STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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 state licensure regulations Minimum Standards for Institutions for the Aged and Infirm. The SA investigated CI MS #2614963, CI MS #2614098, CI MS #2614922 and CI MS #2625345 for residents rights and cited M500 for resident rights. The census at the time of the survey was 50 with a license for 55 beds.	M0000		
M0500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse	M0500		

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

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M0500	Continued from page 1 practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility	M0500		

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M0500	Continued from page 2 must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending	M0500		

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M0500	Continued from page 3 physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level II Based on observation, resident, resident representative, and 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 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.	M0500		

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M0500	Continued from page 4 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 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	M0500		

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M0500	Continued from page 5 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.	M0500		