STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25A162	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOME	512 ROCKWELL DRIVE PO BOX 604, OKOLONA, Mississippi, 38860

(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
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 09/08/2026 through 09/10/2026. During the survey, the SA determined that the facility was not in compliance with the requirements of participation with Medicare and Medicaid Services and cited F688 and F757. The facility held a license for 73 beds, with a census of 69.	F0000		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure interventions were continued to maintain functional range of motion (ROM) for one (1) of three (3) residents reviewed for ROM. The facility failed to ensure Resident #2's right-hand resting splint was applied or range of motion as indicated after the resident was discharged from the restorative nursing program. This failure placed Resident #2 at risk for	F0688		

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 reverse for further 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.

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

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F0688 SS = D	Continued from page 1 worsening contracture, further loss of range of motion, skin impairment, and infection. (Resident #2) Findings Include: Review of the facility policy "Prevention of Decline in Range of Motion" revealed "Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable...3.b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: ...ii. Appropriate equipment (braces or splints)..." Observation on 09/08/2026 at 1:50 PM revealed Resident #2 seated in a wheelchair in the activity room. Resident #2 used his left hand to support his right wrist. Limited range of motion was observed in the right hand and wrist. Resident #2 was unable to open his right hand without using his left hand to assist in opening it and was observed without a splint or device in place on his right hand. Observation on 09/09/2026 at 8:35 AM revealed Resident #2 seated in a wheelchair with no splint or other device in place on the right hand. Record review on 09/09/2026 at 1:15 PM revealed documentation dated 05/26/26 indicating Resident #2 would be "DC (discharged) to floor staff at this time." "Resident is in the RNCA (Restorative Nursing Care Assistant) program for PROM (passive range of motion) to right hand and brace assistance. He will wear his right-hand brace for 3 hours/day with a goal of five (5) hours/day and increase ROM in right hand. RNCA will assist him for 15 minutes/day or as tolerated for at least six (6)/days/week." During an interview on 09/09/2026 at 2:30 PM, Registered Nurse (RN) #1 stated Resident #2 previously wore a splint while participating in the restorative nursing program but was not currently wearing the splint. During an interview on 09/09/2026 at 3:15 PM, Resident #2 stated, "I had something on my hand before, but I don't wear it anymore and I'm not sure why." During an interview on 09/09/2026 at 3:30 PM, the Restorative Certified Nursing Assistant (CNA) stated Resident #2 had participated in restorative nursing for range-of-motion exercises to the bilateral lower extremities and use of a splint to the right hand. The	F0688		

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F0688 SS = D	Continued from page 2 Restorative CNA stated Resident #2 met his goal of tolerating the splint for five to six hours per day and was subsequently discharged from restorative nursing to floor staff to continue his therapy. The Restorative CNA confirmed Resident #2's resting hand splint was located in the restorative office and had not been applied to the resident since 05/26/26. The Restorative CNA stated failure to apply the splint placed Resident #2 at risk for worsening limitation in range of motion. During an interview on 09/09/2026 at 3:45 PM, the Director of Rehabilitation (DOR) stated that if use of the splint was not continued to keep the resident's right hand open, then the muscles in Resident #2's hand could tighten, which could result in the resident's fingernails digging into the skin and potentially causing a skin infection. During an interview on 09/09/2026 at 3:55 PM, the Minimum Data Set (MDS) Nurse confirmed Resident #2 was no longer participating in the restorative nursing program and did not currently have an order for a splint. During an interview on 09/10/2026 at 9:30 AM, the Director of Nursing (DON) confirmed Resident #2 had the potential for worsening range of motion of the right hand and wrist without an intervention. Record review of Resident #2's Admission Record revealed the resident was admitted to the facility on 12/23/2021 with a diagnosis of hemiplegia, unspecified, affecting the right dominant side. Record review of Resident #2's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/23/2026 revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Item GG0115 identified functional limitation in range of motion on both sides of upper extremities.	F0688		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757		

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F0757 SS = D	Continued from page 3 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on facility policy review, record review, and staff interviews, the facility failed to monitor and document potential side effects of psychotropic medications for two (2) of five (5) residents reviewed for medications. Residents #3 and Resident #28 Findings Include: Review of the facility policy titled “Medication Monitoring,” revised 7/25, revealed under, “Policy: This facility takes a collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences...” Record review of Resident #3’s September “Medication Administration Record (MAR)” revealed the resident received the following psychotropic medications: “Duloxetine HCL (hydrochloride) oral capsule 40 MG (milligrams) give 1 (one) capsule by mouth one time a day related to depression, Quetiapine Fumarate oral tablet 50 MG give 1 (one) tablet by mouth at bedtime related to neurocognitive disorder with Lewy Bodies, and Bupropion HCL (Hydrochloride) (ER) (extended release) oral tablet 150 MG give 1 (one) tablet by mouth two times a day related to depression.” Further review of the MAR revealed there was no documentation that the facility monitored the resident for potential side effects of the psychotropic medications. Record review of Resident #28’s September “MAR” revealed the resident received the following psychotropic medications: “Buspirone HCL	F0757		

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F0757 SS = D	Continued from page 4 (Hydrochloride) oral tablet 10 MG give one (1) tablet by mouth in the evening related to anxiety disorder and Lexapro oral tablet give 7.5 MG by mouth one time a day related to depression." Further review of the MAR revealed there was no documentation that the facility monitored the resident for potential side effects of the psychotropic medications. An interview with the Minimum Data Set (MDS) Nurse on 9/10/26 at 9:36 AM confirmed Resident #3 and Resident #28 did not have psychotropic medication side-effect monitoring documented on the MAR. She stated monitoring should be completed to ensure the residents did not experience adverse reactions to the medications. An interview with the Director of Nursing (DON) on 9/10/26 at 9:52 AM revealed she expected the side effects of psychotropic medications to be monitored and documented on the MAR. Record review of the "Admission Record" revealed the facility readmitted Resident #3 on 5/16/26 with medical diagnoses that included Neurocognitive Disorder with Lewy Bodies, Depression Unspecified, and Anxiety Disorder. Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/30/26, revealed under Section C a Brief Interview for Mental Status (BIMS) summary score of 11, which indicated Resident #3 was moderately cognitively impaired. Record review of the "Admission Record" revealed the facility readmitted Resident #28 on 7/25/26 with medical diagnoses that included Type 2 Diabetes Mellitus without Complications, Depression Unspecified, and Anxiety Disorder. Record review of the MDS, with an ARD of 7/19/26, revealed under Section C a BIMS summary score of 11, which indicated Resident #28 was moderately cognitively impaired.	F0757		