MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44MM	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINEYARD COURT NURSING CENTER	2002 5TH STREET NORTH COLUMBUS, MS 39705

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 02/18/25 through 02/20/25. 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 and deficiencies were cited at M 625 and M 1570. The census at the time of the survey was 54 and the facility held a license for 60 beds.	M 000		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Pattern Based on observation, staff interview, record review, and facility policy review, the facility failed to provide the services to ensure a resident maintained/improved his/her highest level of range of motion (ROM) as evidenced by failure to apply an anti-contracture device for (1) one of (5) five residents reviewed for positioning and mobility. (Resident #6) Findings include: Review of the facility policy titled, "Prosthesis and Splint Policy," with no revision date revealed, "Procedure: Applied and removed as ordered." ... On 2/18/25 at 10:00 AM, an observation of Resident #6 revealed a contracture to the left hand, no device in place.	M 625	I. On February 19, 2025, Resident #6 was provided a new anti-contracture device by the Therapy Manager. Resident #6 was assessed on February 19, 2025, by the Director of Nursing. No adverse outcomes were identified to Resident # 6 related to the alleged deficient practice of failure to apply an anti-contracture device as ordered. In service provided with facility nursing staff by the Assistant Director of Nursing on February 19, 2025, regarding applying and monitoring range of motion devices, including anti-contracture devices, and the facility□s prosthesis and splint policy. II. Residents in the facility as identified by the electronic medical record in the computer software system as having an order for an anti-contracture device have	3/17/25

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M 625	Continued From page 1 Record review of the Order Summary Report for Resident #6 revealed an order dated 9/25/24, "remove the anti-contracture device from the left hand at least five minutes every shift and observe the skin for any impaired integrity ..." An observation and interview on 2/19/25 at 8:45 AM, with Licensed Practical Nurse (LPN) #1 he confirmed that Resident # 6 did not have an anti-contracture device on her left hand. He also confirmed the resident was supposed to have a device on the left hand to prevent worsening of the contracture. He stated he also worked 2/18/25 on the day shift and knew the resident had an order for a device but confirmed he did not check to see if the resident had the ant-contracture device on. In continued observation, it was revealed by LPN #1 that he was unable to locate an anti-contracture device in the resident's room. In an interview with the Certified Occupational Therapy Assistant (COTA) on 2/19/25 at 10:48 AM, she confirmed Resident # 6 should have a splinting device on her left hand related to her contracture. She stated if the resident was not wearing it that it could lead to worsening of the contracture. In an interview with the Director of Nursing (DON) on 2/19/25 at 10:50 AM, she confirmed that Resident #6 should have been wearing an anti-contracture device on the left hand to prevent worsening of the contracture. Review of the "Admission Record" revealed the facility admitted Resident # 6 on 8/06/2009 with a diagnosis that included Polyosteoarthritis Unspecified.	M 625	the potential to be affected by the alleged deficient practice. III. An in service was provided with facility nursing staff by the Assistant Director of Nursing on February 19, 2025, regarding applying and monitoring range of motion devices including anti-contracture devices. In service provided with facility nursing staff by the Assistant Director of Nursing on February 19, 2025, regarding facility□s prosthesis and splint policy. On February 19, 2025, a one-on-one education was provided with the Licensed Practical Nurse #1 regarding ensuring placement of devices used to increase and/or prevent decrease in range of motion or mobility by the Administrator. On February 19, 2025, the Occupational Therapist assessed resident #6 hands to determine the need for an anti-contracture device and the Occupation Therapist recommended a splint to the right hand to prevent further contractures. On February 19, 2025, the Occupational Therapist placed an order for replacement anti-contracture devices. On February 19, 2025, a 100% audit was completed by the Treatment Nurse for all residents to identify residents that require anti-contracture devices. The Director of Nursing and Assistant Director of Nursing completed 100% audit of physician orders for range of motion and anti-contracture devices on February 19, 2025, to ensure placement of devices for residents with orders for range of motion devices. IV. The Treatment Nurse will audit all residents of the facility for the need of a device to increase and/or prevent	

