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 _____	05/19/2022

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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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 5/16/2022 through 5/19/2022. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F641 for resident assessment after a significant change, F644 for Pre Admission Screening and Resident Review (PASSAR) and F880 related to infection control all at a D level. The census was 46 and the facility held a license for 55 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility policy review, and staff interviews, the facility failed to accurately complete a Minimum Data Set (MDS) Significant Change Assessment, for a hospice resident for one (1) of 1 hospice residents reviewed. Resident #36. Findings include: Review of facility policy titled, "MDS Assessment," with no date, revealed, "Policy: The facility shall conduct and interdisciplinary assessment using the MDS assessment as defined by Federal/State regulations. This assessment provided information on the resident's condition to facility development of a plan of care and is a means by which the facility can track changes in a resident's status ... 3. A significant change assessment is	F 641	I.The Significant Change Minimum Data Set for Resident #36 with Assessment Reference Date of 12/14/2021 was reviewed on 05/18/2022 by the facility Minimum Data Set Coordinator. A modification assessment for Resident #36 Significant Change Minimum Data Set Assessment Reference Date 12/14/2021 was completed on 05/18/2022 by the facility Minimum Data Set Coordinator and resubmitted. II. Residents in the facility as identified by the electronic medical record in the computer software system as receiving hospice services have the potential to be affected by the alleged deficient practice.	6/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2022

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F 641	Continued From page 1 defined as a change in the resident's status that: a. Impacts on more than one area of the resident's health status and is not self-limiting..." Record review of Section "O" of the Minimum Data Set (MDS) Significant Change Assessment, dated 12/14/21, for Resident #36 revealed hospice was unchecked as a special service provided. An interview on 05/18/22 at 9:53 AM, with the Minimum Data Set (MDS) Nurse and record review of Section "O" of the MDS Significant Change Assessment, dated 12/14/21 confirmed that hospice was not captured as the significant change and confirmed that the physician's order for admission to hospice was written on 12/8/21, for Resident #36. The MDS Nurse revealed the MDS Significant Change Assessment dated 12/14/21, was completed because resident was admitted to hospice, but she failed to select the hospice section to indicate the significant change in status. The MDS Nurse revealed that the MDS Significant Change Assessment should have been completed correctly on 12/14/21 to reflect the status of Resident #36. On 5/18/22 at 09:57 AM, an interview with the Administrator and record review of Section O" of the MDS Significant Change Assessment dated 12/14/21, confirmed that Section "O" was not completed correctly to reflect Resident #36's status change of hospice, for the hospice order that was written on 12/8/21. The Administrator also confirmed that the MDS Significant Change Assessment, dated 12/14/21, should have been completed correctly to reflect Resident #36's correct medical status and to allow the nursing staff to be able to track Resident #36's change in	F 641	III. The Minimum Data Set Coordinator was educated on completion of Significant Change Assessments and correct coding of Section O0100K Hospice Services on 05/19/2022 by the facility Administrator. IV. A complete facility audit of Section O0100 of the Minimum Data Set was completed by the facility Administrator on 05/20/2022 for review of accurate coding. One error identified on the audit was corrected and resubmitted by the Minimum Data Set Coordinator on 05/20/2022. The Director of Nursing will audit five residents Minimum Data Set Section O0100 once per week for four weeks, and then five residents Minimum Data Set Section O0100 once per month for two months beginning the week of 05/23/2022. Findings of the audit will be reviewed with the facility Administrator upon completion and then presented monthly to the facility Quality Assurance Committee for further review and recommendation to ensure ongoing compliance beginning June 2022 x 3 months.	

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F 641	Continued From page 2 medical status. Record review of the "Physician Order List" with an order and start date of 12/8/21 revealed "Admit to (Agency Name) Hospice services." Record review of the Face Sheet revealed Resident #36 was admitted to the facility on 8/6/09 with diagnosis of Alzheimer's Disease with late onset.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interviews, the facility failed to submit a Change in Status Form for a Preadmission Screening and Resident Review (PASARR) Level	F 644	I.Preadmission Screening and Resident Review (PASARR) for Resident #46 reviewed by Administrator on 05/18/2022. Change in Status Request Form	6/10/22

