

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

PRINTED: 04/29/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>255220</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/27/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHARKEY-ISSAQUENA NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>431 WEST RACE STREET</b> <b>ROLLING FORK, MS 39159</b>		
(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	<p>INITIAL COMMENTS</p> <p>CI MS #16675</p> <p>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.</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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.