PRINTED: 06/30/2023
FORM APPROVED
OMB NO 0038-0301

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DATION	CENTERS	FOR MEDICARE & I	MEDICAID SERVICES					APPROVE 0. 0938-039	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE SHARKEY ISSAQUENA NURSING HOME STREET ADDRESS, CITY, STATE, ZP CODE COLLING FORK, MS 39159 SIMELT ADDRESS, CITY, STATE, ZP CODE PARKY SUMMARY STRUCTURY OF DEFICIENCES PARKY SUMMARY STRUCTURY OF DEFICIENCES PARKY SUMMARY STRUCTURY OF DEFICIENCES PARKY PROVIDERS AND CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 884 Reporting - National Health Safety Network F 884 SS-F CFR(s): 483.80(g)(1)(1)(1)(3)(2) Ş483.80(g)(1)(2)(1)(-0)(2) S483.80(g)(1)(1)(1)(-0)(2) S483.80(g)(1) Electronically report information about COVID-19 as tandardized format specified by the Secretary. This report must include but is not limited to— F 884 (i) Suspected and confirmed COVID-19 infections among residents and staff, including residents and staff, including total curbs and corresus; (ii) Access to COVID-19 vaccine receively and supplies in the facility; (iv) Verilator capacity and supplies in the facility; (iv) Staff and staff, including total numbers of residents and staff, including total numbers of residents and staff, numbers of residents and staff (iii) Therapeutics administered to residents for treatment of COVID-19 vaccine received, and COVID-19 vaccination adverse events; and (iv) Therapeutics administered to residents for treatment of COVID-19. S483.80(g)(1)(1) of the section and a frequency specified by the Secretary, but no less than weekly to the Corters to Disease Contin and Prevention'N Nation Heast				· ,					
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

06/26/2023

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 06/30/2023 M APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE	(X3) DATE SURVEY COMPLETED	
		255220	B. WING			06/26/2023		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
SHARKE	-ISSAQUENA NURSING	HOME			431 WEST RACE STREET ROLLING FORK, MS 39159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 884	by: Based on record revi report complete inforr the Centers for Disea (CDC) National Healt (NHSN) during a seve was required by regul The CDC submitted of Centers for Medicare (CMS). Based on revi determined that betwo 06/25/2023, the facilit information to NHSN standardized format a by CMS and the CDC	is not met as evidenced ew, the facility failed to nation about COVID-19 to se Control and Prevention's hcare Safety Network en-day period that reporting lation. lata from the NHSN to the and Medicaid Services ew of that data, CMS een 06/19/2023 and y did not report complete about COVID-19 in the and frequency as specified 5. This failure to report has more than minimal harm to	F	884	4			

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 2 of 2