CENTERS FOR MEDICARE & MEDICAR SERVICES OMB NO. 0382-0 MAID FLANDC CORRECTION (M1) PROVIDENDERUENCUM (V2) MULTIPLE CONSTRUCTION (V2) MULTIPLE CONSTRUCTION <th></th> <th>-</th> <th>ID HUMAN SERVICES</th> <th></th> <th></th> <th></th> <th>FORI</th> <th>M APPROVED</th>		-	ID HUMAN SERVICES				FORI	M APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED 12262023 B. WING TREET ADDRESS, CITY, STATE, 2P DODE SHARKEY-ISSAQUENA NURSING HOME STREET ADDRESS, CITY, STATE, 2P DODE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT OF DESIGNMENTS D PROVIDERS PLAN AND CONCENTION INCLUSE 1226/2023 SUMMONY STATEMENT FOR THE PROVIDERS PLAN AND CONCENTS F 844 1226/2023 SUMMONY STATEMENT FOR THE PROVIDER				(¥2) MI II	тірі				
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431 WEST RACE STREET ROLLING FORK, MS 39159 941 D. SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFIANG INFORMATION) D PRETX TAG DEFICIENCY MUST BE PRECEDED BY PULL (REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0000 (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 12/26/23 5483.80(g)(1) Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to — (I) Suspected and confirmed COVID-19 (II) The COVID-19 Month and hand hygiene supplies in the facility; (V) (No Resident bad and COVID-19 waccine resident is in the facility; (VI) Access to COVID-19 waccine received, and COVID-19. S483.80(g)(2) Provide the Information specified in paragraph (g)(1) of this section at a frequency specified by the Secretary, but no less than			255220	B. WING			12	12/26/2023	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		paragraph (g)(1) of the specified by the Secre- weekly to the Centers Prevention's National This information will be support protecting the residents, personnel,	his section at a frequency etary, but no less than s for Disease Control and I Healthcare Safety Network. be posted publicly by CMS to be health and safety of and the general public.						

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

TITLE

12/26/2023

PRINTED: 01/08/2024

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/08/2024 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	(X3) DATE SURVEY COMPLETED	
		255220	B. WING			12	/26/2023	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
SHARKE	-ISSAQUENA NURSING	HOME			431 WEST RACE STREET ROLLING FORK, MS 39159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 884	by: Based on record revi report complete inforr the Centers for Disea (CDC) National Healt (NHSN) during a seve was required by regul The CDC submitted of Centers for Medicare (CMS). Based on revi determined that betwe 12/24/2023, the facilit information to NHSN standardized format a by CMS and the CDC	is not met as evidenced iew, the facility failed to mation about COVID-19 to se Control and Prevention's hcare Safety Network en-day period that reporting lation. data from the NHSN to the and Medicaid Services iew of that data, CMS een 12/18/2023 and ty did not report complete about COVID-19 in the and frequency as specified 2. This failure to report has emore than minimal harm to	F	884	4			

FORM CMS-2567(02-99) Previous Versions Obsolete