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 ______	07/02/2019

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 The State Agency (SA) conducted an Annual Recertification Survey at the facility from 06/30/19 to 07/02/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare/Medicaid, and cited deficiencies at F623, F641, F758, and F880. The facility was licensed for 44 beds, and had a census of 27 at the time of the survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		8/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 08/05/2019

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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the resident or resident representative of transfer or discharge, and the reason for the transfer or discharge for two (2) of 12 residents reviewed, Residents #12 and #21. Findings include:	F 623	a) On chart review for resident #21 it was noted that the resident was sent to the hospital on 5/18/19, not 5/29/19 as stated in report, and resident returned to the facility on 5/29/19. However, a Transfer/leave/bed hold form was mailed on 8/5/19 for resident #21 showing actual transfer date of 5/18/19 with explanation	

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F 623	Continued From page 3 Record review revealed Resident #12 was transferred to the hospital, on 02/12/19, due to nausea, vomiting and decreased oxygen saturation. There was no documented evidence that the resident and/or resident's representative was notified of the transfer in writing. Record review revealed Resident #21 was admitted to the hospital on 05/29/19. There was no documented evidence that the resident and/or resident's representative was notified of the transfer/admission to the hospital in writing. An interview, on 06/30/19 at 4:50 PM, revealed the Administrator confirmed a Bed Hold form was done. The Administrator stated she notifies the Ombudsman of transfers and discharges to the hospital, but she was not aware they were supposed to notify the resident or resident's representative in writing. The Administrator stated the nurses call the family to notify them when the resident is sent to the hospital. An interview, on 07/01/19 at 4:51 PM, with the Administrator, confirmed she did not have a form written documentation to notify the resident or the resident's representative of a transfer or discharge to the hospital. Review of the facility's Demographic Sheet revealed Resident #12 was admitted by the facility on 05/10/12. Review of the facility's Demographic Sheet revealed Resident #21 was admitted by the facility on 01/21/19.	F 623	of reason for transfer. For resident #12 a Transfer/leave/bed hold form was mailed on 8/5/19 explaining reason for transfer for hospitalization on 2/12/19. b) All resident's being transferred or discharged have the potential to be affected by this alleged deficient practice. c) Administrator from another facility provided inservice to Social Worker (SW) and administrator on 8/5/19 regarding the requirements for transfer/discharge of a resident, procedure and form. New Transfer/leave/bed hold form with explanation of reason for transfer, etc. will be mailed by SW or administrator to the authorized representative for signature or given to the resident prior to transfer to another facility. The administrator will audit the Transfer Notification Log weekly for one(1) month then monthly for three (3) months. d) A report will be submitted to the Quality Assurance (QA) Committee by the administrator on audit findings each quarter. The QA Committee will review reports and make recommendations as needed.	
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		8/5/19

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F 640	Continued From page 4	F 640		

§483.20(f) Automated data processing requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer,

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F 640	Continued From page 5 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to submit Minimum Data Sets (MDS) in a timely manner for 18 of 26 residents on sample who required MDS submissions. Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #29, and #30 Findings include: Review of the records for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #29, and #30 revealed the Minimum Data Sets were over 120 days past due. An interview, on 07/01/19 at 10:50 AM, with the Administrator, revealed the facility did not have a specific policy on MDS assessments. A review of the Resident Assessment Instrument (RAI) 3.0 Manual version 16, dated October 2018, revealed within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the Centers for Medicare and Medicaid Services (CMS) System, including Admission assessment, Annual assessment, Significant change in status	F 640	a) Resident's #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #29, #30 Minimum Data Set (MDS)were submitted as stated on 6/28/19. Resident's upcoming MDS will be submitted in accordance with Centers of Medicare and Medicaid Services (CMS) guidelines. b) All residents who have assessments completed have the potential to be affected by this deficient practice. c) Administrator from another facility provided inservice to the MDS coordinator and administrator on 8/5/19 regarding timely submission of MDS and transmittal requirements. New policy for Electronic Transmission of MDS. A Completion and Transmission Log will be completed at time of entry by MDS Coordinator to include submission deadline date and submission completion date. Administrator will audit transmission log weekly for one (1) month then monthly for three (3) months. d) A report will be submitted by the administrator to the Quality Assurance (QA)Committee on audit findings. The	

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F 640	Continued From page 6 assessment, Significant correction of prior full assessment, Significant correction prior quarterly assessment, Quarterly review, A sub set of resident's transfer, reentry, discharge, and death. Background (face sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. An interview, on 07/01/19 at 1:35 PM , with the Director of Nursing (DON), revealed the person responsible for submitting the Minimum Data Sets (MDSs) was the Administrator. The DON stated all she usually does is the assessment of the resident. An interview, on 07/01/19 at 2:45 PM, with the facility's Administrator, revealed she knew the assessments should be submitted within 14 days after the facility completed the resident's assessment, according to the guidelines listed in the RAI Manual. The Administrator stated, "I just didn't send them in until last Friday." A review of the facility's CMS Submission Report MDS 3.0 NH Final Validation Report revealed a Submission Date/Time of 06/28/19 19:19:29 (7:19:29 PM). Processing Completion Date/Time of 06/28/19 19:22:11 (7:22:11 PM). Further review of the report revealed there was 28 records in the Submission File, Processed, and Accepted.	F 640	QA committee will review the reports and make recommendations as needed.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		8/5/19

