

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2019  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                          |  |                                                                    |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>25A162</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/26/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SHEARER-RICHARDSON MEMORIAL NURSING HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>512 ROCKWELL DRIVE / PO BOX 420</b><br><b>OKOLONA, MS 38860</b>              |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                         |
| F 000                                                                               | <p><b>INITIAL COMMENTS</b></p> <p>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.</p> <p>The census at the time of survey was 66, the facility held a license for 73 beds.</p> | F 000                                                                      |                                                                                                                          |  |                                                                    |

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

TITLE

(X6) DATE

Electronically Signed

08/07/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.