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 _____	01/20/2022

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 and a complaint survey for MS #17803 and MS #17688 at the facility from 1/18/22 through 1/20/22. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA did not substantiate MS #17803 or MS #17688 with no citations cited. The SA cited F563, F644, F645, F646, F658, F695 and F880 during the survey. The facility held a license for 73 beds and had a census of 71 at the time of the survey.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and	F 563		3/10/22

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

Electronically Signed | 02/12/2022

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 _____	01/20/2022

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 563	Continued From page 1 procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, staff, and responsible party interview, record review, facility policy review, and Centers for Medicare and Medicaid Services (CMS) Quality Safety and Oversight (QSO) Memo review, the facility failed to allow visitation for 44 of 71 residents in the west side of the building during an outbreak of COVID-19. Findings Include: Review of the facility policy titled, "Interim COVID-19 Visitation Policy" with no implementation or revision date revealed (Facility Proper Name) will restrict visitation of all visitors and non-essential health care personnel for the duration of the declared national and public health emergency related to COVID-19. Exceptions will be in accordance with current CMS directives and CDC recommendations, or as directed by state government (whichever is more stringent). Review of the Center for Medicare and Medicaid Services (CMS) Quality Safety and Oversight (QSO) Memo with a reference # of "Ref: QSO-20-39-NH" dated "Revised 11-12-21" revealed under, "Memorandum Summary" " Visitation is now allowed for all residents at all times."	F 563	1/19/22-The Responsible Party for Resident #27 was notified by the Social Service Director that they could resume visitation immediately. Social services has placed a progress note into Resident #27's chart related to this discussion. 1/19/22-The social service department identified that 42 of 42 resident who resided on the west side of the facility had been or could have been affected by the stated deficient practice. 1/21/22-An Ad Hoc meeting was completed by the Administrator to inform department managers of the need to replace the Interim Covid-19 Visitation Policy with an updated Interim Visitation Policy that only includes a list of precautionary measures to be taken for visitations that require screening/monitoring of visitors for signs/symptoms of Covid-19. 1/25/22-The Ombudsman held a Resident Council meeting with 23 of 70 residents in attendance to discuss the need and requirement for the facility to allow visitation of residents' choosing at all times as outlined per CMS QSO-20-39	

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 _____	01/20/2022

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 563	Continued From page 2 An observation on 1/18/22 at 10:00 AM, an observation revealed a notice on the front door of the facility that read, "Visitation starts on Saturday at 12 noon and ends at 6 PM." On 1/18/22 at 10:38 AM, an interview with the Administrator stated that the notice on the front door was old and that she removed it. The Administrator revealed that they have been allowing visitors, but they must dress out with Personal Protective Equipment (PPE), especially in the West building since that is where our COVID-19 positive resident are residing. On 01/18/22 at 11:22 AM, an interview with Registered Nurse (RN) # 2 revealed that the facility had not allowed visitors on the west side for a good two weeks due to two of the residents testing positive for COVID-19. On 1/18/22 at 11:45 AM, an interview with the Director of Nurses (DON) confirmed that the facility had not allowed any visitors on the west side in about 3-4 weeks due to having positive COVID-19 residents. When questioned if the facility had reviewed the most recent QSO memo from CMS regarding allowing visitors during a COVID-19 outbreak, the DON stated that she had told them we were supposed to allow visitors into the building and had always thought that it was a bad thing to not allow families to come into the facility. On 01/18/22 at 03:09 PM, an interview with Resident # 27's Responsible Party (RP) revealed she has not been allowed to come in the west side of the facility to visit her mother for at least two weeks. Resident # 27's RP revealed that the	F 563	NH Memorandum. 1/25/22 thru 2/10/22-Social services and activity personnel completed informing 46 of the current 69 resident census of the need and requirement that the facility is to allow visitation to occur of their choosing. 2/3/22-An in-service was completed by the facility's Nursing Consultant regarding visitation for 31 of 76 staff members. The other 45 staff members will be in-serviced by 2/28/2022 regarding the facility's visitation policy. 2/3/22-The Medical Director was informed of the receipt of the facility's 2567 deficiency report with findings. 2/7/22-An Ad Hoc Quality Assurance Performance Improvement meeting was held by the Administrator regarding the facility's visitation policy non-Covid related to identify any concerns with residents' right to make choices about aspects of his or her life in the facility that are significant to the resident including visitation, with policy found to be compliant. 2/7/22-A copy of CMS QSO-20-39NH Memorandum with a revision date of 11/12/2021, was given to each departmental manager, which included the Director of Nurses(DON), Quality Assurance Nurse (QA Nurse), MDS Nurse, Social Service Director, Activity Director, Maintenance Director, Dietary Manager, Housekeeping Supervisor, Staff Development, Assistant Administrator and Receptionist to ensure that all parties involved in facility decision making are aware of the requirement to allow visitation to all residents per their choosing.	

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 _____	01/20/2022

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 563	Continued From page 3 facility called and notified her that the facility was in an outbreak again and had to be shut down for visitors and she could only call her mother on the phone to check on her. Resident # 27's RP stated, "I called to check on Mother this afternoon and the staff that answered the phone told me I could come visit her now. " On 1/19/22 at 2:19 PM, an interview with Registered Nurse-Infection Preventionist (RN-IP) confirmed that visitation was restricted during their current COVID-19 outbreak, but families could come for compassionate care visits. The RN-IP revealed that the staff called all the resident's families to notify them of the COVID-19 outbreak and that visitation was shut down. The RN-IP revealed that families could come for compassionate care visits only, but the families may not have known they could come for a compassionate care visit, because we did not specifically tell them that. The RN-IP revealed that the Administrator received the CMS-QSO memos, and she denied any knowledge of the most recent update on 11/12/2021 by CMS regarding no restriction on visitation. The RN-IP revealed they would begin calling all families now to inform them they could come to visit. On 1/19/22 at 4:15 PM, an interview with the Administrator revealed that visitation was restricted in the West building where the COVID positive residents were, but not in the East building. The Administrator confirmed she received the CMS QSO memos, reviews them, and keeps a copy. On 1/20/22 at 8:45 AM, an interview with Licensed Practical Nurse (LPN) # 1 revealed that Resident # 27 does not speak. LPN # 1 revealed	F 563	2/7/22-All staff will be in-serviced on the Interim Visitation Policy no later than 2/28/22 per snfclinic educational program. 2/7/22-Social services will audit all visitation sign-in sheets weekly beginning with the date of 1/19/22 and ending on 3/3/22 to ensure visitation are being exercised for the residents who could have been affected by the stated deficient practice. If on 2/16/22 social services identifies a possible concern with visitation of a resident, they will interview the resident if possible and/or call the responsible party to ensure individual knowledge of the visitation rule. 2/16/22-The Administrator will distribute copies of the facility's updated Interim Visitation Policy for review by the Quality Assurance Committee members including the Medical Director to allow further discussion if needed and to ensure all members are knowledgeable about the requirement rules and regulations pertaining to the residents' ability to have visits of their choosing at all times. 2/16/22-The Quality Assurance Nurse will audit for completion of the visitation tracking log for percentage of residents who have had visitors or not and for validation of responsible party or resident interviews being completed for the individual who has not had a visitor listed since 1/19/22. The results of the stated reviews will be added to the weekly Quality Assurance Performance Improvement Agenda weekly beginning 2/17/22 and ending on 3/10/22 and presented to the Quality Assurance	

