STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A162	A. BUILDING _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOME	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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey with a Complaint Investigation (CI MS#26480), at the facility from 9/30/24 through 10/3/24. During the survey the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA determined the facility was not in compliance with CI MS#26480 for resident's rights and cited F 550 and F 585. The SA also cited on the annual survey F640 for resident assessments and F656 for development of care plans. During the survey, the census at the facility was 68 with a license for 73 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		11/8/24

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

Electronically Signed | 10/22/2024

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.

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident representative (RR) interview and facility policy review revealed the facility failed to ensure residents were treated with dignity and respect as evidence by staff members calling the residents by their last name only and failing to use a salutation for two (2) of 18 residents sampled during this survey. Resident #2 and Resident #39. Findings Include Record review of the facility policy review titled, "Promoting/Maintaining Resident Dignity" with a revision date of 10/2/23 revealed "Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each	F 550	On 10/2/2024 the administrator spoke with the caregivers of Resident #39 and Resident #2 which included two (2) nurses and eight (8) nursing assistants, about the need to address these residents with respect, as evidenced using a salutation of (Mr./Ms.) with his or her first or last name prior to engaging with either resident. On 10/10/24 social services contacted the spouse of Resident #39 and staff's use of a preferred name that is not indicated in this residents' medical record, with her stating that he is known by the community, friends and family by two other names and gave permission for use of these names. Resident #39's medical record and care-plan was updated on	

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F 550	Continued From page 2 resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality". Resident #2 A phone interview on 9/30/24 at 11:20 AM, with Resident #2's Resident Representative (RR) revealed he has complained numerous times to the Director of Nurses (DON) and Administrator regarding issues with his mother. He revealed he complained most recently about the way the aides call her by her last name only and do not use a salutation and they take personal phone calls while in her room, during times when they are changing and cleaning her. He stated that a week ago when he tried to file that complaint, the DON told him he was just hard to get along with and confirmed that he has never heard back from the facility regarding a resolution to any of his complaints. An interview on 10/02/24 at 8:56 AM, with Certified Nurse's Assistant (CNA) #1 confirmed that she does call some of the residents by their last name only and can see now how that might be disrespectful to the resident by not using a salutation. An interview on 10/2/24 at 3:00 PM, with the DON and the Administrator who confirmed they knew that some residents were called by their last names only and can see how that could appear as a dignity issue. The Administrator revealed the staff have been trained to address the residents as Mr. or Mrs. and she wasn't sure why they were doing this. Record review of Resident #2's "Admission	F 550	10/10/24 to include the agreed upon names per Interdisciplinary Team. Resident #2's representative had been informed that the staff member he referenced had been counseled with and that other staff members had been instructed to utilize salutations when engaging with his mom. Between 10/7/24 and 10/11/24, the social and activity directors conducted interviews with all sixty-eight (68) residents and/or resident representative if needed to identify accuracy of the resident(s) preferred name. It was identified that twenty-seven (27) of 68 residents wanted their preferred name reflective within their medical record. On 10/7/24 the Interdisciplinary Team (IDT) met to initiate a Performance Improvement Plan (PIP), which indicated the need for further education of all staff on the facility's Resident Rights policy regarding the need to provide dignity and respect when addressing a resident, along with where to locate the residents' name preference within the electronic health record. That A satisfaction survey should be developed and distributed to all residents or resident representative addressing their opinion with staff's performance in providing dignity and respect. Social services should be responsible for training of all new hires within 5 days of hire on the facility's policy on resident rights. The administrator initiated a mail-out of the satisfaction survey on 10/10/24 to 63 resident	

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F 550	Continued From page 3	F 550		

Record" revealed the resident was admitted to the facility on 2/10/23.

Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired.

Resident #39

During an observation on 9/30/24 at 2:30 PM, it was noted that Resident #39 was in his wheelchair sitting by a window in the dayroom and the resident had called out to CNA #1 for assistance. As CNA #1 was walking towards him, she stated, "You can't get no sugar, (resident's last name)". Then she turned and walked away shaking her head and said, "(resident's last name, resident's last name)."

