STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A162	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shearer-Richardson Memorial Nursing Home	512 Rockwell Drive Okolona, MS 38860

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on observation, staff and resident representative (RR) interview and facility policy review revealed the facility failed to ensure residents were treated with dignity and respect as evidence by staff members calling the residents by their last name only and failing to use a salutation for two (2) of 18 residents sampled during this survey. Resident #2 and Resident #39. Findings Include Record review of the facility policy review titled, Promoting/Maintaining Resident Dignity with a revision date of 10/2/23 revealed Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Resident #2 A phone interview on 9/30/24 at 11:20 AM, with Resident #2's Resident Representative (RR) revealed he has complained numerous times to the Director of Nurses (DON) and Administrator regarding issues with his mother. He revealed he complained most recently about the way the aides call her by her last name only and do not use a salutation and they take personal phone calls while in her room, during times when they are changing and cleaning her. He stated that a week ago when he tried to file that complaint, the DON told him he was just hard to get along with and confirmed that he has never heard back from the facility regarding a resolution to any of his complaints. An interview on 10/02/24 at 8:56 AM, with Certified Nurse's Assistant (CNA) #1 confirmed that she does call some of the residents by their last name only and can see now how that might be disrespectful to the resident by not using a salutation. An interview on 10/2/24 at 3:00 PM, with the DON and the Administrator who confirmed they knew that some residents were called by their last names only and can see how that could appear as a dignity issue. The Administrator revealed the staff have been trained to address the residents as Mr. or Mrs. and she wasn't sure why they were doing this. Record review of Resident #2's Admission Record revealed the resident was admitted to the facility on [DATE]. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired. 41878 Resident #39 During an observation on 9/30/24 at 2:30 PM, it was noted that Resident #39 was in his wheelchair sitting by a window in the dayroom and the resident had called out to CNA #1 for assistance. As CNA #1 was walking towards him, she stated, You can't get no sugar, (resident's last name). Then she turned and walked away shaking her head and said, (resident's last name, resident's last name). An interview with CNA #1 on 10/2/24 at 9:00 AM, confirmed she called Resident #39 by his last name and acknowledged this could be seen as disrespectful since he had not told her that he preferred to be called by only his last name. During an observation and interview on 10/2/24 at 9:30 AM, CNA #2 was observed to be in the dayroom with Resident #39 and said, Hey (resident's last name). During the interview, CNA #2 acknowledged she called him by only his last name and thought he preferred that name since that was what everyone called him and she was not sure if he liked being called that or not. During an observation and attempted interview with Resident #39 on 10/2/24 at 1:55 PM, when asked his name and what he preferred to be called, it sounded like he said his first and last name together to both questions. Resident was difficult to interview since he had a BIMS of 4 which indicated he had severe cognitive impairment. During an interview on 10/2/24 at 3:00 PM, the DON and the Administrator confirmed they were aware that some residents were called by their last names only and could see how that could appear as a being disrespectful. The Administrator revealed that the staff know they should call them Mr. or Mrs. The record review of Resident #39's Admission Record revealed the facility admitted the resident on 10/30/23. Record review of Resident #39's MDS with ARD of 9/20/24, revealed a Brief Interview for BIMS of 4 which indicated the resident had a severe cognitive impairment.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on resident representative (RR) and staff interview, record review and facility policy review the facility failed to ensure a resident representative's grievance was resolved for one (1) of 18 residents reviewed, Resident #2. Findings Include Record review of the facility policy titled, Resident and Family Grievances with a revision date of 10/1/23 revealed under, Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines .#12. The facility will make prompt efforts to resolve grievances. On 9/30/24 at 11:20 AM, during a phone interview with Resident #2's RR revealed he has complained numerous times to the Director of Nurses (DON) and Administrator regarding his mother. He revealed he complained most recently about the way the aides call her by her last name only and that they take personal phone calls in her room, while they are changing and cleaning her. He stated that a week ago when he tried to file that complaint, the DON told him he was just hard to get along with and confirmed that he has never heard back from the facility regarding a resolution to any of his complaints. An interview on 10/01/24 at 3:18 PM, with the DON and the Administrator confirmed that Resident #2's RR had made numerous complaints. The Administrator confirmed that they have never written