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 _____	01/20/2022

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 563	Continued From page 4 that all the resident's benefit from visiting with their family and friends; "they just need it." LPN # 1 stated that when the facility is shut down for visitation, then the staff must be their everything and as hard as we try, we are not able to give them the same kind of attention that a family member could. On 1/20/22 at 10:45 AM, an interview with the Administrator revealed that the policy titled, "Interim COVID-19 Visitation Policy" was implemented at the beginning of COVID-19, so it would have been around 2/2020 or 3/2020 and confirmed that she believes allowing visitors to visit the residents is important. Record review of the Resident #27's Face Sheet revealed an admission date of 12/12/19 with medical diagnoses that included: Cerebral Infarction, Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side and Memory Deficit following Cerebral Infarction. Record review of the Resident #27's nurse's note dated 1/3/2022 revealed the nurse documented that she spoke with the RP (RP's name). Notified that we have new COVID positive cases at facility, and there will be no visitation for 2 weeks. Also notified that if resident has a decline in her condition, they will be allowed to visit. Record review of the resident's Minimum Data Set with an Assessment Reference Date of 8/24/21 revealed Resident #27 had Brief Interview of Mental Status Score (BIMS) of 2, indicating that the resident has a severe cognitive deficit.	F 563	Committee meeting beginning 2/23/22 and ending no later than 3/31/22 till further notice of an outbreak. Ongoing-If the facility incurs a future outbreak of Covid-19 the facility assigned personnel will notify the Responsible Party (RP) of the outbreak and address that visitations may continue if the resident so chooses with notation being placed in the resident's chart. Social Services will be responsible to review resident charts for proper notification of visitation and place calls to at least 10% of the RPs of the affected unit to validate that they are aware of the continuance of visitation as evidenced by the COVID-19 Visitation Tracking Log. The Social Services Director will report any negative findings to the Administrator or QA Nurse immediately for evaluation of deficient practice with follow up discussion with QA Committee and governing board for other corrective measures to be taken.	
F 644 SS=D	Coordination of PASARR and Assessments	F 644		3/10/22

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 _____	01/20/2022

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 644	Continued From page 5 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 staff interview and record review, the facility failed to submit a Preadmission Screening and Resident Review (PASRR) Level II Change in Status Request Form (look at the form) for a resident with a new mental health diagnosis and a new psychotropic medication for one (1) of three (3) residents reviewed for PASRR Level II. Resident #59. Findings include: An interview and record review, on 1/19/22 at 03:15 PM, with the Director of Nursing (DON), confirmed Resident #59 had a mental health status change, due to a diagnosis of Major	F 644	Resident #59 had a Level II Change in Status Request Form completed by the DON and submitted on 1/27/2022. On 2/1/2022 the Director of Nurses (DON) completed and submitted a Level of Care Request Form for Resident #59 per discussion with a representative from the agency handling Preadmission Screening and Resident Review. Upon receipt of correspondence from the appropriate agency who handles the PASRR process the facility will implement any and all recommendations made for resident #59. The Psych Nurse Practitioner continues to monitor Resident #59 as evident per notation in resident chart for a visit on	

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 _____	01/20/2022

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 644	Continued From page 6 Depressive Disorder, Recurrent, Unspecified, which was added to his medical record on 7/20/20. The DON confirmed that Resident #59 had another status change, due to a physician's order for Cymbalta 60 milligrams (MG) by mouth one (1) time a day, which was added to his medical record on 11/24/20. The DON revealed she did not submit a Change in Status Request Form, to the appropriate agency, to find out if a Preadmission Screening and Resident Review (PASRR) Level II needed to be completed for Resident #59. The facility did not have a policy related PASRR. Record review, of the Preadmission Screening (PAS) Level I, completed by the facility upon admission, dated 6/27/18, for Resident #59, revealed the answer, no, to the questions; "Person has a diagnosis of a major mental illness and person has a recent history of a major mental illness." Record review of the Order Summary Report, for Resident #59, revealed a physician's order for Cymbalta 60 milligrams (MG), for depression, with an order date of 11/24/20, and a start date 11/25/20. Record review, of the diagnosis list, for Resident #59, revealed a diagnosis of Major Depressive Disorder with an onset date of 7/20/20.	F 644	2/3/22, with no further recommendations. Resident #59's diagnosis and psychotropic use will continue to monitored for a need to complete a Change in Status Request Form. On 1/24/2022 the Minimum Data Set (MDS) Coordinator completed a review of seventy (70) resident charts and identified that there were 4 of 22 residents with a current mental health diagnosis that could have been affected by the stated deficient practice, with 4 residents being identified as possibly needing a Level II Change in Status Request Form completed. These 4 residents have had Change of Status Request forms submitted. The Minimum Data Set Nurse or DON will review at least 5 times a week the new diagnosis report for any new mental illness diagnosis and the new order listing for any new psychotropic medication orders that would warrant a Change in Status Request form. Between the dates of 1/27/2022 thru 2/1/2022 the Director of Nursing has completed and submitted a Level II Change in Status Request form for all 5 residents identified. The Minimum Data Set Coordinator or Director of Nursing will be responsible to review any new physician orders, diagnosis listing report and report at the daily stand up meeting as scheduled 5 days a week Monday through Friday of any resident who has had a change in their mental health diagnosis and/or condition, along with any new psychotropic medication ordered per	

