MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	63CI	A. BUILDING: _____ B. WING _____	C 02/08/2023

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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS CI #20282 at the facility from 2/6/23 to 2/8/23. During the survey, the SA determined that the facility was in compliance with the Mississippi Regulations for Minimm Standards for Institutions for Aged or Infirm. There were no deficiencies cited for MS CI #20282 for allegations of Quality of Care/Treatment related to Facility Staffing related to no Registered Nurse (RN) in the building, Infection Control related to the spread of COVID-19 not being controlled by the nursing facility, and Administration/Personnel related to the nursing facility not having a Director of Nursing (DON). The facility is licensed for 54 beds and at the time of the survey the census was 40.	M 000		

Mississippi State Department of Health

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