An interview with CNA #1 on 10/2/24 at 9:00 AM, confirmed she called Resident #39 by his last name and acknowledged this could be seen as disrespectful since he had not told her that he preferred to be called by only his last name.

During an observation and interview on 10/2/24 at 9:30 AM, CNA #2 was observed to be in the dayroom with Resident #39 and said, "Hey (resident's last name)." During the interview, CNA #2 acknowledged she called him by only his last name and thought he preferred that name since that was what everyone called him and she was not sure if he liked being called that or not.

During an observation and attempted interview with Resident #39 on 10/2/24 at 1:55 PM, when

representatives, and five (5) self-representatives. A follow-up survey will be distributed by 04/30/2025 and repeated annually to help identify with any noncompliance in providing dignity and respect to all residents. The administrator and social services began in-servicing staff on resident's rights beginning 10/16/24 with 88% of staff attendance as of 10/21/24. All other staff will be in-serviced on resident rights by 11/8/24 or they cannot return to work till they have met this requirement. 10/18/24, the administrator ran a report reflective of thirty-six (36) residents scoring an eight (8) or above on their Brief Interview Mental Status received a satisfaction survey for completion. Beginning the week of 10/20/24, the social service director will be responsible to educate all new hires within 5 days of hire on resident rights with emphasis on honoring all name preferences with emphasis on including a salutation when greeting or engaging in care and will conduct annually an in-service to all staff on Resident Rights. Upon review by the Compliance Officer on 10/21/24, there were no negative findings found regarding the 27 residents that were identified with name preferences.

The Quality Assurance Nurse (QA) will be responsible for monitoring effectiveness of the Performance Improvement Plan (PIP) beginning 10/14/24 through the QAPI Program as outlined per review of all new admissions at least one day a week for eight (8) weeks to ensure any noted name preference has been added

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F 550	Continued From page 4 asked his name and what he preferred to be called, it sounded like he said his first and last name together to both questions. Resident was difficult to interview since he had a BIMS of 4 which indicated he had severe cognitive impairment. During an interview on 10/2/24 at 3:00 PM, the DON and the Administrator confirmed they were aware that some residents were called by their last names only and could see how that could appear as a being disrespectful. The Administrator revealed that the staff know they should call them Mr. or Mrs. The record review of Resident #39's "Admission Record" revealed the facility admitted the resident on 10/30/23. Record review of Resident #39's MDS with ARD of 9/20/24, revealed a Brief Interview for BIMS of 4 which indicated the resident had a severe cognitive impairment.	F 550	to the individuals care plan and interview staff regarding knowledge of preference. Social services will interview at least 15% of current residents weekly for 8 weeks beginning the week of 10/21/24 to ensure staff is utilizing name preferences as indicated per resident. The QA Nurse and the Administrator will review all returned surveys for any negative reviews regarding staff's performance with dignity and respect and apply any actions necessary for compliance. The Administrator will report any negative findings to the governing board (meets the 3rd. Monday of each calendar month), and the Quality Assurance Committee including the Medical Director as scheduled for the 3rd Wednesday of each month, after being held on Friday, October 18, 2024.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		11/8/24

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§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all

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F 585	Continued From page 6	F 585		