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 _____	01/20/2022

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 644	Continued From page 7	F 644	physician that would warrant the need to complete a new Status Change Request form. On 2/7/2022 the Administrator and the Compliance Nurse drafted a policy that addresses the Preadmission Screening and Resident Review requirements as per Resident Assessment Instrument manual and surveying guidelines. The PASRR policy will be presented at the next scheduled Quality Assurance meeting on 2/23/22 to ensure that the policy is reviewed and approved by the Medical Director and the Committee. On 02/07/2022 the Quality Assurance Nurse developed a Quality Assurance Performance Improvement focus plan that includes a log that will be maintained by the Social Service department starting 02/08/2022 that will track residents completed PAS information for new admissions and for residents who have had a Status Change Request Form completed through the new Preadmission Screening and Resident Review process. 2/16/22-The Administrator will distribute copies of the facility's updated PASRR Policy for review by the Quality Assurance Committee members including the Medical Director to allow further discussion if needed and to ensure all members are knowledgeable about the requirement rules and regulations pertaining to the Preadmission Screening and Resident Review process. 2/16/22-The Quality Assurance Nurse will audit for completion of the PASRR log for validation that the Preadmission	

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 _____	01/20/2022

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 644	Continued From page 8	F 644	Screening and Resident Review process has been recorded appropriately with the results of the stated reviews to be added to the weekly Quality Assurance Performance Improvement Agenda weekly beginning 2/17/22 and ending on 3/10/22 and monthly thereafter no later than 7/31/22 and presented to the Quality Assurance Committee meeting beginning 2/23/22 and ending no later than 7/31/22. Any negative findings will be reported to the Administrator immediately for further review and possible corrective action to be taken.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		3/10/22

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 _____	01/20/2022

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 645	Continued From page 9	F 645		

intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

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 _____	01/20/2022

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 645	Continued From page 10 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a Preadmission Screening and Resident Review (PASRR) Level II on a resident, as indicated on the response letter to the Preadmission Screening (PAS) Level I, for one (1) of three (3) residents reviewed for No PASRR Level II. Resident #20 Findings include: Record review of the PAS Level I response letter, from the state mental health agency that completed the PASRR Level II and noted that Resident #20 had a negative PASRR Level II, was from a PASRR Level II that was done for Resident #20 ' s previous admission to another nursing facility. The documentation in the PAS Level I response letter noted a diagnosis of Depression NOS, that was revealed to have derived from a history and physical dated November 23, 2020. The PAS Level I, submitted January 11, 2021, revealed diagnoses of Major Depressive Disorder, Unspecified, Post Traumatic Stress Disorder, and Anxiety Disorder. The DON failed to follow up to ensure a PASRR Level II was completed, for Resident #20, based on the mental health diagnoses submitted, on the PAS Level I dated January 11, 2021. The PASRR Level II, completed from the previous nursing facility admission, was accepted by the present facility for PASRR Level II completion for	F 645	02/01/2022 the Director of Nurses completed a Change in Status Request form for submission to the state agency for Preadmission Screening and Resident Review for Resident #20, with supporting documentation dated 1/13/22 from Geri-Psyche Nurse Practitioner, the most current History & Physical dated 01/26/2022, a list of current diagnosis and psychotropic medication use for further review of Resident #20's diagnosis of a serious mental illness which may or may not be continued as an exemption to the Level II process by the appropriate agency. Upon receipt of correspondence from the appropriate agency for Preadmission Screening and Resident Review completion the facility will implement any and all recommendations made for resident #20. The Psyche Nurse Practitioner continues to monitor Resident#20 as evident per notation in resident chart for visit on 2/3/22 with no further recommendations being initiated. On 1/24/2022 the Minimum Data Set Coordinator completed a review of seventy (70)of 70 resident charts and identified that Resident #20 was the only resident identified as being diagnosed with a mental health diagnosis that had been "ruled out" for further assessments	

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 _____	01/20/2022

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 645	Continued From page 11 Resident #20. An interview, on 1/19/22 at 03:15 PM, with the Director of Nursing (DON), revealed she confirmed she submitted the Preadmission Screening (PAS) Level I request, she was aware of the response letter noting a Preadmission Screening and Resident Review (PASRR) Level II was required, and she felt she had received a sufficient PASRR Level II final determination report from the state mental health agency that completed the PASRR Level II screening, for Resident #20. An interview and record review, on 1/20/22 at 02:15 PM, with the DON, revealed that she placed fault with the state mental health agency that the PASRR Level II was not completed for Resident #20. DON revealed the state mental health agency submitted a PASRR Level II final determination report without using the information that she submitted on the PAS Level I Screen, for Resident #20, dated 1/11/21. DON revealed the PASRR Level II, not being done correctly, is not her fault, and she could not follow up for correction of the PASRR Level II final determination report, because she did not know who to call, nor did she have a contact number for the state mental health agency. The facility did not have a policy related to PASRR. Record review of the Face Sheet, for Resident #20, revealed an original admission date of 1/7/21. Record review of the Diagnosis Report, for Resident #20, revealed admission diagnoses of Major Depressive Disorder, Recurrent, Moderate, Post-Traumatic Stress Disorder, Unspecified, and	F 645	through the Preadmission Screening and Resident Review process due to not having sufficient evidence of a Serious Mental Illness. For any other resident who is "ruled out" for insufficient evidence of a serious major mental illness the Director of Nurses and/or social services will attempt to obtain additional historical data for submission of a change in status request for further review. On 2/7/2022 the Administrator and the Compliance Nurse drafted a policy that addresses the Preadmission Screening and Resident Review requirements as per Resident Assessment Instrument manual and surveying guidelines. The Preadmission Screening and Resident Review policy will be presented at the next scheduled Quality Assurance meeting scheduled for February 23, 2022 to ensure that the policy is reviewed and approved by the Medical Director and the Committee. Effective 1/26/2022, the Social Service Director will be responsible to maintain a tracking log of all submitted Preadmission Screening and Resident Review and Change in Status Request forms to ensure that any resident admitted with a serious mental illness diagnosis is followed up with a Level II Preadmission Screening and Resident Review process or receive exclusions that may need further review, in which the facility will attempt to obtain additional information related to mental illness diagnosis for submission. 02/07/2022 the Quality Assurance Nurse	

