STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15CL	A. BUILDING: _____ B. WING _____	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPIAH LIVING CENTER	806 WEST GEORGETOWN STREET CRYSTAL SPRINGS, MS 39059

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs) at the facility from 10/30/23 through 11/2/23. The SA investigated CI MS #23005 related to not following physician orders, not offering water, and residents being left wet and soiled for extended periods of time, CI MS#23078 was investigated related to admission, transfer, and discharge rights and CI MS #23081 was investigated for rehabilitation services and pressure sores. CI MS #23080 related to residents being left wet for extended periods of time, not following physician orders and improper incontinent care was investigated. No deficiencies were cited for these investigations. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements related to CI MS #23079 related to notification of Resident Representative, adequate grooming, pressure sores, and infection control M1570 was cited. During the annual survey M815 was cited. The facility held a license for 60 beds, with a census of 52.	M 000		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interviews and facility	M 815	a. On 10/30/2023, all of the expired food items in the pantry and refrigerator were immediately removed by the facility□s	12/1/23

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/20/23

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M 815	Continued From page 1 policy review, the facility failed to ensure items in the kitchen refrigerators, freezers, and dry storage room were dated, labeled, and discarded by the expiration date for one (1) of three (3) dietary observations. This has a potential to affect all residents receiving meals prepared by the facility's dietary department. Findings include: A review of the facility's policy titled "Food Storage Labeling," with a revision date of 05/18, revealed, "Policy: The facility will ensure the safety and quality of food by following good storage and labeling procedures. Procedure: 1. Labeling a. All temperature-controlled foods and ready-to-eat foods prepared in the facility and held for longer than twenty-four hours will be labeled. Information included on the label: Name of the food, Date of storage... 3. Rotation ...b. Food stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufacturer's use-by date or expiration date. Suggested time frames: Dry storage - Weekly, Refrigerator storage- Weekly ..." During the initial tour of the kitchen with the Dietary Manager (DM) on 10/30/2023 at 9:46 AM, revealed expired food items in the pantry that included three (3) 128 oz. (ounce) plastic containers of Goldens Mustard with an expiration date of 8/06/23, two (2) 128 oz. plastic containers of Ken's Steakhouse Barbecue Dressing with an expiration date of 9/28/23 and (3) 128 oz. plastic containers of Kikkoman Sauce with an expiration date of 10/13/22. Observation of the items in the refrigerator revealed (2) 5 lb. (pound) containers of Wholesale Cottage Cheese, opened, with a green substance around the top. Both containers	M 815	Dietary Manager and was discarded to prevent it from being served. All residents that received a meal tray from the kitchen were assessed by the facility Registered Nurse with no issues identified. b. All residents that receive meals from the kitchen have the potential to be affected by this alleged deficient practice. c. On 10/30/2023 the Dietary manager began in-servicing Dietary staff on Food Storage Labeling Policy and Recommended Food Storage Chart and checking dates on deliveries prior to storing it. Dietary Staff In-services completed on 11/2/2023. All dry goods and dairy products delivered were checked in by the Dietary Manager and/or facility cook for the expiration date and ensure that all items were labeled and dated on 11/1/2023. d. On 11/1/2023, Dietary Manager checked the expiration dates and labels on all food items that were delivered. Any food items that were found to be expired, was immediately discarded on 11/1/2023. On 11/6/2023, the Dietary Manager and Administrator began monitoring expiration dates on dairy products and condiments 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then 2 times a week for 4 weeks. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 11/29/2023 to discuss further recommendations as needed and then review for 3 months. The next QAPI committee meeting will	