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F 644	Continued From page 3 II Assessment request as evidenced by no Change in Status Form in the medical record for one (1) of four (4) residents reviewed for PASARR Level II. Resident #46. Findings include: Review of the facility policy titled Resident Assessment-Coordination with PASARR Program, revised 1/2/2020, revealed, "Policy: This facility coordinates assessments with the Preadmission Screening and Resident Review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs...Policy Explanation and Compliance Guidelines...4. The Social Service Director shall be responsible for keeping track of each residents PASARR screening status and referring to the appropriate authority...6. Any level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review..." Record review of the medical record for Resident #46 regarding a change in status submission for Resident #46's geriatric psychiatric hospital admission, dated 7/21/21, revealed that there was not a copy of a completed Change in Status Form or a copy of a PASARR II response letter in Resident #46's medical record. An interview on 5/18/22 at 08:40 AM, with the Administrator confirmed there was not a copy of a completed Change in Status Form or a copy of a PASARR II response letter from the state mental health service agency in Resident #46's medical	F 644	completed and submitted to the appropriate agency on Resident #46 by the Social Services Director on 05/18/2022. II. All residents in the facility as identified by the electronic medical record in the computer software system have the potential to be affected by the alleged deficient practice. III. Current Social Services Director inserviced by the facility Administrator on PASARR requirements and completing Change in Status Requests on 05/19/2022. IV. A complete facility audit of PASARR changes completed by the Director of Nursing on 05/31/2022. Weekly audit of transfers, diagnosis changes, and medication changes will be completed by the Medical Records Nurse weekly x four weeks then monthly x 2 months beginning the week of 05/23/2022 to identify residents requiring Change in Status Requests. Any residents identified will be reported to Social Services Director for completion and submission of the Change in Status Request form to the appropriate agency. Findings of the audit will be reviewed with the facility Administrator upon completion and then presented monthly to the facility Quality Assurance Committee for further review and recommendation to ensure ongoing compliance beginning June 2022 x 3 months.	

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F 644	Continued From page 4	F 644		

record related to the geriatric psychiatric hospital admission dated 7/21/21. The Administrator confirmed the Change in Status Form was not completed and should have been submitted to the state mental health agency to initiate a request for a possible PASARR Level II Assessment from the state mental health agency that would have possibly provided recommendations for needed psychiatric care in the nursing facility.

An interview on 5/19/22 at 11:00 AM, with the Social Worker revealed she was not aware that Resident #46 did not have a Change in Status Form submitted for the geriatric psychiatric hospital admission on 7/21/21. Social Worker confirmed the Change in Status Form should have been submitted to the state mental health agency.

Record review of the Face Sheet for Resident #46 revealed an admission date of 5/14/21.

Record review of the "Diagnosis/History" for Resident #46, revealed a diagnosis of an Unspecified Mood (affective) Disorder with on an onset date of 7/21/21.

Record review of Section A of the Minimum Date Set (MDS) Discharge Assessment dated 7/21/21, for Resident #46, revealed Unspecified Mood (affective) Disorder as an active diagnosis, and revealed a discharge status of psychiatric hospital.

Record review of the "Physician Order List," revealed the physician's order, "Evaluation and treatment at (facility name) for behavioral issues," dated 7/21/21.

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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 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 §483.70(e) 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:	F 880		6/10/22

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F 880	Continued From page 6 (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 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 observations, facility policy review, and staff interviews, the facility failed to prevent the likelihood of cross contamination as evidenced by a Certified Nursing Assistant (CNA) not using hand sanitizer during the ice pass when going in and out of residents rooms and placing the ice scoop inside the ice cooler on top of the ice for one (1) of four (4) days of survey. Findings include:	F 880	I.Certified Nursing Assistant #4 was inserviced on handwashing and following Infection Control procedures by the Assistant Director of Nursing on 05/17/2022. Certified Nursing Assistant #4 was observed performing handwashing checkoff by the Assistant Director of Nursing on 05/17/2022. Ice Scoop Caddy ordered by Dietary Manager on 05/16/2022 and was installed	