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 _____	01/20/2022

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 645	Continued From page 12 Anxiety Disorder, Unspecified, with an onset date of 1/6/21 for all diagnoses. Record review of the PAS Level I, for Resident #20, dated 1/11/21, revealed the answer, yes, to the questions: "Person has a diagnosis of major mental illness, Person has a recent history of a major mental illness, and Person takes, or has a history of taking psychotropic medication." Record review of the PAS Level I response letter, dated 1/26/21, for Resident #20, revealed the determination, "Notice of need for Level II PASRR Screen." Record review, of the fax cover sheet, titled "PASRR OFFICE," dated 1/29/21, that was attached to the copy of the PASRR Level II final determination report, from the state mental health agency who completed the PASRR Level II, for Resident #20, revealed the name, the telephone number, address, and the fax number of the PASRR Coordinator for Mental Illness (MI) Services. Record review, of the letter dated 1/29/21, titled, "PASRR NOTICE OF EXEMPTION FROM PASRR," from the state mental health agency that completed the PASRR Level II, for Resident #20, revealed the name of the executive director, the telephone number, the fax number, and the address. Record review of the PASRR Level II final determination report, dated 1/29/21, from the state mental health agency, for Resident #20, revealed the information: "PASRR NOTICE OF EXEMPTION FROM PASRR; Based on the PASRR evaluation completed for you, you do not	F 645	developed a Quality Assurance Performance Improvement Focus plan that includes a tracking log that will be maintained by the social service department beginning 2/8/22 that will track residents completed Preadmission Screening Information for new admissions and for residents who have had a status change request form completed through the new Preadmission Screening and Resident review process. 2/16/22-Administrator will distribute copies of the facility's updated Preadmission Screening and Resident Review policy for review by the Quality Assurance Committee members including the Medical Director to allow further discussion if needed and to ensure all members are knowledgeable about the requirement, rules & regulations pertaining to the Preadmission Screening and Resident Review process. 2/16/22-The Quality Assurance Nurse will audit for completion of the stated log for validation that the preadmission and screening forms have been recorded appropriately with the results of the stated reviews to be added to the Quality Assurance Performance Improvement Agenda weekly beginning 2/17/22 and ending no later than 3/10/22 and then monthly thereafter ending no later than 7/31/22 and presented to the Quality Assurance Committee meeting beginning 2/23/22 and ending no later than 7/31/22. The Quality Assurance Nurse will report any negative findings upon review to the Administrator immediately for further discussion and possible corrective	

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 _____	01/20/2022

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 645	Continued From page 13 meet the criteria for serious mental illness or a developmental condition and are therefore not subject to PASRR requirements at this time. You were 'Ruled out' from further assessments through the PASRR Program: There is not sufficient evidence of Serious Mental Illness, Prior PASRRs: 11/30/20: Preadmission approved without services due to no sufficient evidence of Serious Mental Illness. Psychiatric History: The History and Physical (H&P) dated 11/23/20 documents the diagnosis of Depressive Disorder NOS. The Preadmission Screening assessment indicated that (Resident #20's name was omitted here) condition is not subject to the federal PASRR program due to there is not sufficient evidence of persistent Serious Mental Illness. Due to a complex psychotropic regimen, (Resident #20's name was omitted here) may benefit from an initial psychiatric evaluation for clarification of diagnosis and treatment planning." Record review of the face sheet, for Resident #20, revealed an original admission date of 1/7/21. Record review of the Diagnosis Report, for Resident #20, revealed admission diagnoses of Major Depressive Disorder, Recurrent, Moderate, Post-Traumatic Stress Disorder, Unspecified, and Anxiety Disorder, Unspecified, with an onset date of 1/6/21 for all diagnoses.	F 645	measures to be taken.	
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical	F 646		3/10/22

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 _____	01/20/2022

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 646	Continued From page 14 condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review,the facility failed to submit a Change in Status Request Form for a resident with a physical condition change related to Preadmission Screening and Resident Review (PASRR) Level II for one (1) of three (3) residents reviewed for No PASRR Level II. Resident #15. Findings include: An interview, on 1/19/21 at 03:15 PM, with the Director of Nursing (DON), confirmed she did not submit a Change in Status Request Form for an updated PASRR Level II for Resident #15. DON revealed she did not think to submit a Change in Status Request Form, for an updated PASRR Level II, when hospice was discontinued and the terminal illness status was removed, that showed Resident #15 had a change in her physical condition. Record review of Resident #15's Diagnosis List revealed diagnoses of Schizophrenia, Unspecified, Major Depressive Disorder, Recurrent, Moderate, and Anxiety Disorder, Unspecified, with an onset date of 7/20/18 for all diagnoses. Record review of the response letter to the Pre Admission Screening (PAS) Level I, dated 7/27/18, noted "NOTICE OF PASRR CATEGORICAL APPROVAL DUE TO TERMINAL ILLNESS. No Recommendations at this time.	F 646	A new Change in Status Request form was completed and submitted for Resident #15 by the Director of Nursing (DON) on 1/26/2022. Upon receipt of correspondence from the appropriate agency that handles the process for review the facility will implement any and all recommendations made for resident #15. Resident #15 will continued to be monitored by the Psyche Nurse Practitioner as evident by a note charted on 2/3/22 by nurse practitioner with no additional recommendations at this time. On 1/24/2022 the Minimum Data Set (MDS) Coordinator completed a review of seventy (70) resident charts and identified that there were 1 of 70 residents that remained in the facility who had previously been given a NOTICE OF PASRR CATEGORICAL APPROVAL DUE TO TERMINAL ILLNESS that could have been affected by the stated deficient practice which was resident #15. The Director of Nursing and/or social services will review at least 5 times a week an Action Summary form that indicates when a resident has had a level of care change such as hospice that may indicate the need for a Change in Status Request Form to be completed for review. All residents admitted with a terminal illness along with a mental illness and excluded for a level II evaluation will have	

