

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/13/2023
NAME OF PROVIDER OR SUPPLIER SHEARER-RICHARDSON MEMORIAL NURSING HOMI		STREET ADDRESS, CITY, STATE, ZIP CODE 512 ROCKWELL DRIVE OKOLONA, MS 38860		
(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) COMPLETE DATE
{M 000}	Initial Comments The State Agency (SA) conducted a follow-up/revisit survey at the facility from 9/12/23 through 9/13/23. During the survey, the SA determined the facility was in compliance with the Mississippi Regulations for Aged or Infirm and the facility was placed back in compliance with the plan of correction date of 9/2/23. The census at the time of the survey was 67 with a bed capacity of 73 beds.	{M 000}		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/29/23