STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E015	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITFIELD NURSING HOME	2101 EAST PROPER STREET CORINTH, MS 38834

(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 A Recertification Survey was conducted by Healthcare Management Solutions, LLC on 09/17/18 through 09/20/18, on behalf of the Mississippi State Department of Health. The facility was found not in substantial compliance for participation in Medicare and Medicaid and cited F641 and F813. Census: 26. The facility held a license for 44 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the current the "MDS 3.0 RAI Manual," the facility failed to ensure "Minimum Data Set (MDS)" assessments were correctly coded for falls for one (1) of 12 sampled residents, Resident (R) #24. Findings include: 1. Review of Resident #24's "Progress Notes" revealed a note dated 08/19/18, indicated Resident #24 had a fall that day and had sustained a hematoma on his forehead. Resident #24 had also complained of hip pain and had been sent to the hospital for evaluation. That evaluation revealed no major injury. Review of Resident #2424's "MDS," an	F 641	a) The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/18 was modified on 10/12/18 by Director of Nursing (DON), to accurately reflect Resident #24's fall on 8/19/18 to fall w/ injury (except major) J1900-B. b)All residents have the potential to be affected, especially residents with falls, by the alleged deficient practice. c) MDS coordinator from another facility provided inservice to MDS staff on 10/15/18 regarding accurately coding of falls on MDS by reviewing fall reports and nurses notes. A chart audit was conducted on 10/11/18 by Nursing Home Administrator/DON on last three (3) months falls to ensure accuracy of coding	10/22/18

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F 641	Continued From page 1 assessment tool completed by the facility staff, used to identify resident care problems and assist with care planning, with an "Assessment Reference Date (ARD)," end point of the evaluation period, of 08/20/18, "Section J"-question "J1800," had been coded, "yes" for R24 having falls since the prior assessment. The next question, "J1900" had been coded "A. 1," Resident #24 having one (1) fall without injury since the prior assessment. The available coding options for question "J1900" were: "A. No injury-no evidence of any injury is noted on physical assessment ...no complaints of pain or injury by the resident ...; B. Injury (except major)- skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains ...or any fall-related injury that causes the resident to complain of pain; or C. Major injury- bone fractures, joint dislocations ..." The 08/20/18 MDS should have been coded, "B. Injury (except major)- skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains ...or any fall-related injury that causes the resident to complain of pain." Interview on 09/20/18 at 11:50 AM, with the Administrator and the Director of Nursing (DON), revealed they split the responsibilities of entering MDS data. The Administrator confirmed that fall (8/19/18) should have been coded as a fall with injury. They were unsure why it was coded incorrectly, and stated it must have been an oversight. The DON stated they try to review "Progress Notes" to ensure coding accuracy. The facility used the current "MDS 3.0 RAI Manual" as their policy for MDS completion.	F 641	for falls and found no negative findings. DON will audit MDS weekly for four(4) weeks, bimonthly for two(2) months then monthly for two(2) months. d) A report will be submitted to the Quality Assurance (QA) Committee by the DON on audit findings each quarter. The QA Committee will review reports and make recommendations as needed.	

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F 641	Continued From page 2 Review of the "MDS 3.0 RAI Manual", used by the facility, confirmed the MDS should have been coded accurately for falls and it was important "to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS."	F 641		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review: "Food handling practices must assure that safe food is received and kept safe for human consumption," the facility failed to ensure policies and procedures had been written for the safe handling and storage of food brought into the facility by visitors or family for residents. This had the potential to affect residents Resident (R) #4, #9, #23, and #22, four (4) of 26 current residents in the facility. Findings include: Observation throughout the survey from 09/17/18 through 09/20/18 revealed four (4) residents, R4, R9, R23, and R22, had personal refrigerators in their rooms. There was various food items stored in the refrigerators. Interview on 09/19/18 at 5:54 PM, with the Dietary	F 813	a) A personal food storage policy and procedure was developed on 10/8/18 by the Nursing Home Administrator(NHA) and Registered Dietician(RD). All resident personal refrigerators (Resident #4,#9, #13(not #23), and #22 did not have a refrigerator, but another resident not on sample did); were inspected on 9/21/18 by the Activity Director and the NHA for expired or out of date foods. Any resident food items found out of date or unlabeled were discarded by NHA with resident's permission. Refrigerator thermometers were placed in Resident #4 and #9 refrigerators on 10/10/18, Resident #13(not #23) and Resident not on sample had thermometers already in refrigerators. Refrigerator temperature logs were placed on outside of refrigerators on 10/10/18 and recording of inside temperatures were	10/22/18

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F 813	Continued From page 3 Manager (DM), revealed the facility had not had a policy for handling and storing food brought in by visitors and family. Interview on 09/20/18 at 11:55 AM, with the Administrator, revealed the facility did not have a policy for handling food brought in by visitors and family, but it was allowed. Housekeeping was responsible for checking refrigerators in resident rooms to ensure food was not outdated and was stored properly. There was no record of the personal refrigerators being checked for safe food storage. Interview on 09/20/18 at 1:40 PM, with a confidential resident, revealed housekeeping had just come to her room earlier and asked to check her refrigerator for outdated food. That resident stated, "That is the first time they ever checked my fridge." Observation at that time revealed there were food items in the refrigerator, but nothing was outdated. Review of the facility's "Food handling practices ..." policy, no date, revealed personal refrigerators and food handling and storage of food from visitors or family had not been included in that policy. No other policies regarding that storage and food handling had been available at the time of the survey. There were no procedures in place to make certain resident's refrigerators were monitored for safe and sanitary food storage.	F 813	started on 10/11/18. b) All residents with personal refrigerators have the potential to be affected by this alleged deficient practice. Any resident that has a refrigerator placed in their room will have a thermometer placed inside and refrigerator temperature log placed outside on the refrigerator so temperatures can be recorded daily. Food Storage Policy will be given to all new admissions. c) RD in-serviced housekeeping staff, Licensed Social Worker(LSW) and Dietary Manager(DM) on 10/10/18 regarding policy and procedure for personal food storage, monitoring and cleaning of resident refrigerators. RD and DM in-serviced Resident's #4, #9, and another resident with personal refrigerator, Resident #13(not #23) was in hosptial. Housekeeping placed thermometers and daily temperature logs on refrigerators in Resident's (#4, #9, #13(not #23) and other personal refrigerator)on 10/10/18 and started recording daily temperatures on 10/11/18. Temperature of refrigerators will be checked by housekeeping daily and inspection of food items will be checked weekly by housekeeping for out of date or expired foods. LSW sending out a letter with Food Storage Policy to all families regarding food brought into facility and proper storage of that food. New admissions will be given the policy and if a refrigerator is brought to a new resident's room, then a thermometer will be placed inside and a Temperature Log Sheet will be placed outside so daily temperature	

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F 813	Continued From page 4	F 813	checks and weekly inspections can be recorded. NHA will check resident refrigerators for monitoring of temperatures and inspection of refrigerators, weekly for four(4) weeks, then every two(2) weeks for two(2) months, and then monthly for two (2) months. d) The NHA will make a report quarterly to the Quality Assurance (QA) Committee regarding the resident personal food storage and personal refrigerator monitoring. The QA Committee will review the reports and make recommendations as needed.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 9/19/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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