

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09SR	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/10/2021
NAME OF PROVIDER OR SUPPLIER SHEARER-RICHARDSON MEMORIAL NURSING HOMI		STREET ADDRESS, CITY, STATE, ZIP CODE 512 ROCKWELL DRIVE OKOLONA, MS 38860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments A complaint investigation (CI) MS #17428, was conducted by State Agency (SA) on 02/10/2021. The facility was found to be in compliance with state regulations for the Aged and Infirm and CI MS #17428 was not substantiated for Resident Neglect and Quality of Care. The census at the time of the survey was 65.	M 000		

Mississippi State Department of Health

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

TITLE

(X6) DATE