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 _____	07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOME	512 ROCKWELL DRIVE / PO BOX 420 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 along with complaints, MS #16038, MS# 15807 and MS# 16030 from 7/23/19 to 7/26/19. During the survey, the SA determined that the facility was in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate MS #16038 for allegations related to improper discharge. The SA did not substantiate MS #16030 for Residents Rights related to choices. The SA did not substantiate MS # 15807 for abuse and neglect. The census at the time of survey was 66, the facility held a license for 73 beds.	F 000		

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

Electronically Signed | 08/07/2019

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	25A162	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/22/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOME	**512 ROCKWELL DRIVE / PO BOX 420** **OKOLONA, MS 38860**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly inspect fire doors as required by S&C Letter 17-38. This deficiency practice affected one (1) of three (3) smoke compartments and of the 66 residents in the facility on the day of survey. Findings include: On July 23, 2019 at 11:00 AM, observation revealed a fire door to the stairwell near Room 126 of the facility. The facility was unable to produce annual inspection documentation of fire door in the facility. The facility staff and maintenance director were unaware of the requirement annual inspection of fire door in the facility in accordance CMS S&C 17-38.	K 211	An inspection of the stated fire door was completed on 8/9/2019 by the Chickasaw County Fire Chief with documentation obtained from said person to support the findings of their inspection. The maintenance person repaired the stated hole with a bolt and washer on 8/9/19 as instructed by the fire chief. Sixty-six (66) of 66 Residents could have possibly been affected by the stated deficient practice if a fire had occurred within the facility. The Chickasaw County Fire Chief provided the facility with a report to indicate the stated inspection which include 3/3 fire doors being inspected without identifying any additional negative findings to the integrity of any of the	8/9/19

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Electronically Signed | 08/12/2019

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	25A162	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/22/2019**

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K 211	Continued From page 1	K 211	facility's fire doors. The Administrator and both maintenance personnel were in-serviced by the state inspector on 7/23/19 of the need and requirement to maintain written documentation of the facility's annual inspections of fire doors. Both maintenance personnel were given copies of the Fire Safety Survey Report-2012 Life Safety Code for Healthcare on 7/26/19 by the Administrator for review and compliance of K Tags associated with Life Safety Code and the requirement for annual inspections of fire doors as outlined in CMS S&C 17-38. To maintain compliance with the need and requirement of obtaining supporting documentation for inspections of the facility's fire doors, the Quality Assurance Nurse (QA Nurse) will audit both maintenance personnel preventive maintenance logs at least every twelve (12) months beginning with an 8/9/19 date to ensure that there is evidence that the Fire Chief has inspected all fire doors of the facility as evidence by a written report. If noncompliance is identified at the end of twelve months as outlined per the facility's QAPI program, the QA Nurse she will report her findings to the Administrator for immediate corrective measures to take place. The Administrator will be responsible to report any non compliance issues to the Board of Trustees and the QA&A Committee at the next scheduled monthly meeting after the noted infraction.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		8/12/19

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	25A162	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/22/2019**

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K 918	Continued From page 2 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to properly test the emergency generator as per	K 918	Both the East and West Side generators were tested under full load for at least 3o	

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K 918	Continued From page 3 NFPA 110 8.4.2. This deficiency affected all 66 residents in the facility on the day or survey. Findings include: On July 23, 2019 at 11:30 AM, the facility was unable to provide adequate documentation of monthly load tests for the generator of the facility: 1. No monthly load test documentation of East generator for months of April 2019 and May 2019 2. No monthly load test documentation of West generator for months of March, April, May, and June 2019.	K 918	minutes on 7/25/19 to ensure proper working order of both generators. The lack of documentation to validate monthly generator testing could have affected 66 of 66 Residents. Both maintenance personnel were counseled by the Administrator on 7/26/2019 for the need and requirement to conduct monthly generator testing and recorded on the facility's generator testing log. The East Side generator was tested on 7/25/19, 7/31/19 and 8/7/19 under full load to ensure proper working order. The West Side generator was tested on 7/25/19 and 8/3/19. On 7/26/19 the Administrator gave both maintenance personnel a copy of the Fire Safety Survey Report-2012 Life Safety Code for healthcare with emphasis place on tag K918. The Administrator and/or the QA Nurse will review monthly generator testing logs to ensure ongoing compliance with monthly generator testing under full load for at least 30 minutes has been conducted. If noncompliance is identified by either parties, they will perform the appropriate testing of the generator and be responsible to develop a QAPI focus program to ensure ongoing compliance. The Administrator will be responsible to report any negative findings of the action of not completing monthly generator testing under full load to the Board of Trustees and the Quality Assurance and Assessment Committee at the next scheduled monthly meeting following the noted infraction.	

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E 000	Initial Comments EMERGENCY PREPAREDNESS Survey conducted on 07/22/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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