STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255291	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copiah Living Center	806 West Georgetown Street Crystal Springs, MS 39059

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. Based on observation, record review, facility policy review and interviews, the facility failed to ensure resident right to respectful, dignified care as evidenced by staff failed to position themselves at the resident's side while assisting the resident with eating for one (1) of four (4) sampled residents. Resident #2 Findings included:Record review of the facility policy, Tray Setup for Resident Who Will Dine Independently with Latest Review Date 01/24 (January 2024) PURPOSE To ensure that the resident obtains sufficient nourishment and fluids.7. Provide beverage from meal tray. 8. Be attentive to resident's needs during the meal: offer appropriate assistance as needed.Record review of the facility policy revealed, Feeding the Dependent Resident with latest review date 01/24 (January 2024) revealed the policy stated, PURPOSE To ensure adequate nutrition for resident who are unable to feed themselves.PROCEDURE.Ensure that resident is seated comfortable in upright position.Record review of the facility policy Resident's Rights Policy with latest review date 03/24 (March 2024) revealed Every resident in this facility has the right to. 12. Be treated courteously, fairly and with the fullest measure of dignity.On 9/25/25 at 12:45 PM, observation revealed Resident #2 in his bed with his lunch tray in front of him on the over-the-bed table and Licensed Practical Nurse (LPN) #1 standing at the bedside with a spoon assisting the resident to eat. On 9/25/25 at 12:48 PM, observation revealed the Staff Development Nurse provided correction to LPN #1 regarding resident's rights to include sitting at the resident's side to assist with eating/feeding the resident.On 9/25/25 at 1:00 PM, observation and interview with Resident #2 revealed he was usually able to feed himself, but he nonverbally indicated that he was not feeling well on 9/25/25. On 9/25/25 at 1:55 PM, interview with the Staff Development Nurse revealed she stated that the facility policy and current standards of practice for resident meal service included sitting beside the resident while assisting to eat or feeding them. She confirmed that she had observed LPN #1 attempting to assist Resident #2 to eat while standing at his bedside. On 9/25/25 at 2:30 PM, during an interview the Director of Nurses (DON) confirmed that the policy of the facility and current standards of practice included to sit beside the residents when assisting with meals/feeding residents. Record review of the admission Record for Resident #2 revealed the facility admitted the resident on 10/18/22 and the resident had diagnoses that included chronic kidney disease, diabetes and cerebral palsy. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD)of 5/20/25 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview. with documentation that the resident was unable to complete the interview. Long- and short-term memory was coded OK. Resident #2 had modified independence with cognitive skills for daily decision making. Section GG indicated the resident required set-up assistance for eating.

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, record review, facility policy review and interviews, the facility failed to promote dignity for a resident during dining as evidenced by a resident was observed unsafely positioned during a meal and the call light was out of reach for one (1) of four (4) sampled residents. Resident #1. Findings include: Record review of the facility policy Call Light/Bell with the latest review date 01/24 (January 2024) revealed PURPOSE To provide the resident a means of communication with staff members.PROCEDURE 1. Ensure resident has call light in reach when in resident room.7. Place the call light within the resident's reach before leaving the room .Record review of the facility policy, Tray Setup for Resident Who Will Dine Independently with Latest Review Date 01/24 (January 2024) PURPOSE To ensure that the resident obtains sufficient nourishment and fluids.7. Provide beverage from meal tray. 8. Be attentive to resident's needs during the meal: offer appropriate assistance as needed.Record review of the facility policy Feeding the Dependent Resident with the latest review date of 01/24 (January 2024) revealed PURPOSE To ensure adequate nutrition for resident who are unable to feed themselves.PROCEDURE.5. Ensure that resident is seated comfortable in upright position .On 9/24/25 at 4:00 PM, interview with Certified Nurse Aide (CNA) #1 revealed that the resident declined offers of assistance to transfer into her wheelchair for activities or to go to the dining room for meals.On 9/24/25 at 4:40 PM, a telephone interview with a family member of Resident #1 revealed the family member visited the resident weekly and had noticed upon entrance to her room that her call light was out of the resident's reach. He stated that he felt the staff should pay more attention upon exiting the residents' rooms. On 9/24/25 at 4:49 PM, a telephone interview with the Resident Representative (RR) of record for Resident #1 revealed she had concerns related to staff leaving the resident's room and leaving her call light out of reach of the resident. She said she was also concerned that the resident needed more assistance for meals, and that she didn't think the resident should be left alone while eating meals. She confirmed that the resident said she preferred to stay in bed.On 9/25/25 at 12:30 PM, the State Agency (SA) entered the room of Resident #1 and the resident's call light was hanging down below the mattress next to the floor out of the reach of the resident. The resident had slid down in the bed with her feet at the footboard and the head of the bed was elevated approximately forty-five (45) degrees. The resident had her lunch tray on the over-the-bed table in front of her and was feeding herself chicken. She could not reach her water or tea. CNA #1 entered the room and Resident #1 reached out for her water glass and asked CNA #1 to hand her her drink. CNA #1 stated that the resident was served meals in bed according to the resident's preference and set-up assistance was provided. She stated that the resident preferred not to be sat up in a seated position for meals. CNA #1 and another staff member repositioned Resident #1 in bed (pulled her up in bed) and raised the head of the bed so that the resident was in a slightly reclined but in a seated position and the resident was able to reach all lunch items. CNA #1 took a seat at the resident's bedside and provided verbal cues and encouragement for the resident to continue to eat.On 9/25/25 at 12:32 PM, during an interview with Licensed Practical Nurse (LPN) #1, she confirmed that Resident #1 did not have access to her call light as it was out of sight and out of reach, hanging down below the mattress. LPN #1 stated, She isn't going to reach it there. She confirmed that Resident #1 was routinely served meals while in a reclined position, not in an upright position, and was left alone to feed herself. On 9/25/25 at 1:55 PM, interview with the Staff Development Nurse she stated that the facility policy and current standards of practice for resident meal service included positioning the residents in an upright position for safety prior to meal service and while eating, ensuring that all items were within the residents' reach and sitting beside the resident while assisting to eat or feeding them. She stated (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that it was facility policy that all staff ensured each resident's call light was within their reach each time they exited a resident room to provide a means for residents to summon assistance as needed. On 9/25/25 at 2:30 PM, an interview with the Director of Nurses (DON) revealed she stated that the policy of the facility and current standards of practice included positioning residents properly in an upright position prior to serving meals. She confirmed that the reason for seating the resident upright was for safety while eating. She stated that she expected nursing staff to position residents appropriately prior to serving meals for the safety of the resident during eating and to sit beside the residents when assisting with meals/feeding residents. She stated that it was important for all staff to ensure the resident's call light was within the reach of the resident prior to exiting the residents' rooms as the residents relied on the call light to alert staff of their need for assistance. On 9/25/25 at 2:50 PM, during an interview CNA#2 revealed that she had been the CNA assigned to the care of Resident #1's care for 6:00 AM through 2:00 PM on 9/24/25. She stated that it was important for residents' call light to be kept within reach as a way for the residents to summon assistance as needed. She confirmed staff were responsible for making sure call lights were left within the resident's reach. She stated that she had not been aware that the resident's call light was not in reach at 12:30 PM and said, It must have fallen.Record review of the admission Record for Resident #1 revealed the facility admitted the resident on 8/14/23 and the resident had diagnoses of diabetes, dementia and chronic kidney disease.Record review of the admission Minimum Data Set (MDS) for Resident #1 with an Assessment Reference Date (ARD) of 8/08/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Section GG indicated that the resident required partial/moderate assistance for eating.