouth Care, revised February 2018, indicated that The purposes of this procedure are to keep the resident's lips and oral tissue moist, to cleanse and freshen the resident's mouth, and to prevent oral infection . Observations and interviews conducted on 01/05/2026 at 11:00 AM and on 01/06/2026 at 4:35 PM revealed Resident #64 lying in bed and receiving nutrition through his Percutaneous Endoscopic Gastrostomy (PEG) tube. The resident stated that he was unable to take anything by mouth due to difficulty swallowing. Observation revealed a yellowish-tan substance present along the lower gum line and between each tooth. Resident #64 stated that staff did not brush his teeth or keep his mouth clean and reported that he would feel better and cleaner if his teeth were brushed. He further stated that staff didn't have time, but they needed to take time to provide this care. During an observation and interview on 01/06/2026 at 4:40 PM, Licensed Practical Nurse (LPN) #4 confirmed the presence of a yellowish-tan substance along Resident #64's lower gum line and between his teeth. LPN #4 stated that mouth care was to be completed every shift and that failure to provide oral care could result in tooth decay, pain, gingivitis, and possible infection. An observation and interview on 01/06/2026 at 4:50 PM with the DON confirmed that Resident #64's teeth were visibly soiled and required brushing. DON stated that CNAs were responsible for providing mouth care every shift. DON further stated that failure to provide appropriate mouth care could result in tooth decay, mouth sores, foul odors, and possible infection and stated that staff would address the issue. An interview conducted on 01/07/2026 at 10:37 AM with CNA #5 revealed that she had provided care for Resident #64 the previous day. CNA #5 stated that mouth care was expected to be completed every shift but confirmed that she did not brush the resident's teeth. She stated that providing mouth care was difficult due to the resident's PEG tube feeding and the need for the resident to remain upright during that time. CNA #5 further stated that she would want her own teeth brushed daily and agreed that Resident #64 should have his teeth cleaned as well. Record review of the admission Record indicated that Resident #64 was admitted on [DATE] with diagnoses including dysphagia, hemiplegia, and hemiparesis. Record review of the MDS with an ARD of 12/23/2025 revealed a BIMS score of 9, indicating moderate cognitive impairment. Section GG indicated that Resident #64 was dependent on staff for oral hygiene. Resident #105 An observation on 1/05/26 at 11:30 AM revealed Resident #105's bilateral hands appeared contracted in appearance, and his fingernails were approximately one inch in length. An observation on 1/05/26 at 3:00 PM revealed Resident #105's fingernails remained approximately (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one inch in length. An observation of Resident #105's hands with CNA #2 on 1/06/26 at 2:18 PM revealed he confirmed the resident's fingernails were very long and needed to be trimmed. He stated the nurses are responsible for trimming residents' nails. Upon continued observation of the resident's right hand, it was observed that the first and second fingernails were digging into the resident's palm. CNA #2 stated that untrimmed fingernails could lead to skin breakdown. An observation of Resident #105's fingernails with LPN #1 on 1/06/26 at 2:35 PM revealed he confirmed the resident's fingernails were long, bent inward toward the palm of the hand, and needed to be trimmed. He stated the nurses are responsible for trimming the resident's fingernails due to the resident being diabetic. An interview with the DON on 1/06/26 at 3:00 PM revealed she had observed the resident's contracted hands and that the fingernails on the right hand were digging into the palm and required trimming. She stated failure to provide nail care services could result in worsening skin breakdown and accidents. Record review of the admission Record revealed Resident #105 was admitted on [DATE] with diagnoses including type 2 diabetes and contracture of the right hand. Record review of the BIMS for Resident #105 dated 11/20/25 revealed a score of 9, indicating the resident was moderately cognitively impaired.