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M 625	Continued From page 2 Record review of Resident #6's Section GG: 0115 of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/24 was coded impairment on both sides of the upper and lower extremities.	M 625	decrease in range of motion or mobility and verify placement once per week for four weeks and once per month for two months beginning February 24, 2025. Any adverse findings will be reported to the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning March 17, 2025, for three months.	
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	M1570		3/17/25

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M1570	Continued From page 3 and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interview, record review and facility policy review, the facility failed to implement infection control practices to prevent the possibility of the spread of infection for 2 (two) of sixteen sampled residents. Resident #6 and Resident #7. Findings Include: Review of the facility policy titled, "Infection Prevention and Control Program," revised March 23, 2023, revealed, " ...Equipment Protocol: ...b.) Single-use items must be discarded after use ..." Review of the facility policy titled, "Enteral Tube Medication Administration Procedures," revised July 14, 2015, revealed, "...Procedure: ...10.) Clean feeding syringe..." Review of the facility policy, "Nebulizer Policy" dated 02/06/15 revealed that "...12. When not in use the nebulizer and the tubing should be stored in a zip lock bag..." Resident #6 An observation and interview during medication administration for Resident # 6 on 2/19/25 at 8:35 AM, revealed Licensed Practical Nurse (LPN) #1 administer medications via percutaneous endoscopic gastrostomy (PEG) tube , the PEG became clogged, and LPN #1 removed a de-clogging device from an open package laying on the bedside table and used it to unclog the	M1570	I. Director of Nursing immediately replaced Resident #7 used nebulizer mask and tubing with a new nebulizer mask and tubing and placed into a clean bag. 100% audit by the Director of Nursing and Assistant Director of Nursing of all residents with nebulizer medication treatment orders with nebulizer masks were stored properly on February 19, 2025. 100% audit by Director of Nursing and Assistant Director of Nursing of all residents with a percutaneous endoscopic gastrostomy tube to ensure that no opened declogger package was in the resident rooms on February 19, 2025. 100% residents with a percutaneous endoscopic gastrostomy tube had all percutaneous endoscopic gastrostomy tube syringes replaced with a new percutaneous endoscopic gastrostomy tube syringe inside a sealed bag to ensure proper infection prevention was followed moving forward and stored properly by Director of Nursing and Assistant Director of Nursing on February 19, 2025. Licensed Practice Nurse #1 was provided one-on-one education with the Administrator regarding percutaneous endoscopic gastrostomy tube syringe usage and storage, the use of a one-time use percutaneous endoscopic gastrostomy tube declogger, and the storage of nebulizer masks after each use on February 19, 2025. II. Residents in the facility as identified by	

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M1570	Continued From page 4 PEG. He then put the de-clogging device back into the open package it was removed from. He finished his medication administration and placed the PEG syringe plunger that was used to flush the PEG back into the storage bag without cleaning. LPN #1 confirmed the de-clogger device was in an opened package before using it, and he did not know if it had been used prior. He stated with the package being opened; it was most likely used and confirmed that it was for single use only and should be disposed of after use. LPN #1 then confirmed he should not have used the de-clogger that was in the open package but should have gotten a new one to ensure it was sanitary. Furthermore, he confirmed he failed to clean the PEG syringe plunger before placing it back in the clean storage bag. He stated that using a dirty de-clogger device and failing to clean the PEG syringe plunger could lead to an infection. Review of the manufacturer guidelines for the enteral feeding tube de-clogging devices revealed "Designed for single use only...: In an interview with the Director of Nursing (DON) on 2/19/25 at 10:50 AM, she confirmed that the de-clogging devices are for single use only and should be disposed of after each use. She stated the nurse should not have used the de-clogger in the opened package. She also stated that the PEG syringe plunger should have been cleaned before placing it in the clean storage bag, and both practices could lead to an increased risk of the spread of infection. Record review of the "Admission Record" revealed the facility admitted Resident # 6 on 8/06/2009 with diagnoses that included Encounter for Attention to Gastrostomy.	M1570	the electronic medical record in the computer software system as having a percutaneous endoscopic gastrostomy tube have the potential to be affected by the alleged deficient practice. Residents in the facility as identified by the electronic medical record in the computer software system that receive nebulizer treatments with a nebulizer mask ordered by a physician have the potential to be affected by the alleged deficient practice. III. Inservice provided with the nursing staff by the Assistant Director of Nursing on February 19, 2025, regarding the facility's nebulizer policy and placement of nebulizer masks when not in use to prevent infection. Inservice provided with the nursing staff by Assistant Director of Nursing on February 19, 2025, regarding proper cleaning and storage of a percutaneous endoscopic gastrostomy tube syringe to prevent infection. Inservice provided with the nursing staff by Licensed Nurse Practitioner on February 19, 2025, regarding the use of a percutaneous endoscopic gastrostomy tube declogger and the discarding of device after a single use to prevent infection. Inservice provided with the nursing staff by Assistant Director of Nursing on February 19, 2025, regarding the facility's infection control policy and infection control procedures to be followed. IV. Assistant Director of Nursing and Director of Nursing will audit all residents' rooms with nebulizer treatments ordered by the	

