STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255220	A. BUILDING _____ B. WING _____	C 07/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARKEY-ISSAQUENA NURSING HOME	**431 WEST RACE STREET ROLLING FORK, MS 39159**

(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 CI MS #16675 The State Agency (SA) conducted investigating MS CI 16675 beginning 7/24/20 through 7/27/20. Concerns identified in the complaint were related to Quality of Care, Pressure Ulcers, and Neglect of Resident #1. Specific concerns included the allegation that Resident #1 had several pressure sores that had worsened. The concerns were substantiated with no deficiencies cited. During the survey the SA determined the facility was in substantial compliance with requirements for participation in Medicare and Medicaid. The facility had a census of 45 at the the time of the complaint survey and held a license for 54 beds.	F 000		

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