

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

PRINTED: 06/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/25/2022
NAME OF PROVIDER OR SUPPLIER SHARKEY-ISSAQUENA NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Entrance into facility on 5/24/22 at 11:20 AM for Complaint Investigations (CI) #18809 and CI #18276 along with a COVID-19 staff vaccine survey. The facility was found to be in compliance with Infection Control Regulations related to COVID 19 Employee/Staff vaccines and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 staff vaccination or exemption status. CI#18809 was unsubstantiated with no deficiencies cited for allegations of Safety/Quality of Care. This was a facility reported incident. CI#18276 was unsubstantiated with no deficiencies cited for allegations of Quality of Care/grooming, Quality of Care/Diets, Quality of Care/staffing. This CI was anonymous. The facility is licensed for 54 beds with a census of 46 at the time of survey.	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.