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	06/08/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, staff interview, and facility policy review the facility failed to ensure a resident who was admitted with multiple pressure ulcers and other wounds received necessary treatment and services to promote healing and prevent worsening by failing to obtain wound treatment orders and initiate wound care upon admission for one (1) of three (3) residents reviewed for pressure ulcers. Resident #1.Findings included:Record review of the facility policy Wound Care revealed Policy.Wound Care Orders and Care Plans. Each individual wound site requires a separate wound care order.A record review of progress notes for Resident #1, dated 4/17/26, revealed the resident refused assessment of her wounds. The physician was notified; however, there was no documentation that wound treatment orders were obtained.Further record review of a nursing progress note for Resident #1, dated 4/19/26, documented the resident had multiple wounds including a right heel pressure ulcer with slough, a right hip pressure ulcer with eschar, Stage four (4) pressure ulcers to the right buttock, sacrum, and left buttock with tunneling, and additional wounds to the lower extremities. Despite documentation identifying the wounds, no wound treatment orders were obtained.Record review of the April 2026 Order Summary Report for Resident #1 revealed no wound treatment orders were entered until 4/28/26.Record review of the April 2026 Treatment Administration Record (TAR) revealed no documented wound care treatments were provided prior to 4/22/26.Telephone interview on 6/8/26 at 3:39 PM, the Wound Care Nurse Practitioner verified that she attempted to assess Resident #1's wounds on 4/21/26 but the resident refused to allow her to. The Wound Care Nurse Practitioner stated she was unaware the facility had not obtained treatment orders and agreed that basic treatment orders to clean and dress the wounds could have been obtained despite the resident's refusal of assessment.During an interview on 6/8/26 at 3:47 PM, Registered Nurse (RN) #1 stated the resident refused wound assessment upon admission and that he notified the Director of Nursing of the refusal. He stated he did not recall whether wound care orders were obtained at that time but agreed wound treatment orders should have been obtained.Interview with the Director of Nursing on 6/8/26 at 4:05 PM, she verified the resident had no wound treatment orders prior to 4/22/26 and agreed wound treatment orders should have been obtained upon admission.During a telephone interview, on 6/8/26 at 4:39 PM, the Treatment Nurse stated Resident #1 initially refused wound assessment but agreed wound treatment orders should have been obtained at the time of admission and acknowledged that failure to obtain treatment orders could result in worsening of wounds.Record review of the admission Record revealed that the facility admitted Resident #1 on 4/17/26 with diagnoses that included Diabetes Mellitus, Chronic Venous Hypertension with Ulcer of the Left Lower Extremity, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Schizophrenia.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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