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M 815	Continued From page 2 were unlabeled, with an expiration date of 7/15/23. There was (1) 5 lb. bag of shredded parmesan cheese unlabeled, with an expiration date of 6/14/23. On 10/30/23 at 10:46 AM, in an interview with the DM, regarding kitchen duties, she specified that all staff members of her dietary department are accountable for the proper dating, labeling, and removal of expired foods. Additionally, she disclosed that the Registered Dietitian conducts a monthly inspection to verify that expired foods are appropriately dated, labeled, and removed from the kitchen. Furthermore, the DM affirmed that expired foods must be removed from the kitchen to prevent being served to the residents. She acknowledged that it would be harmful to the residents' health to serve them expired foods. On 11/2/23 at 10:04 AM, during an interview with Dietary Aide (DA) #1, she stated that the DM typically labels and dates food as soon as it is unloaded from the morning truck. However, the assigned responsibility of inspecting expired foods is not established. She stated that instead, it is dependent upon the amount of available time during the shift. DA #1 did not recall attending an in-service that focused on the dating, labeling, and removal of expired foods a few weeks ago. On 11/02/23 at 10:10 AM, during an interview with DA #2, she shared that the DM had a responsibility to verify the food's expiration dates. She acknowledges being new to the job and is still learning. She admitted that failure to remove expired goods from the kitchen could result in them being served to the residents, causing them to become sick. On 11/2/23 at 11:50 AM, the Administrator verified	M 815	convene on 12/15/2023. Additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to consent the findings of allegations as part of any proceedings and submit the responses pursuant to the regulatory	

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M 815	Continued From page 3 in an interview that she is ultimately liable for ensuring that expired foods are removed from the kitchen. However, she mentioned that the Registered Dietician does monthly inspections to ensure the proper labeling, dating, and removal of expired foods from the kitchen. The Administrator acknowledged that residents could be harmed if expired foods are served.	M 815		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by:	M1570		12/1/23

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M1570	Continued From page 4 Level II Based on observation, interviews, record review, and facility policy review, the facility failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of infection for two (2) of 17 sampled residents. Residents #26 and #33 Findings include: Record review of facility's policy, "Hand Hygiene," with a revision date of 8/21, revealed, PURPOSE To cleanse hands to prevent transmission of infection or other conditions. To provide clean health environment for residents, staff, and visitor... INDICATIONS FOR HAND WASHING ... 3. Before and after procedures 4. Before and after applying gloves ... 9. Wearing gloves does not replace the need to perform hand hygiene ..." Resident #26 On 10/31/23 at 2:50 PM, an observation of Certified Nursing Aide (CNA) #2 performing perineal care for Resident #26 revealed she did not perform hand hygiene prior to applying gloves. After she applied gloves and before beginning care, the resident's call light fell on the floor and the CNA picked it up with her gloved hands and placed it on resident's bed. CNA #2 did not remove the soiled gloves, but instead, began cleaning the perineal area. During the procedure, CNA #2 removed her soiled gloves five (5) times, however, did not perform hand hygiene prior to applying clean gloves and continuing with care. On 10/31/23 at 4:33 PM, in an interview with CNA	M1570	a. Root cause analysis was conducted by the Interdisciplinary Team (IDT) on 11/2/2023 and based on findings Certified Nursing Assistant (CNA) #2 and Registered Nurse (RN) #1 failed to follow hand hygiene policy. Resident #26 and Resident #33 were assessed by facility Registered Nurse Supervisor on 11/1/2023 with no issues identified. b. All residents receiving perineal care and Percutaneous Endoscopic gastrostomy (PEG) tube care have the potential to be affected by this alleged deficient practice. c. on 10/31/2023, the Infection Preventionist Nurse in-serviced Certified Nursing Assistant (CNA) #2 and 11/01/23 the Registered Nurse (RN)#1 on the Hand Hygiene Policy. On 11/1/2023 Infection Preventionist Nurse began in-servicing current Certified Nursing Assistants, Registered Nurses and Licensed practical Nurses on Hand Hygiene Policy. New hires and/or returns from Family Medical Leave (FMLA) will be in-serviced upon hire and or return to work on Hand Hygiene Policy. d. On 11/3/2023, Infection Preventionist Nurse observed 3 CNA's perform Perineal care with no concern identified. Beginning on 11/6/2023 the Director of nursing, Registered Nurse Supervisor, and or Infection Preventionist Nurse will observe a total of 6 Certified Nursing Assistants (CNA) perform perineal care 5 times a week for 4 weeks and then 3 times per week for 4 weeks and 2 times a week for 4 weeks. Beginning on 11/6/2023 the	

