

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255114		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/08/2026	
NAME OF PROVIDER OR SUPPLIER CLEVELAND COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4036 HIGHWAY 8 EAST P. O. BOX 1688, CLEVELAND, Mississippi, 38732			
(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted three (3) Complaint Investigations (CI MS# 2969227, CI MS# 2976550, and CI MS# 3020366) at the facility on 6/8/26. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The facility was cited F686 for CI MS #3020366 related to Treatment/Services to Prevent/Heal Pressure Ulcers. No deficiencies were cited for CI MS# 2969227 or CI MS# 2976550. Census at the time of the survey was 108 with a bed capacity of 120 beds.			F0000			
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: 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			F0686			

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
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F0686 SS = D	Continued from page 1 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			F0686			

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F0686 SS = D	Continued from page 2 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.			F0686			