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 _____	01/20/2022

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 646	Continued From page 15 Nursing home staff must report any significant changes associated with this individual to (agency named omitted) through submission of a Change in Status Request Form." Record review, of the Order Recap Report, revealed Resident #15 had a discontinued order for (Proper Name) Hospice, dated 2/5/20.	F 646	a Change in Status Request form completed by Director of Nursing or Minimum Data Set Coordinator at the point of change of condition 2/7/22-The Quality Assurance (QA) Nurse developed a Quality Assurance Performance Improvement (QAPI) focus plan that includes a log that will be maintained by the social service department beginning 02/08/2022 that will track residents who have had a Status Change Request form completed through the new Preadmission Screening and Resident Review process. 2/7/22-On 1/26/22 the Social Worker will keep a tracking log of all residents who have been identified as having a NOTICE OF PASRR CATEGORICAL APPROVAL DUE TO TERMINAL ILLNESS and if change of condition is noted the Social Service Director and/or the hospice coordinator will notify the Director of Nursing or designee of the need to complete a Change in Status Request form. 2/7/2022 the Administrator and the Compliance Nurse drafted a policy that addresses the Preadmission Screening and Resident Review requirements as per Resident Assessment Instrument (RAI) manual and surveying guidelines. The Pre Admission Screening and Resident Review (PASRR) policy will be presented at the next scheduled QA meeting for February 23, 2022 to ensure that the policy is reviewed and approved by the Medical Director and the Committee. 2/16/22-The administrator will distribute	

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 _____	01/20/2022

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 646	Continued From page 16	F 646	copies of the facility's updated Preadmission Screening and Resident Review policy to the Quality Assurance Committee meeting which shall include the Medical Director to allow further discussion if needed and to ensure all members are knowledgeable of the requirement, rules and regulations pertaining to the preadmission and screening process. 2/16/22-The Quality Assurance Nurse will audit for completion of the PASSR tracking log for validation that the preadmission screening and resident review process has been recorded appropriately with the results of the stated reviews to be added to the weekly Quality Assurance Performance Improvement Agenda beginning 2/17/22 and ending no later than 3/10/22 and monthly thereafter till 7/31/22 and presented to the Quality Assurance Committee meeting beginning 2/23/22 with an end date of 7/31/22 if compliance has been met. Any negative findings identified during the quality assurance audits will be reported immediately to the administrator for further review and possible corrective actions.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		3/10/22

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 _____	01/20/2022

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 658	Continued From page 17 by: Based on observation, staff interview, facility policy review, and record review, the facility failed to properly administer percutaneous endoscopic gastrostomy (PEG) tube medications as evidenced by not administering each medication separately or flushing between each medication for one (1) of two (2) PEG tube medication administrations observed. Resident #17. Findings include: Review of the facility policy titled, "Medication Administration via Enteral Tube", undated, revealed, "It is the policy of this facility to ensure the safe and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines." Policy revealed, "...6. each medication will be administered separately, not combined or added to an enteral feeding formula." Review of the facility policy titled, "Medication Administering Via Gastrostomy Tube", undated, revealed, "Purpose: To ensure that residents who are unable to take medications by mouth and have a G-tube in place receive medications in a safe manner." Policy revealed, "...11. Each medication is to be given separately per policy unless the physician orders a specific way to administer medications." An observation, on 1/19/2022 at 8:00 AM, revealed Registered Nurse (RN) #1 administered PEG tube medications to Resident #17. RN #1 administered seven (7) crushed medications and one (1) liquid pain medication by the PEG tube. RN #1 crushed the seven (7) medications and placed in a single cup. The liquid pain medication	F 658	Upon review of medications mixed and given per Percutaneous Endoscopic Gastrostomy on 1/19/2022 for Resident #17 it was determined that she should be monitored for hypotension due to possible side effect from multiple blood pressure medications being mixed and given at the same time through Percutaneous Endoscopic Gastrostomy. As of 1/22/2022 Resident #17 has not incurred any significant drop in blood pressure and her Percutaneous Endoscopic Gastrostomy remains free flowing. 01/24/2022 the Minimum Data Set Coordinator reviewed 70 of 70 resident charts and identified that there were only 3 residents with enteral feedings that could have been affected by the deficient practice. Current residents and future admissions physician orders written per facility policy outlining the need and requirement to administer medications separately through a Percutaneous Endoscopic Gastrostomy unless otherwise instructed and written by physician. On 1/19/2022, RN#1 responsible for the deficient practice for Resident #17 was counseled and given a copy of the facility policy concerning Percutaneous Endoscopic Gastrostomy feedings regarding the need to administer medications separately per policy for peg feeder such as Resident #17. On 2/3/2022 the facility's contracted Compliance Nurse conducted an	

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 _____	01/20/2022

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 658	Continued From page 18 was in an individual cup. The PEG tube was flushed with 30 milliliters (ml) water and liquid pain medication was given. RN #1 then mixed the crushed medications with approximately 20 ml of water and administered them and then flushed the tube with 30 ml of water. An interview, with RN #1 on 1/19/2022 at 8:10 AM, revealed she did not normally work the medication cart. She confirmed she administered the medications together and thought it was appropriate to mix the medications as long as the PEG tube was flushed before and after the medication administration. She stated she had been in-serviced on medication administration, but she was uncertain what the facility policy on PEG tube medication administration was. An interview, on 1/20/2022 at 9:55 AM, with the Director of Nursing revealed for PEG medication administration, it is best practice to crush medications and give each medication mixed with a little water separately, give water between each medication, and flush with water before and after medication administration. She revealed potential concerns of giving medications together include a possible reaction between the medications and that the PEG tube could be occluded. She stated it is facility policy to give one medication at a time, flush between each medication, and flush before and after medication administration. She stated the pharmacist gave an in-service on PEG tube medication administration. She confirmed the facility failed to properly administer the PEG tube medications for this resident. Record review of the attendance log and discussed topics of the 7/6/2021 in-service titled "Med Pass" by the facility pharmacist revealed	F 658	in-service with 12 of 20 licensed nurses regarding the proper techniques for Percutaneous Endoscopic Gastrostomy medication administration and other survey related topics. The remaining 8 nurses will be in-serviced no later than 02/19/2022. All attendees were aware of the facility's Percutaneous Endoscopic Gastrostomy feeding policy and stated that they were compliant with administering Percutaneous Endoscopic Gastrostomy medications separately and with water between each medication. On 2/7/2022 the Administrator and the Compliance Nurse updated the policy addressing the Percutaneous Endoscopic Gastrostomy Feedings to include a date for review and revision of 2/7/22. On 2/9/2022 the Minimum Data Set Coordinator updated current residents with an order for Percutaneous Endoscopic Gastrostomy medication administration to include specific instructions to give at least 15ml of water before med and then crush meds individually and administer separately with at least 15 ml of water between each medication and then finish with a final flush of 15ml to ensure all nurses understand the need and requirement to administer medications separately through PEG unless otherwise written by a physician. On 02/07/2022 the QA Nurse developed a Focus Review Plan through the facility's Quality Assurance Performance Improvement program to include observation and completion of a	