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M1570	Continued From page 5 Record review of Resident #6's Section K Item 0520B of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/24 was coded feeding tube ...PEG; while a resident. Resident #7 An observation on 02/18/25 at 11:45 AM revealed a nebulizer mask on the top of the nightstand next to Resident #7's bed and it was not in a protective storage bag. The mask and tubing were hooked to the nebulizer machine next to it. An observation and interview with Resident #7 on 02/19/25 at 10:15 AM, revealed a nebulizer mask with attached tubing on top of the nightstand next to her bed and it was not in a storage bag. Resident #7 revealed that she received scheduled breathing treatments about three times a day and that she had received one earlier that morning. An interview with Licensed Practical Nurse (LPN) #1 on 02/19/25 at 10:45 AM, revealed that Resident #7 had frequent shortness of breath and that she received scheduled and as needed nebulizer breathing treatments . In an interview and observation with LPN #1 on 02/19/25 at 10:55 AM in Resident #7's room, he confirmed that Resident #7's nebulizer mask with attached tubing was setting on top of the nightstand next to her bed without a covering. He revealed that nebulizer masks and tubing were supposed to be kept in a plastic bag when not in use to prevent the spread of germs which could lead to respiratory infections. LPN #1 revealed that it was the nurses' responsibility to ensure that	M1570	physician to ensure masks are store properly weekly for four weeks, and then monthly for two months beginning the week of February 24, 2025. Assistant Director of Nursing and Director of Nursing will observe two nurses administering percutaneous endoscopic gastrostomy tube feedings or medications to ensure the syringe is cleaned and store properly weekly for four weeks, and then monthly for two months beginning the week of February 24, 2025. Assistant Director of Nursing and Director of Nursing will audit all rooms with residents with a percutaneous endoscopic gastrostomy tube for storage of decloggers to ensure the package remains unopened and the declogger is discarded after one use weekly for four weeks, and then monthly for two months beginning the week of February 24, 2025. Any adverse findings will be reported to the Administrator. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning March 17, 2025, for three months.	

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M1570	Continued From page 6 nebulizer masks and tubing were placed in a protective bag when breathing treatments were completed. An interview with the Administrator on 02/19/25 at 11:00 AM, revealed that nebulizer masks and tubing were supposed to be kept in a plastic protective bag when not in use. She confirmed that failure to properly store nebulizer masks could cause infection. Record review of Resident #7's "Medication Administration Record" revealed that she received Ipratropium-Albuterol Inhalation Solution 0.5-2.5 MG (milligrams)/3ML (milliliters) three times a day related to Acute Respiratory Failure with Hypercapnia with a start date of 01/09/25. Record review of Resident #7's "Admission Record" revealed the facility admitted the resident on 01/09/25 with medical diagnoses that included Acute on Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia and Hypercapnia. Record review of Resident #7's MDS with an ARD of 1/15/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.	M1570		