any of his complaints up formally and included them on the grievance log. She stated that she usually just follows up and jots notes down and then calls him back. The DON stated we have not heard back from him, so we thought everything was ok. They both admitted that he came to the last care plan meeting a couple of weeks ago and complained about an aid cussing and talking loudly outside his mother's room. The Administrator confirmed she should have written these up so that they would have documentation of the grievances and what was done to resolve it and provided follow up back to the RR, but they had failed to do so. An interview on 10/02/24 at 2:53 PM, with Social Services confirmed she was aware that Resident #2's son had complained about stuff in the past. She stated that he always goes to either the DON or Administrator, but she had never been told to write it up as a formal grievance. Record review of the Grievance Summary Log for the past six (6) months revealed there was one grievance documented for Resident #2 and that was related to broken glasses and revealed no other grievances. Record review of Resident #2's Admission Record revealed the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/19/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident was severely cognitively impaired.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on record review, staff interview, and facility policy review, the facility failed to complete and transmit a discharge Minimum Data Set (MDS) Assessment for one (1) of 21 residents reviewed for MDS assessments. Resident #33 Findings include: A review of the facility policy titled Resident Assessment-RAI (Resident Assessment Instrument) with a revision date of 3/10/24 revealed, This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS. A record review of Resident #33's Admission Record revealed an admitted [DATE] and a discharge date of [DATE]. A record review of the Discharge Summary revealed Resident #33 was discharged home on 5/2/24. During an interview on 10/02/24 at 2:45 PM, the MDS Coordinator confirmed that Resident #33 was admitted to the facility on [DATE] and discharged home on 5/2/24. She revealed that she had, in error, omitted entering and transmitting the discharge MDS assessment for the Assessment Reference Date (ARD) of 5/2/24, which resulted in the assessment being not completed and transmitted over 120 days late.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41878 Based on observation, record review, staff and resident interviews and facility policy review, the facility failed to develop a care plan for Resident #10 related to chronic pain for one (1) of 18 residents reviewed. Findings include: Record review of facility policy titled, Comprehensive Care Plans with revision date of 3/10/23, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The policy also revealed, 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being, During an interview on 9/30/24 at 10:50 AM, Resident #10 stated that she has swelling in her left leg and at times it caused her to have pain in this leg. Record review of Resident #10's Care Plan revealed no care plan for pain was developed for this resident who had a diagnosis of Chronic Pain Syndrome. An interview with Registered Nurse (RN) #1 on 9/30/24 at 10:55 AM, revealed the resident had swelling in her leg which caused pain. She stated Resident #10 received scheduled Tylenol and a fluid pill as needed (PRN) for the swelling. During an interview on 10/1/24 at 2:00 PM, the RN Supervisor revealed the resident has pain in her foot and leg occasionally which improved when elevated. She stated she received Tylenol two times a day which generally controlled her pain and also has an order for a cream to use as needed. An interview with the Minimum Data Set (MDS) Coordinator on 10/2/24 at 9:40 AM, revealed she was the person responsible for the development of care plans which provided the staff the information of the needed care and preferences of each resident. She confirmed the resident had a diagnosis of chronic pain syndrome and was receiving a scheduled analgesic medication for her pain and confirmed she failed to develop a care plan for this resident's pain. During an interview on 10/2/24 at 2:00 PM, the Director of Nursing (DON) acknowledged Resident #10 had a diagnosis of chronic pain syndrome and received a scheduled analgesic medication two times each day. She confirmed a care plan for pain was needed to inform the staff of care that was desired and needed and since this resident had pain, a pain care plan should have been developed and confirmed that the facility had failed to do this. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's Order Summary Report revealed an order for Biofreeze External Gel 4% to apply to hands topically every four hours as needed for arthritis pain, Diclofenac Sodium External Gel 1% to apply to affected areas topically every 12 hours as needed for pain related to arthropathy, Tylenol Extra Strength 500 mg - give one tablet two times a day related to chronic pain syndrome and Tylenol 325 mg give 2 tablets every four (4) hours as needed for pain/discomfort. Record review of Resident #10's Admission Record revealed the facility admitted her on 5/10/24 with diagnoses that included Erosive Osteoarthritis, Arthropathy, and Chronic Pain Syndrome. Record review of Resident #10's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 8/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.