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 _____	01/20/2022

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 658	Continued From page 19 RN #1 attended the in-service. PEG tube administration topics covered in this in-service included, "Meds must be administered individually. There will be a flush before and after each medication via whatever facility policy calls for." A record review of Face Sheet revealed Resident #17 was admitted to the facility on 10/11/2021, with diagnoses of Dysphagia following Cerebral Infarction, Aphagia following Cerebral Infarction, and Dysphagia Oropharyngeal Phase.	F 658	competency check off for each licensed nurse regarding Percutaneous Endoscopic Gastrostomy medication administration beginning 2/10/22 and to be completed no later than 2/28/2022. The results of this review will be added to the Quality Assurance Performance Improvement Agenda weekly beginning 2/17/22 and ending 3/10/22 and presented to the Quality Assurance Committee meeting beginning 2/23/22 for 6 months with an ending date of 8/31/22. The Staff Development Nurse and/or the Director of Nurses will complete competency check off with newly hired nurses within 10 days of employment beginning 3/1/22, six months from hire date and then annually thereafter. The facility's consulting pharmacist will be asked to complete a check off for medication Percutaneous Endoscopic Gastrostomy administration along with an additional in-service of licensed personnel times 3 months beginning with his next scheduled visit in February 2022 and ending no later than 5/31/22. The Quality Assurance Nurse will maintain a calendar beginning 3/1/2022 regarding Percutaneous Endoscopic Gastrostomy medication administration for 6 months with an ending date of 8/31/2022 to ensure ongoing compliance with check-offs and will report to the Administrator any negative findings upon review for further evaluation of plan and actions to be taken.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		3/10/22

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 _____	01/20/2022

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 695	Continued From page 20 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review and facility policy review, the facility failed to change oxygen (O2) tubing for, failed to date humidifier bottles for humified O2, failed to date the storage bags and failed to provide storage bags for O2 tubing, nebulizer masks and C-PAP masks for three (3) of eight (8) residents reviewed that are using the respiratory equipment and oxygen therapy for Resident #15, Resident #20, and Resident #24. Findings include: Review of facility policy titled, "Oxygen Administration," with a policy number of NP.VI-28, revealed, " ...12. Cannulas and masks should be changed and dated every other week. *Humidifier container with distilled water is NOT required unless Oxygen (O2) is ordered at four (4) liters (L)/ (per) Minute or higher." The facility policy did not contain information addressing the storage of the O2 tubing, when it was not in use, and did not contain information addressing that a date was needed on the humidifier bottle. There was not an effective date on the policy. Review of facility policy titled, "Nebulizer Policy	F 695	On 01/19/2022 the Director of Nursing replaced Resident #15's oxygen humidifier bottle and tubing and placed a storage bag onto the oxygen concentrator and provided a storage bag for the nebulizer mask with all supplies being dated 01/19/2022. On 01/19/2022 the Director of Nursing provided Resident #20 with a storage bag for her Continuous Positive Airway Pressure mask with a new date of 01/19/2022. On 01/19/2022 the Director of Nursing replaced Resident #24's oxygen tubing and placed a storage bag onto the oxygen concentrator with a new date of 01/19/2022, which will be checked after every 14 day interval scheduled for respiratory equipment changes. On 01/24/2022 with Minimum Data Set Coordinator identified 13 of 70 residents who required the need for respiratory devices that could have been affected by the deficient practice. On 02/03/2022 the Compliance Nurse in-serviced 12 of 20 licensed nurses on	

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 _____	01/20/2022

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 695	Continued From page 21 and Procedure," revealed it did not contain information addressing the storage of a nebulizer mask, when not in use. The policy was not dated. Review of facility policy titled, "CPAP/BiPAP (Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure) Cleaning," revealed, " ...6. Cover with plastic bag or completely enclosed in machine storage when not in use." The policy was not dated. Resident #15 An observation, on 1/18/22 at 10:55 AM, for Resident #15, revealed there was no date on the O2 humidifier bottle and there was not a storage bag, on the O2 concentrator, for the O2 tubing. An observation and interview, on 01/19/21 at 09:15 AM, with Resident #15, revealed there was a nebulizer machine, and mask being stored between Resident #15's mattress and the wall. The mask was not in a storage bag. Resident #15 stated this was where she always kept the nebulizer, used it 2-3 times a day, and had never put her nebulizer mask in a bag. An observation and interview, on 1/19/22 at 03:13 PM, with the Director of Nursing (DON), confirmed Resident #15 did not have a date on the humidification bottle, did not have an O2 tubing storage bag, and did not have a storage bag for the nebulizer mask. The DON confirmed that resident is at risk of infection because there was no date on the humidifier bottle to indicate how long it had been on the concentrator and there was no storage bag available to cover the O2 tubing and nebulizer mask, when it was not in use.	F 695	proper dating and storage of respiratory equipment. The remaining 8 licensed nurses will be in-serviced on proper dating and storage of respiratory equipment no later than 02/28/2022. On 02/07/2022 the Administrator and Compliance Nurse reviewed and revised the Continuous Positive Airway Pressure and Bilevel Positive Airway Pressure, Nebulizer and Oxygen policies to include storage procedures, labeling of equipment, listed dates of review and/or revision to policy, with a 2/7/22 review/revised date. The Quality Assurance Nurse developed a Quality Assurance Performance Improvement Focus Plan on 02/07/2022, to include that the Staff Development Nurse will ensure professional standards are known while completing competency check offs within 10 days of hire, 6 months from hire date and annually thereafter with each nurse beginning 3/1/2022 and will be reviewed by the Administrator upon receipt of annual employee evaluation. On 02/07/2022 the Quality Assurance Nurse developed a Focus Review Plan through the facility's Quality Assurance Performance Improvement Program to include audits to be completed by the Quality Assurance Nurse and/or the Director of Nursing bi-weekly beginning 2/7/22 times 3 months with an end date no later than 5/31/22 to ensure proper equipment storage, tubing changes, humidifier bottles are changed labeled/dated. The updated policies will be presented at the next Quality	