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M1570	Continued From page 5 #2, she confirmed she should have performed hand hygiene before beginning care and should have removed her gloves, performed hand hygiene and applied clean gloves after picking up the call light. CNA #2 also confirmed she did not perform hand hygiene when she changed gloves during the procedure. She stated Resident #26 could get a urinary tract infection from her not washing her hands. CNA #2 revealed that she had attended recently attended an in-service on the importance of performing hand hygiene. On 11/1/23 at 4:13 PM, in an interview the Director of Nursing (DON) confirmed CNA #2 should have performed hand hygiene prior to beginning care and each time she removed her soiled gloves. The DON also confirmed CNA #2 should have removed her gloves and performed hand hygiene after picking up the call light from the floor. She stated the actions of CNA #2 could cause Resident #26 to develop a urinary tract infection. On 11/2/23 at 11:05 AM, in an interview with Licensed Practical Nurse (LPN) #2/ IP (Infection Preventionist) confirmed CNA #2 should have performed hand hygiene before beginning care and each time she removed her gloves. She also stated CNA #2 should have removed her gloves and performed hand hygiene after she picked up the call light from the floor. The IP commented that the actions of CNA #2 could cause Resident #26 to develop an infection. Record review of the sign-in sheets for an in-service on handwashing, dated 8/29/23, revealed CNA #2's signature. Record review of the "Face Sheet" for Resident #26 revealed the facility admitted the resident to	M1570	Director of Nurses and/or Infection Preventionist Nurse will observe one Registered Nurse and /or Licensed practical Nurse perform Percutaneous Endoscopic Gastrostomy (PEG) tube care 5 times a week for 4 weeks and then 3 times a week for 4 weeks and 2 times a week for 4 weeks. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for Review. The QAPI Committee will convene on 11/29/2023 to discuss further recommendations as needed and then review for 3 months. The next QAPI committee meeting will convene on 12/15/2023. Additional training and/or disciplinary action will be considered as warranted. By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the rights to consent the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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M1570	Continued From page 6 the facility on 10/4/22, with diagnoses that included Alzheimer's Disease, Dysphagia, and Cognitive Communication Deficit. Record review of the Admission Minimum Data Set (MDS), with Assessment Reference Date (ARD) 9/29/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident was unable to complete the BIMS. Resident #33 On 10/31/23 at 3:55 PM, during an observation of Percutaneous Endoscopic Gastrostomy (PEG) tube care for Resident #33 with Registered Nurse (RN) #1 revealed RN #1 did not perform hand hygiene after removing the PEG site dressing and before applying new gloves to clean the PEG site, or prior to applying the clean dressing. RN #1 removed her gloves and exited the room without performing hand hygiene. She then returned to room after touching the doorknob and removing a pen from her pocket to date the dressing and again failed to perform hand hygiene prior to touching the dressing to add the date. On 10/31/23 at 4:20 PM, in an interview RN #1 confirmed that while she performed care, she should have performed hand hygiene each time she removed her soiled gloves and applied clean gloves. She stated there is a possibility Resident # 33 could get an infection from her care. She stated the resident's immune system is compromised due to health and age. RN #1 explained she knew she should have performed hand hygiene but forgot. She stated she has had attended in-services on PEG tube care and infection control.	M1570		

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M1570	Continued From page 7 On 11/1/23 at 4:16 PM, in an interview the Director of Nurses (DON) she stated RN #1 should have performed hand hygiene each time she removed her gloves. She stated she also should have performed hygiene when she returned to the room to continue care and should not have used a pen in her pocket to date the dressing. The DON confirmed that the actions of RN #1 could cause the Resident #33 to develop an infection. On 11/2/23 at 11:11 AM, in an interview with LPN #2/IP confirmed RN #1 should have performed hand hygiene before leaving the room to get tape and when she returned to the room. She also confirmed that each time the nurse removed her soiled gloves, she should have performed hand hygiene. The IP stated the actions of RN #1 could cause Resident #33 to develop an infection. Record review of the "Face Sheet" for Resident #33 revealed the facility admitted the resident to the facility on 3/22/19, with diagnoses that included Chronic Diastolic Heart Failure, Cognitive Communication Deficit, and Dysphagia. Record review the MDS, with an ARD of 8/7/23 for Resident #33, revealed a BIMS score of 99, indicating the resident could not participate in the interview. A record review of the physician orders revealed there was an order, dated 8/16/22, for Resident #33's PEG site to be cleaned and dressed every shift, due to increased drainage. Record review of facility in-service sign-in sheets revealed RN #1 attended an in-service on PEG/wound care on 11/24/22.	M1570		