

Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 431 WEST RACE STREET PO BOX 279, ROLLING FORK, Mississippi, 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
M0000	Initial Comments The State Agency (SA) conducted a follow-up revisit at the facility on 08/05/26 related to an annual recertification survey that was conducted on 06/08/26 through 06/11/26. The SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement and recommends the facility be placed back into compliance effective 07/24/26. The facility held a license for 60 beds and had a census of 52 at the time of the survey.			M0000			

Office of Primary Care and Health Systems Management

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