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 _____	01/20/2022

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 695	Continued From page 22 Record review of the Order Summary Report revealed Resident #15 had a physician's order for Oxygen @ (at) two (2) - (to) four (4) liters (L) continuous, dated 7/20/18. Record review, of the Order Summary Report, for Resident #15, revealed physician's orders for medications to be given with a nebulizer: Albuterol Sulfate 2.5 milligrams (MG)/3 milliliters (ML) every 4 hours as needed (PRN), dated 3/25/21, and for Albuterol 2.5 MG/3ML 4 times a day, dated 3/25/21. Record review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/21, for Resident #15, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #15 is cognitively intact. Resident #20 An observation, on 1/18/21 at 02:00 PM, for Resident #20, revealed she had a C-PAP on her bedside table, with no storage bag for the mask. An observation, on 1/19/21 at 4:15 PM, revealed Resident #20's C-PAP mask was on the floor and not in a storage bag. An interview, on 1/19/21 at 04:15 PM, with Resident #20, revealed she ordered all her supplies for her personal C-PAP and changed her own tubing. Resident #20 revealed she did not allow the facility nursing staff to clean her C-PAP often and she prefers to clean her own C-PAP. Resident revealed the nursing staff had not offered her a storage bag for her C-PAP mask. Resident stated she knew it was not good for her	F 695	Assurance Committee meeting scheduled for February 23,2022 with the Medical Director for review and approval. The Quality Assurance Nurse will report any negative findings of audits to the Administrator immediately for further review and possible corrective actions to be taken.	

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 _____	01/20/2022

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 695	Continued From page 23	F 695		

C-PAP mask to be on the floor. Resident stated she used her C-PAP every night.

An interview, on 1/19/21 at 04:25 PM, with the Director of Nursing, (DON), revealed Resident #20 cared for her personal C-PAP, preferred to order her own C-PAP supplies, and did not allow staff to touch her C-PAP. The DON stated the resident had not been offered a storage bag, by the facility, for the C-PAP mask.

Record review of the Order Summary Report for Resident #20 revealed a physician's order to apply C-PAP at bedtime, dated 2/8/21.

Record review of a Quarterly Minimum Data Set (MDS), with an ARD of 11/10/21, for Resident #20, revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #20 is cognitively intact.

Resident #24

An observation and interview, on 01/18/22 at 10:50 AM, with Resident #24, revealed O2 tubing dated 12/2/21 and a zip lock bag, for tubing storage, that was not dated. Resident #24 stated he used the O2 every night as ordered by his doctor. Resident revealed he could not recall the last day the O2 tubing had been changed.

An observation and interview, on 1/19/22 at 04:20 PM, with the DON, confirmed Resident #24 had an O2 tubing on his concentrator dated for 12/2/21. The DON confirmed the tubing should have been changed since that date, should be changed every 14 days, and could cause Resident #24 to be at risk of infection for not being changed according to policy.

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 _____	01/20/2022

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 695	Continued From page 24 Record review, of the Order Summary Report revealed Resident #24 has a physician's order for Oxygen at (@) 2 liters (L) at night (PM), dated 6/5/2018. Record review of an Annual Minimum Data Set (MDS), with an ARD of 11/16/21, for Resident #24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #24 is cognitively intact.	F 695		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		3/10/22

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 _____	01/20/2022

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 880	Continued From page 25	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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 _____	01/20/2022

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 880	Continued From page 26 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and record review, the facility failed to prevent the likelihood of the spread of infection as evidenced by failure to perform hand hygiene during the lunch tray pass in the west dining room and on east hall and while performing incontinent care for Resident #67 for two (2) of three (3) survey days. Findings Include: Review of the facility policy titled, "Infection Prevention and Control Program" dated April 2018 with no revision date revealed under "Policy:" "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections" and revealed under "Policy Explanation and Compliance Guidelines:" " ...# 4 Hand Hygiene Protocol: a. All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after PPE removal, before/after eating, before/after toileting, and before going off duty. b. Staff shall wash their hands before and after performing resident care procedures." Meal Tray Pass On 01/18/2022 at 11:55 AM, an observation of the noon meal tray pass for east wing rooms 119 through 134 revealed three (3) Certified Nursing Assistants (CNAs) did not utilize hand hygiene between residents while passing trays or	F 880	On 1/19/2022 through 1/22/2022, Resident #67 was observed for possible infection by obtaining vital signs per shift, with no negative findings incurred by resident. The Quality Assurance Nurse will review resident chart for elevation of temp, low blood pressure, elevated heart rate, elevated respiration or change in mental status that may indicate a possible infection for dates of 1/19/22-1/26/22. Resident #67 will be provided care and services by certified nursing staff in accordance with the facility's infection prevention program regarding hand hygiene and incontinent care. Certified Nursing Assistant #2 and #3 were given a copy of the infection prevention policy regarding hand hygiene and incontinent care, with the Staff Development Nurse observing their performance for completion of incontinent care for Resident #67 on 2/3/22. On 1/19/2022 of becoming aware of the concern with passing of trays, the Director of Nursing met with certified nursing assists on duty to discuss the need and requirement to sanitize hands between each tray pass. On 01/24/2022 the Minimum Data Set Coordinator reviewed 70 of 70 resident charts and identified that that 40 residents were coded to be incontinent of bowel and bladder. All 70 of 70 residents could have been affected by the deficient practice of improper hand sanitizing after rendering incontinent care, along with 70 of 70	

