STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A162	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOME	512 ROCKWELL DRIVE PO BOX 604, OKOLONA, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 10/06/25 through 10/08/25. During the survey, the SA determined that the facility was not compliance with the requirements for participation in Medicare and Medicaid and cited F584, F644, F726, F770, and F919. The census at the time of the survey was 67 and the facility is licensed for 73 beds.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in	F0584		

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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F0584 SS = D	Continued from page 1 good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to ensure a resident had a safe and homelike environment as evidenced by a broken bathroom wall tile and a broken towel holder in the bathroom for one (1) of 67 residents' rooms observed. Resident #55 Findings include: Review of the facility's policy titled, "Safe and Homelike Environment" dated 7/29/25, revealed, "In accordance with residents' rights, the facility will provide a safe, clean comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the residents can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk. ... 'Environment' refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. ... 'Orderly' is defined as an uncluttered physical environment that is neat and well-kept..." During an interview and observation on 10/6/25 at 10:44 AM, Resident #55 stated her towel holder had been broken since she moved in the room, and she would like to be able to use it. An observation revealed the left side of the towel holder was partially out of the wall and the tile was broken. The right side was secured in	F0584		

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F0584 SS = D	Continued from page 2 place, but there was no bar between the ends. An interview and observation on 10/7/25 at 2:45 PM, with the Director of Nursing (DON) revealed that it was her expectation that every area of the facility be in good repair and not a safety risk. She confirmed the facility failed to maintain the towel rack adequately and the broken tile was sharp and could cause an injury. During an interview on 10/7/25 at 2:50 PM, the Administrator confirmed that facility failed to maintain the resident's bathroom towel rack in safe and functioning condition. Record review of the "Admission Record" for Resident #55 revealed the facility admitted the resident on 6/24/24 with diagnoses that included Hypertensive Chronic Kidney Disease and weakness. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/1/25 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated a moderate cognitive impairment.	F0584		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	F0644		

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F0644 SS = D	Continued from page 3 failed to ensure a Preadmission Screening and Resident Review (PASRR) status change was completed when a resident's original diagnosis was corrected to reflect the presence of a mental illness for one (1) of four (4) residents reviewed for PASRR. Resident #25. Findings included: In an interview with the Administrator (ADM) on 10/8/25 at 8:05 AM, she stated that the facility did not have a policy regarding submitting Status Change for PASRR. Record review of Resident #25's "Intake Information" dated 7/19/23, revealed in Section J-Disease Diagnoses that a mental illness was not included in the diagnosis section. Section M PASRR revealed that "No" was answered under the section "PASRR Activity Required." Record review of the "Admission Record" for Resident #25 revealed the resident was originally admitted to the facility on 12/12/2023 with diagnoses that included generalized anxiety disorder. Further review revealed that on 3/20/25, the resident's diagnosis list was updated to include "Other psychotic disorder not due to a substance known physiological condition." Record review of the medical record revealed that the facility did not submit a Status Change following the correction of the resident's diagnosis to reflect a qualifying mental illness and there was no Level II evaluation was requested or completed. On 10/7/25 at 1:00 PM, the Social Worker (SW) confirmed that she did not complete a Status Change Request for Resident #25 because she was not aware of the diagnosis. She stated that she usually reviews the psychiatric Nurse Practitioner's notes to determine if a Status Change should be done. She verified the purpose of completing a Status Change is to ensure the resident is appropriate for the nursing home and may identify services that a resident with a mental illness may need. She agreed that a Status Change should have been completed for Resident #25. In a further interview with the ADM on 10/8/25 at 8:45 AM, she stated that the Minimum Data Set (MDS) nurse is responsible for coding resident diagnoses, and she did not correctly code Resident #25's diagnosis on admission. She stated the MDS nurse identified her error on 3/20/25 and corrected the diagnosis but did not notify the SW of the correction. She agreed the SW should have been notified so a Status Change could be submitted.	F0644		
F0726 SS = D	Competent Nursing Staff	F0726		

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F0726 SS = D	Continued from page 4 CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to ensure that all nursing staff had valid and current certification to provide care to residents. This deficient practice resulted in a Certified Nursing Assistant (CNA) working 15 shifts while her certification was expired, which placed residents at risk of receiving care from an unqualified individual for one (1) of (44) CNA certifications reviewed. (CNA #1). Findings include:	F0726		

