STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255299	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINEYARD COURT NURSING CENTER	2002 5TH STREET NORTH , COLUMBUS, Mississippi, 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
F0000	INITIAL COMMENTS The State Agency (SA) conducted four (4) Complaint Investigations (CI) MS #2614098, CI MS #2614922, CI MS #2614963, and CI MS #2625345 at the facility from 9/22/25 through 9/23/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA investigated CI MS #2614963 for quality of care related to not positioned timely, resident rights, and hydration, CI MS #2614098 for verbal abuse, CI MS #2614922 related to abuse, misappropriation, positioning of resident, and neglect and CI MS #2625345 for verbal abuse. The SA cited F550 related to resident rights for all four complaint investigations. The census at the time of the survey was 50 with a license for 55 beds.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550		

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 reverse for further 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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F0550 SS = D	Continued from page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and resident representative interviews, staff interviews, record review, and facility policy review, the facility failed to ensure each resident was treated with dignity and respect by the use of inappropriate language and by not providing privacy during care for two (2) of five (5) residents sampled. Resident #1 and Resident #4 Findings include: Record review of facility policy titled, “Resident Rights” with date of 2022, revealed, “The resident has the right to a dignified existence … 4. The resident has a right to be treated with respect and dignity”. Resident #1 An observation of facility’s video footage with the Administrator and an interview with the Administrator on 9/22/25 at 1:05 PM revealed Resident #1 in her wheelchair in the hallway and Certified Nursing Assistant (CNA) #1 leaned the resident forward in her wheelchair and looked in the back of the resident’s brief in a common area where other residents were present. The Administrator stated this treated the resident “like she was a child.” A phone interview on 9/22/25 at 1:12 PM with Certified Nursing Assistant (CNA) #1 revealed that while she and Resident #1 were in the hallway, she looked in the back	F0550		

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F0550 SS = D	Continued from page 2 of the resident's brief to see if she had diarrhea. She stated she felt that the resident was far enough in the doorway of the room to not be visible to anyone in the hall. She acknowledged that each resident should receive their care in privacy, and checking Resident #1's brief in the hallway did not respect her dignity. She confirmed that she had been in-serviced on dignity, respect, resident rights, and the need to provide care in privacy. During an interview on 9/23/25 at 11:30 AM, the Administrator acknowledged it was her expectation that resident care be done in privacy. She confirmed the facility failed to ensure each resident was treated with dignity and respect when the care of Resident #1 was provided in the hallway. Record review of CNA #1's Resident Rights training dated 2/27/24. Review of Resident #1's "Admission Record" revealed she was admitted to the facility on 5/24/25, with medical diagnoses that included Congestive Heart Failure, Type 2 Diabetes Mellitus, and Encephalopathy. Record review of Resident #1's Brief Interview for Mental Status (BIMS) score dated 7/22/25, revealed a score of 6 which indicated a severe cognitive impairment. Resident #4 During a phone interview on 9/22/25 at 3:20 PM, the resident's representative stated she and her sister brought the resident back to the facility after an outing and the resident was near the nurses' station when Certified Nursing Assistant (CNA) #2 came up to her and told her to, "Back your a** up". She stated this was disrespectful and unprofessional and upset the resident. She acknowledged that caregivers in a nursing facility should be held to a higher standard and that should be upheld. On 9/22/25 at 8:30 PM, CNA #2 returned phone call for an interview with the State Agency (SA) and during the interview, she acknowledged that when Resident #4 returned to the facility with her food, she asked her if she had brought her some food and the resident said she did not. She stated she told the resident, "Then just turn your a** around and get out of here." She stated she was joking and did not mean to cause any bad feelings to the resident with her language, but she now realized that speaking to a resident that way was	F0550		

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F0550 SS = D	Continued from page 3 disrespectful. She stated she did not know that a** was a curse word and should not be used in the facility. She acknowledged that she was in-serviced by the Administrator about not using profanity at work. She stated she had been in-serviced on dignity, respect, and resident rights and she was wrong to use disrespectful language to a resident. An interview with Resident #4 on 9/23/25 at 9:20 AM, revealed the incident occurred when she and her daughters returned to the facility from going out to eat and she had a bag of food with her. She was near the nurses' station and CNA #2 asked, "Did you bring me some food" and when I said I did not, CNA #2 told her, "Well get your a** back out of here". This was heard by staff members, other residents, and her 12-year-old and 24-year-old daughters. She stated that this employee uses inappropriate language frequently when speaking with her. Once, she had not eaten much of her food and CNA #2 came to pick it up and commented that she did not eat much. She told her that she did not have much of an appetite and CNA responded with, "I know the h*** you don't. You're not eating any d*** food". She stated she was a minister and evangelist and did not use curse words. She acknowledged it was not respectful, and it was embarrassing to be spoken to that way, especially when her children were with her. She acknowledged that bad language was heard in other places, but for a care giver at work in a nursing facility to curse so easily and use such disrespectful language when speaking to residents was not appropriate or professional. She stated the staff members at a nursing facility were held to a higher standard and they should not curse in front of the residents or residents' families. During an interview on 9/23/25 at 11:30 AM, the Administrator acknowledged that it was her expectation that each resident be treated with dignity and respect. She confirmed the facility failed to honor the resident's right to be treated with dignity and respect when a staff member used profanity to a resident. Record review of CNA #2's Resident Rights training dated 7/15/25. Record review of "Admission Record" revealed the resident was admitted to the facility on 7/8/25 with medical diagnoses that included End Stage Renal Disease and Type 2 Diabetes Mellitus. Record review of BIMS dated 7/14/25, revealed a score of 15 which indicated the resident was intact cognitively.	F0550		