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 _____	01/20/2022

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 880	Continued From page 27 returning to the tray cart. On 1/18/22 at 12:00 PM, an observation revealed that Certified Nurse Assistant (CNA) #1 in the west dining room did not perform hand hygiene in between resident's lunch tray delivery and set up. On 1/18/22 at 3:00 PM, an interview with CNA #1 revealed she was supposed to perform hand hygiene in between each tray she hands out to the residents and confirmed that she had attended hand hygiene in-services. CNA # 1 stated, "I think I performed hand hygiene between each tray." On 1/18/22 at 3: 08 PM, an interview with Registered Nurse (RN) # 2 revealed that anyone passing out meal trays is supposed to use hand sanitizer or wash their hands with soap and water in between each tray to prevent the spread of germs. On 1/19/22 at 2:19 PM, an interview with the RN Infection Preventionist (RN-IP) confirmed that staff handing out meal trays should perform hand hygiene before and after touching the meal tray and the resident to prevent the spread of infection. The RN-IP revealed that staff had attended a hand hygiene in-service and the facility has a hand hygiene policy. RN-IP stated, " I go out on the hall fairly often to verify that the staff is performing hand hygiene like they know to." Review of the facility in-services revealed the facility had a hand hygiene in-service on 1/14/21 that was attended by CNA #1. Incontinent Care	F 880	residents for the lack of proper hand hygiene between delivery of meal trays. 1/31/22-Perineal and Handwashing video posted on snfclinic educational program to in-service nursing staff on proper technique of perineal care and the process for donnin/doffing of gloves. As of 2/3/22 there has been 32 of 52 nursing staff members who have viewed this video, with the remaining 20 individuals having to complete the in-service no later than 2/19/22. 2/2/22-Maintenance applied hand sanitizing dispensers to tray carts to assist with accessibility of hand sanitizer by staff between meal tray deliveries. 2/3/22-The facility's contracted compliance Nurse in-serviced 31 of 76 staff members on infection control involving perineal care and hand hygiene. Included in this in-service was two video's sponsored by the Center for Disease Control titled "Sparkling Surfaces" and "Clean Hands" were presented at this in-service. As of 2/9/22 there are only 26 of 76 staff members remaining to view the "Sparkling Surfaces" and "Clean Hands" video by the assigned end date of 2/19/22. 2/7/22-The Administrator will assign certain department heads to observe for proper hygiene being applied during passing of trays during meals at least 3 times a week beginning 2/7/22 and ending no later than 5/31/22. 2/3/22-The Compliance Nurse and the Quality Assurance Nurse completed a Root Cause Analysis for completion of a	

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 _____	01/20/2022

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 880	Continued From page 28 On 1/19/2022 at 2:00 PM, an observation of CNA #2 and CNA #3 performing incontinent care for Resident #67 revealed that CNA #2 did not utilize hand hygiene between glove changes and after completing assisting CNA #3 with incontinent care. CNA #2 set up water and a snack within the residents reach without utilizing hand hygiene. CNA #3 initiated the incontinent care, for Resident #67 and did not change gloves or perform hand hygiene between cleaning the resident's perineal area and reaching into the clean rinse water with a clean cloth. CNA #2 removed a bag of dirty linen, a bag of dirty gloves and an incontinent brief without wearing gloves. On 01/20/2022 at 8:30 AM, an interview with RN #1 Staff Development Nurse revealed the staff should wash their hands before and after resident care, any time hands are visibly soiled, between dirty and clean, when performing resident care, and between each resident when passing meal trays. RN #1 reported she is the Staff Development Nurse and provides annual infection control in-services and intermittent should a problem occur. The Infection Preventionist /Infection Control Nurse performs infection control in-services. RN #1 reported we sometimes do return demonstrations for hand hygiene and donning/doffing Personal Protective Equipment (PPE). On 01/20/2022 at 8:55 AM, an interview with CNA #2 confirmed she was supposed to wash her hands or perform hand hygiene with the hand sanitizer, before and after resident care, when changing gloves, between dirty and clean and between tray pass for the residents. CNA #2 confirmed she did not utilize good hand hygiene	F 880	Quality Performance Improvement Program regarding infection control prevention regarding hand hygiene and perineal care. This performance improvement review will be incorporated into the weekly Quality Assurance Improvement Agenda beginning 2/17/22 and ending no later than 3/10/22. 2/7/22-An Ad Hoc Quality Assurance meeting was held by the Administrator to discuss the improvement plan as outlined per the Performance Improvement Plan to ensure individual knowledge of assignments and the needed outcomes. 2/07/22-The Quality Assurance Nurse, the Director of Nursing and the Staff Development Nurse will complete skills check off regarding perineal care no later than 2/28/22 to all applicable nursing staff. The same individuals will be responsible to observe for proper hand hygiene by all staff no later than 2/28/22. 3/1/22-The two stated video's will be added to the facility's orientation program by the Staff Development Nurse to assist in core knowledge regarding infection control measures and the need and requirement to administer proper hand hygiene. The Staff Development Nurse will be responsible to perform a skills check off regarding perineal care and proper hand hygiene within 10 days of hire, every 6 months for the first year of employment and annually thereafter along with the employees annual evaluation which is reviewed by the Administrator and/or the Director of Nursing. The Quality Assurance Nurse, the Director	

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 _____	01/20/2022

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 880	Continued From page 29 practices when performing incontinence care on 01/19/2022 for Resident #67. CNA #2 confirmed she did not wash hands or use hand gel between changing gloves and only changed gloves once. She confirmed she did not wash her hands before setting up residents' snack and drink and carried out the trash and dirty linen bags without wearing gloves. Record review of physician "Order Summery Report" revealed Resident #67 to have diagnoses including Cerebrovascular disease affecting right dominant side and Cerebral Palsy. On 01/20/2022 at 9:30 AM, an interview with the Director of Nurses (DON) revealed that infection control in-services are assigned to the staff, and they go online to complete. If we find a problem area, we will do a teachable moment on the hall. We do two formal in-services for infection control annually and the Dietitian performs any in-services pertaining to dietary or nutrition.	F 880	of Nursing and the Staff Development Nurse will perform observation for proper hand hygiene with at least 25% of staff regarding proper hand hygiene quarterly beginning 2/28/2022 and ending no later than 2/28/2023, with documented outcomes of pass/fail to be reported to the Quality Assurance Committee meeting for at least 6 months beginning 2/28/22 and ending no later than 8/31/22 to ensure compliance is being met. Any negative findings during observation will be corrected immediately and reported to the Director of Nursing and/or the Administrator for further review and possible corrective measures to be taken.	