STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A162	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/01/2024**

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
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit discharge as per NFPA 101 sections 19.2.1, and 7.1.10.1. This deficiency affected 4 of 11 exits in the facility and 16 of 68 residents in the facility on the day of survey. Findings include: Observations on October 1, 2024, at 1:50 PM revealed the exit discharge from the Main Lobby, West Lobby, A Hall West, and East South Hall of the facility were blocked by construction work, heavy equipment and fencing. Thees exit	K 211	The following exits were: On 10/3/24 the main lobby-exit was taken offline and signage placed to identify closure (not required); West lobby-all exit signage was covered with signage stating this is not an exit (exit not required per code); East south hall-exit door taken offline with a temporary barrier added; A hall west-taken offline and added signage for not an exit. Forty-seven (47) of sixty-eight (68) residents could have been affected by the stated deficiency. On 10/1/24 the architect was called and informed of the concerns with the stated deficiency. Upon notification to the	10/22/24

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

Electronically Signed | 10/22/2024

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K 211	Continued From page 1 discharges also lacked all weather safe surfaces to the public way.	K 211	architect a call was made to the state department of health for clarification of concern with noted exits. On 10/3/24 the administrator was contacted and was informed that the facility would need to begin making changes in several areas and came to the facility on 10/4/24 and upon evaluation the exit signs were covered in the stated areas with placement of signage stating NO Exit. Signage placed to redirect traffic to the appropriate exit areas. The main lobby was closed and a barrier placed to prevent passage. Met with construction project manager to discuss adding a temporary wall to replace the temporary barrier, which was completed on 10/22/24. The architect has provided the state department of health with the construction plans for approval. The assigned architect and Administrator will ensure that the stated corrective measures are completed by the stated dates.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		10/22/24

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K 363	Continued From page 2 materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to properly protect corridor openings as directed by NFPA 101 section 19.3.6.3.5. This deficiency affected two (2) of three (3) smoke compartments and 28 of 68 residents in the facility during the survey. Findings include:	K 363	The doorstops were removed on the day of survey 10/1/24. Twenty-eight (28) residents out of a total of sixty-eight(68) residents could have been affected by the stated deficient practice. The administrator and maintenance personnel were verbally educated on	

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K 363	Continued From page 3 Observations on October 1, 2024, at 1:10 PM revealed corridor doors to the DON Office and Social Service Directors Office were obstructed and wedge opened with a piece of wood blocked.	K 363	10/1/24 by the surveyor regarding K371 and then both individuals reviewed the entire code requirement within the NFPA 101 on 10/2/24. The Administrator will make facility rounds at least 1 time a month beginning November 2024 for six (6) months to ensure that no employee has placed a doorstop on any doors that would impede the safety of residents.	
K 371 SS=E	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and measurements, the facility failed to properly subdivide the building in accordance with NFPA 101 sections 19.3.7.1 and 19.3.7.2 This deficiency affected 28 of 68 residents in the facility on the day of survey. Findings include:	K 371	Arrangements were made with the rehab department in providing a smoke barrier compartment availble to staff twenty-four hours(24) a day while waiting for the completion of a new smoke compartment in meeting the regulation in meeting the travel distance between smoke barriers. Received a 45 day waiver from the Okolona Fire Chief to allow a 250 foot travel distance to the current smoke	11/11/24

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K 371	Continued From page 4 On October 1, 2024, at 2:10 PM observation revealed a travel distance of over 200 feet from any point to a smoke barrier wall of the facility. The travel distance shall be less than 200 feet between smoke barrier walls in the facility.	K 371	compartmetn while construction is underway for the new compartment. Twenty-eight (28) of sixty-eight (68) residents could have been affected by the stated deficient practice. A commitment for purchases and construction of an additional smoke compartment should be completed by 11/11/2024 per construction project maanger. This installation should meet the requirements for providing less than 200' from the most remote area to an adjacent smoke compartment without including the therapy department. Plans have been submitted to the state department of health for approval. The architect and the administrator will ensure that the corrective actions are completed by 11/11/2024, and report to the state department of health and the faciity's governing board.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of	K 374		10/1/24

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K 374	Continued From page 5 egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and testing, the facility failed to properly maintain door openings in smoke barrier walls as per NFPA 101 section 19.3.7.8. This deficiency affected two (2) of three (3) smoke compartments and 28 of 68 residents in the facility on the day of the survey. Findings Include: Observations on October 1, 2024, at 1:10 PM revealed smoke barrier door to the Kitchen of the facility was obstructed and wedged open with a kick stop device.	K 374	Kickstop removed on day of discovery 10/1/24 Twenty-eight of sixty-eight residents could have been affected by the stated deficient practice. On 10/1/24 maintenance personnel were counseled on the requirement of K374 and to never apply any type of kickstop to a fire door. The dietary manager and staff were in-serviced by the administrator on the requirement to never block open the fire door located on the southside of the kitchens' adjoining hallway. The administrator will make rounds at least 1 time a month for 6 months to ensure that no one has applied any type of kickstand that would allow for blockage of a firewall or impede the safety of a resident.	