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F 758	Continued From page 7 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 8 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide a stop date for an as needed antipsychotic medication for one (1) of 12 residents reviewed, Resident #4. Findings include: Record review revealed Resident #4 had an order for Ativan 0.25 milligram (mg) by mouth (PO) every six (6) hours as needed (PRN), for respiratory distress only. The order date was 03/29/19, with no stop date. On 07/02/19 at 9:38 AM, an interview with the Director of Nursing (DON) revealed she stated she was not aware of the federal tag for stop dates, but this resident received the medication for her breathing, and she felt that was different. The DON confirmed she was also not aware that this regulation pertained to PRN psychotropic medications ordered for terminally ill residents. On 07/02/19 at 9:56 AM, a phone interview with the Consultant Pharmacist revealed he had spoken with the DON concerning stop dates, and written pharmacy recommendations concerning this. The Consultant Pharmacist stated he missed the order for the PRN Ativan on Resident #4, and just did not pick up on it. The Consultant Pharmacist confirmed the Ativan order should have had a stop date.	F 758	a) Resident #4 prn Ativan order was discontinued on 7/7/19. b) All resident's with prn psychotropic orders without stop dates have the potential to be affected by this alleged deficient practice. c) Pharmacy consultant in-serviced nursing staff on 7/10/19 regarding psychotropic medication prn and fourteen (14) day "stop date" requirement. New Antipsychotic Medication Use policy with prn language. Pharmacy consultant conducted a chart audit and found no prn psychotropic or antipsychotic orders. Administrator will audit new orders for prn psychotropic medications with stop date weekly for one month then monthly for three months. Pharmacy consultant will audit charts for psychoactive prn orders on monthly visits. d) A report will be submitted to the Quality Assurance (QA) Committee by the Administrator on audit findings each quarter. The QA committee will review reports and make recommendations as needed.	
F 880	Infection Prevention & Control	F 880		8/5/19

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F 880 SS=D	Continued From page 9 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 10 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to prevent the possibility for the spread of infection during medication pass as evidenced by the administration of a contaminated capsule to a resident, Resident #26. Findings include: Review of the facility's "Infection Prevention	F 880	a) LPN #1 was in-serviced on 7/8/19 by the administrator on proper procedure for handling a dropped pill. b) All resident's have the potential to be affected by this alleged deficient practice during the medication pass. c) Pharmacy consultant in-serviced nursing staff on 7/10/19 on medication pass procedures and the procedure for handling a dropped pill. New policy for	

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F 880	Continued From page 11 Control Program", not dated, revealed the facility's goals are to limit resident, visitor, and staff unprotected exposure to limit the transmission of infections associated with care procedures. Review of the facility's policy and procedure, not dated, revealed Standard Precautions will be utilized on all residents admitted/transferred to Whitfield Nursing Home. On 07/01/19 at 8:47 AM, an observation, during medication pass with Licensed Practical Nurse (LPN) #1, revealed LPN #1 dropped a Metoprolol capsule on the floor. LPN #1 stated she did not know how to accommodate for that since they don't have any backup medications. LPN #1 picked the capsule up with a tissue and placed it on the top of the medication cart, and continued with the medication pass. The white capsule was observed in the medication cup when LPN #1 administered the medications to Resident #26. On 07/01/19 at 3:10 PM, during an interview, LPN #1 was asked what steps she took with the medication she dropped on the floor. LPN #1 stated she wiped it off with the tissue and gave it to Resident #26 because they don't have any back up medications. She confirmed she did not think about calling the pharmacy. LPN #1 stated she realized the medication was contaminated. On 07/02/19 at 7:30 AM, an interview with the Director of Nursing (DON) revealed that giving a medication that had been dropped on the floor was a problem, and does not even begin to be acceptable. The DON stated the medication was contaminated, and the nurse should have called the pharmacy or let her know and she would have	F 880	Administering Medications and Discarding and Destroying Medications that includes handling of dropped medication. Pharmacy consultant will observe medication pass on monthly visit for infection control technique. Director of Nursing (DON), RN supervisor or administrator will monitor medication weekly for one(1) month then monthly for three (3) months. d) DON will report on medication pass audits to the Quality Assurance Committee to ensure infection control techniques during medication pass are followed. The QA committee will review reports and make recommendations as needed.	

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	25E015	A. BUILDING ______ B. WING ______	07/02/2019

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 880	Continued From page 12 called for her.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E015	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/01/2019**

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
K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly insure the operability of the sprinkler system as required by NFPA 25 table 5.1.1.2 and Table 2-1. This deficient practice affected all residents in the facility at the time of survey.	K 353	a) On 7/1/19 the administrator notified State Systems of need for annual sprinkler inspection. State Systems came and completed annual sprinkler inspection on 7/2/19. b) All resident's have the potential to be affected by not having current sprinkler	8/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E015	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**07/01/2019**

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
K 353	Continued From page 1 Findings include: On 7/1/19 at 11:30 AM, observation and record review revealed the facility could not provide a current annual inspection documentation for fire sprinkler system. The finding was acknowledged by the Administrator and Maintenance Supervisor during the exit interview on 7/1/19.	K 353	inspection. c) State Systems conducted an annual sprinkler inspection on 7/2/19. Annual Fire Systems inspection log generated with all fire systems to show last annual or semi-annual inspection date to include next due date. Annual Fire System log will be maintained by the Administrator for quick reference for annual due dates for follow up with inspection agencies. d) Administrator will report on upcoming and completed fire systems inspections to the Quality Assurance (QA) committee. The QA committee will review reports and make recommendations as needed.	

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OMB NO. 0938-0391

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 ______	07/01/2019

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
E 000	Initial Comments EMERGENCY PREPAREDNESS Survey conducted on 07/01/19 revealed the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2019

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.