information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance

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F 585	Continued From page 7 decision. This REQUIREMENT is not met as evidenced by: Based on resident representative (RR) and staff interview, record review and facility policy review the facility failed to ensure a resident representative's grievance was resolved for one (1) of 18 residents reviewed, Resident #2. Findings Include Record review of the facility policy titled, "Resident and Family Grievances" with a revision date of 10/1/23 revealed under, "Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines ...#12. The facility will make prompt efforts to resolve grievances". On 9/30/24 at 11:20 AM, during a phone interview with Resident #2's RR revealed he has complained numerous times to the Director of Nurses (DON) and Administrator regarding his mother. He revealed he complained most recently about the way the aides call her by her last name only and that they take personal phone calls in her room, while they are changing and cleaning her. He stated that a week ago when he tried to file that complaint, the DON told him he was just hard to get along with and confirmed that he has never heard back from the facility regarding a resolution to any of his complaints. An interview on 10/01/24 at 3:18 PM, with the DON and the Administrator confirmed that Resident #2's RR had made numerous complaints. The Administrator confirmed that	F 585	10/4/24 the administrator completed a written grievance form regarding the stated concern regarding the stated deficiency. Resident #2's responsible party was called on 10/9/24 and noted by the Social Service Director the actions taken by the facility for resolution of his noted concern, with responsible representative stating he was okay with the actions taken. Sixty-eight (68) of 68 residents could have been affected by the stated deficient practice. On 10/3/24 the administrator in-serviced the facility's grievance policy with eight (8) of twelve (12) department managers, with emphasis placed on utilizing a written form for record keeping, monitoring and tracking of grievances by the social service department and the administrator till resolution can be met. On 10/7/24, the Interdisciplinary Team (IDT), met to initiate a Performance Improvement Plan (PIP) outlining the need for further education of all staff regarding the facility's Resident and Family Grievance policy including reporting, investigating, notification of outcome and logging of grievance. As of 10/21/2024, there has been 88% of staff in-serviced on the grievance policy. All other staff will be in-serviced by 11/8/24 or will not be allowed to return to work until receipt of in-service. Upon receipt of a grievance, social services will be	

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they have never written any of his complaints up formally and included them on the grievance log. She stated that she usually just follows up and jots notes down and then calls him back. The DON stated we have not heard back from him, so we thought everything was ok. They both admitted that he came to the last care plan meeting a couple of weeks ago and complained about an aid cussing and talking loudly outside his mother's room. The Administrator confirmed she should have written these up so that they would have documentation of the grievances and what was done to resolve it and provided follow up back to the RR, but they had failed to do so.

An interview on 10/02/24 at 2:53 PM, with Social Services confirmed she was aware that Resident #2's son had complained about stuff in the past. She stated that he always goes to either the DON or Administrator, but she had never been told to write it up as a formal grievance.

Record review of the Grievance Summary Log for the past six (6) months revealed there was one grievance documented for Resident #2 and that was related to broken glasses and revealed no other grievances.

Record review of Resident #2's "Admission Record" revealed the resident was admitted to the facility on 2/10/23.

Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired.

responsible to share the information to the attention of other needed disciplines during the facility's morning stand up meeting scheduled Monday-Friday for assignment and follow up. The administrator will be responsible to follow up with the social service director and ensuring a written grievance form is on file. A satisfaction survey regarding the handling of grievances was mailed on 10/10/24 to assist in identifying any unknown issues. The social service director will be responsible to inform the resident council of the survey outcome at the next scheduled meeting 10/29/2024. The QAPI committee met on 10/16/24 and discussed the PIP regarding grievances and expectations of monitoring for written grievances and follow-up beginning the week of 10/21/24 and reviewed during the next scheduled QAPI meeting on 10/23/24 and weekly till 01/31/2025.

The Quality Assurance Nurse will review grievance log at least 1 day a week for 3 months, beginning 10/17/24 till 01/31/2025 to ensure ongoing compliance with record keeping, logging of event and resolution.
Any negative findings found will be reported to the administrator immediately for further action(s). This will be reviewed by the QAPI Committee on the third Wednesday of the month beginning 10/23/2024 thru 01/31/2025. The administrator will be responsible to inform the governing body of any negative findings during the monthly meeting

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F 585	Continued From page 9	F 585	scheduled for the 3rd Monday of the month. The QA Nurse will be responsible to report any negative findings at the Quality Assurance Committee meeting scheduled the 3rd Wednesday of the month.	