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F0726 SS = D	Continued from page 5 Review of the facility policy titled, “Nursing Services and Sufficient Staff,” last reviewed 3/20/25, revealed the following: “It is the policy of the facility to provide staff with appropriate competencies to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident...” Record review of the “Nurse Aide Registry” with an inquiry date of 6/14/24 at 4:30 PM, revealed CNA #1’s certification expired on 8/31/25. An interview with the Staff Educator on 10/8/25 at 11:09 AM, confirmed that CNA #1’s certification expired 8/31/25. She stated that she accidentally missed the expiration date on the CNA log used to track certification dates. She acknowledged that allowing the CNA to work while her certification was expired was a violation of state and federal regulations. Record review of the time sheet for CNA #1 revealed that from 9/1/25 through 10/8/25, CNA #1 worked 15 days while her certification was expired. An interview with the Administrator (ADM) on 10/8/25 at 11:30 AM, confirmed that CNA #1’s certification was expired and that the CNA had continued to work at the facility during that time. The ADM stated that the facility tracks CNA certification dates, but this particular lapse was overlooked. She confirmed CNA#1 should not have worked while her certification was expired. A phone interview with CNA #1 on 10/8/25 at 11:40 AM, revealed she was unaware that her certification had expired until she was notified by the ADM. She stated that she had recently moved and did not receive a renewal notice in the mail. She acknowledged she would be required to retest to regain her certification.	F0726		
F0770 SS = D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of	F0770		

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F0770 SS = D	Continued from page 6 this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to ensure laboratory tests were obtained as ordered by the physician for (1) one of five (5) resident laboratory reviews conducted. (Resident # 14). Findings include: Review of the facility policy titled, “Diagnostic Testing Services,” last reviewed 7/22/25, revealed: “Policy: This facility will provide the appropriate diagnostic services (laboratory/radiology) required to maintain the overall health of its residents and in accordance with State and Federal guidelines...” Record review of “Order Details” revealed a physician’s order dated 6/7/24 to obtain a HGBA1C (Glycated Hemoglobin) every 3 months (July, Oct, Jan, April). Record review of Resident #14’s HGBA1C results revealed there were no results for January 2025 or July of 2025. An interview with the Director of Nursing (DON) on 10/7/25 at 1:49 PM, confirmed that Resident #14 did not have a HGBA1C obtained for January 2025 or July of 2025. She revealed that the physician’s order for the HGBA1C was not correctly entered into the electronic medical record, and the lab was not scheduled. The DON stated that failure to obtain the lab as ordered could result in missed elevated levels and adversely affect the resident’s diabetic management. Record review of the “Admission Record” revealed the facility admitted Resident #14 on 5/16/25 with diagnoses that included of Type 2 Diabetes Mellitus.	F0770		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F0919		

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F0919 SS = D	Continued from page 7 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident had a functioning call light system in the bathroom for one (1) of 67 residents' rooms observed. Resident #55 Findings include: Review of the facility's policy titled, "... Call Lights: Accessibility and Timely Response" dated 5/21/25, revealed, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. ... 7. The call system must be accessible to the residents at each toilet and bath or shower facility. The call system should be accessible to a resident lying on the floor. 8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied..." During an observation and interview on 10/6/25 at 10:44 AM, Resident #55 revealed that when she pulls the cord on the call light in her bathroom, it does not activate the call light system. She stated that she took her phone into the bathroom with her, so that she had a way to call for assistance if needed. An observation of the bathroom call light system confirmed that the cord was not able to be pulled to activate the call system. On 10/7/25 at 2:45 PM, during an observation and interview, the Director of Nursing (DON) confirmed that the call light system in Resident #55's bathroom could not be activated with the pull cord. Resident #55 informed the DON that she took her phone in the bathroom with her in case assistance was needed. The DON confirmed that each call light in resident's room and bathroom was required to function properly to alert the staff if needed. She confirmed the facility failed to ensure a call light in a resident's bathroom was functioning properly. During an interview on 10/7/25 at 2:50 PM, the Administrator revealed it was her expectation that each	F0919		

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F0919 SS = D	Continued from page 8 resident's room and bathroom have a call light system to alert staff of the need for assistance. She confirmed the facility failed to provide a functioning call light in Resident #55's bathroom. Record review of the "Admission Record" for Resident #55 revealed the facility admitted the resident on 7/6/25 with diagnoses that included Hypertensive Chronic Kidney Disease and weakness. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/1/25 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated a moderate cognitive impairment.	F0919		