PRINTED: 09/11/2023
FORM APPROVED
OMB NO 0028 0201

NDE PLAN OF CORRECTION DERNTIFICATION NUMBER A BULDING COMPLET 125220 B. WING 08/28/ NAME OF PROVIDER OR SUPPLER 31 WEST ACCESTREET STREET ADDRESS, CITY. STATE, ZIP CODE 31 MARKEY JSSAQUENA NURSING HOME 31 WEST ACCESTREET ROLLING FORK, MS 39159 (Ma) ID SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NULST EX PRECEDED IN TULL (RECOVERCIPTIVE AND ON EXCENTION TO PRICIPACIES (EACH DEFICIENCY NULST EX PRECEDED IN TULL (RECOVERCIPTIVE AND ON EXCENTION TO PRICIPACIES (RECOVERCIPTIVE AND ON EXCENTION TO PRICIPACIES (RECOVERCIPTIVE AND ON EXCENTION TO PRICIPACIES (RECOVERCIPTIVE AND ON EXCENTION TO PRICIPACIES (RECOVERCIPTIVE AND ON EXCENTION TO PRICIPACIES (RECOVERCIPTICAL AND AND AND ON TO PRICIPACIES (RECOVERCIPTICAL AND AND AND ON TO PRICIPACIES (RECOVERCIPTICAL AND AND AND ON TO PRICIPACIES (RECOVERCIPTICAL AND	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
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support protecting the health and safety of residents, personnel, and the general public.		This information will b support protecting the	be posted publicly by CMS to e health and safety of				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

08/28/2023

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: 09/11/2023 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
255220		255220	B. WING	i		08/28/2023	
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 TAC	=IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD 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 08/27/2023, 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 08/21/2023 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

Facility ID: 63CI

If continuation sheet Page 2 of 2