STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255299	A. BUILDING _____ B. WING _____	02/20/2025

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VINEYARD COURT NURSING CENTER	2002 5TH STREET NORTH COLUMBUS, MS 39705

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F 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 Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F 656, F 688, and F 880. The census at the time of the survey was 54 and the facility held a license for 60 beds.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		3/17/25

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

Electronically Signed | 03/06/2025

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.

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F 656	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a care plan for the use of an anti-contracture device for (1) one of 16 resident care plans reviewed. (Resident #6) Findings include: Review of the facility policy titled, "Care Plans," with an update of 2/20/20 revealed, "Policy: Each resident will have a person-centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care..." Record review of a care plan for Resident #6 revealed, "Focus: (Resident proper name)	F 656	I. 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 place anti-contracture device as ordered for Range of Motion on the comprehensive care plan. II. Residents in the facility as identified by the electronic medical record in the computer software system as having an anti-contracture device for range of motion have the potential to be affected by the alleged deficient practice. III. Inservice was provided with nursing	

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F 656	Continued From page 2 requires assistance with anti-contracture device to left hand", revised 12/11/24, with "Goal ...will have application of anti-contracture...Interventions ...assist with applying for scheduled wearing time ..." An observation of Resident #6 on 2/18/25 at 10:00 AM revealed the resident's left hand was contracted with no contracture device in place. In an interview with the Director of Nursing (DON) on 2/19/25 at 10:50 AM, she confirmed after review of the contracture care plan for Resident #6 that staff did not implement the care plan when they failed to apply the device. She stated the purpose of the care plan is to direct staff of the resident specific care needed. Record review of the "Admission Record" revealed the facility admitted Resident # 6 on 8/06/2009 with medical diagnosis that included Polyosteoarthritis Unspecified. 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.	F 656	staff by Assistant Director of Nursing on February 19, 2025, regarding following the comprehensive plan of care for all physician orders to provide highest level of care and treatment for each resident and where to locate the care plans in the electronic medical record in the computer software system. A 100% audit of comprehensive care plans for anti-contracture devices was completed on February 19, 2025, by Minimum Data Set Coordinator Corporate Nurse to validate all anti-contracture devices are care planned as ordered by the physician. A one-on-one education was provided with the License Practical Nurse #1 regarding following comprehensive care plans for each resident. IV. The Minimum Data Set Coordinator Corporate Nurse will audit 100% residents comprehensive care plan for all residents requiring a device to increase or prevent decrease in range of motion or mobility once per week for four weeks, and then once per month for two months beginning the week of February 24, 2025. The Assistant Director of Nursing will observe two nurses to ensure comprehensive care plans are being followed as ordered by physician for residents requiring a device to increase or prevent decrease in range of motion or mobility weekly for four weeks, and then once per month for two months beginning the week of February 24, 2025. Any adverse findings will be reported to the Administrator.	

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F 656	Continued From page 3	F 656	This plan of correction will be monitored at the monthly Quality Assurance meeting beginning March 17, 2025, for three months.	
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: 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:	F 688	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	3/17/25

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F 688	Continued From page 4 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. 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)	F 688	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 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	

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F 688	Continued From page 5 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. 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.	F 688	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 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.	
F 880 SS=D	Infection Prevention & Control 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	F 880		3/17/25

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F 880	Continued From page 6	F 880		

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 §483.71 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 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

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F 880	Continued From page 7 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 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..."	F 880	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	

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F 880	Continued From page 8 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 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	F 880	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 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	

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F 880	Continued From page 9 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. 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. Surveyor: Wooten, Angela 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)	F 880	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 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.	

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F 880	Continued From page 10 #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 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	F 880	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255299	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

(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 11 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.	F 880		