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F 880	Continued From page 7 Review of the facility policy titled, "Hand Washing," obtained from, "Source: See CDC (Centers for Disease Control) Guideline for Isolation Precautions: Preventing Transmissions of Infectious Agents in Healthcare Settings 2007," revealed, Policy: Staff will use proper hand washing technique to prevent the spread of infection ... Equipment: ... 4. Alcohol base hand rub as indicated by facility ... B. Hand Sanitizer ... 1. Apply alcohol-based hand rub to the palm of one hand ... 2. Rub hands together, covering all surfaces of hands and fingers until hands are dry." The Administrator provided documentation on the facility's letterhead, dated 5/17/22, noting, "Current Handwashing Policy for facility presented. Policy is being reviewed and updated presently by Director of Operations." An observation of the ice pass for three (3) of 14 resident rooms on the east wing nursing unit on 05/16/22 at 10:55 AM, revealed Certified Nurse Aide (CNA) #4, took a resident's water pitcher back in room #11, then exited the room, and did not use hand sanitizer. CNA #4 was then observed to push the ice cart to room #13, entered the room without use of hand sanitizer, brought the resident water pitcher out of the room to the ice cart, then opened the ice cooler's top, picked the scoop up off of the ice inside the cooler, scooped ice into the resident water pitcher, then dropped the ice scoop back inside the cooler on top of the ice, closed the ice cooler's top, placed the top back on the resident water pitcher, walked back into the resident room to put the water pitcher back on the over-the-bed table, and then exited the room without the use of hand sanitizer. CNA #4 was again observed to push the ice cart to room #14, entered the room without use of hand sanitizer, picked up the	F 880	by the Maintenance Supervisor onto the hydration cart on 05/20/2022. II. All residents who receive ice in the facility have the potential to be affected by the alleged deficient practice. III. Facility Staff inserviced on handwashing and following Infection Control procedures by the Assistant Director of Nursing on 05/16/2022. Facility Staff observed performing handwashing checkoffs beginning on 05/16/2022-05/31/2022 by the Assistant Director of Nursing. Facility Nursing Staff inserviced on Infection Control procedures for hydration pass on 05/20/2022 by the Assistant Director of Nursing. A Root Cause Analysis was conducted with the assistance of the Infection Preventionist/ Director of Nursing and the Quality Assurance and Performance Improvement Committee on 05/31/2022. Staff training was provided on infection control and prevention using the online CDC COVID 19 Clean Hands Video and the CDC COVID 19 Sparkling Surfaces Video beginning on 05/30/2022-06/02/2022. IV. Assistant Director of Nursing will observe Certified Nursing Assistants perform handwashing on five residents weekly x four weeks then monthly x 2 months beginning the week of 05/23/2022. Director of Nursing will observe Certified Nursing Assistants perform handwashing	

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F 880	Continued From page 8 resident's pitcher from the stand in the corner, entered the resident bathroom with the pitcher, immediately exited the bathroom with the resident water pitcher in hand, exited the room, and approached the ice cart. CNA #4 opened the ice cooler's top, picked the scoop up from inside the cooler, filled the resident water pitcher with ice, dropped the scoop back into the ice cooler on top of the ice, closed the top of the cooler, placed the top back on the resident water pitcher, took the water pitcher back in the resident room, exited the room without the use of hand sanitizer, grabbed the handle of the cart, and attempted to move to the next resident room. An interview on 5/16/21 at 11:00 AM, with CNA #4 confirmed she did not use hand sanitizer when she entered and exited rooms #11, #13, and #14, for ice pass and that she had dropped the ice scoop into the ice cooler on top of the ice. CNA #4 revealed she had been in-serviced on proper hand hygiene in January 2022. CNA #4 revealed she should have used hand sanitizer between each resident because she could passed germs that can make a resident sick. CNA #4 confirmed she had contaminated the ice cart, that included the ice cooler, the ice scoop, and the ice. CNA #4 also confirmed the ice needed to be thrown out, and the resident water pitchers, the ice cart, the ice cooler, and the ice scoop needed to be cleaned and sanitized before the ice pass continued. An interview on 5/16/22 at 11:05 AM, with the Director of Nursing (DON), confirmed CNA #4 should have used hand sanitizer between each resident room during ice pass. The DON also confirmed that the absence of the use of hand sanitizer and the scoop being placed in the cooler	F 880	and complete hydration pass for Infection Control procedures on five residents weekly x four weeks then monthly x 2 months beginning the week of 05/23/2022. Findings of the audit will be reviewed with the facility Administrator upon completion and then presented monthly to the facility Quality Assurance Committee for further review and recommendation to ensure ongoing compliance beginning June 2022 x 3 months.	

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F 880	Continued From page 9	F 880		

with the ice could possibly cause a risk of infection and cross contamination for the residents. The DON revealed that there are in-services held weekly, with the nursing staff, regarding hand hygiene.

An interview on 5/16/22 at 11:08 AM, with the Administrator, revealed she confirmed the CNA #4 should have used hand sanitizer, between each resident room during the ice pass. The Administrator confirmed that CNA #4 did contaminate the ice cart, that included the ice cooler, the ice scoop, and the ice. The Administrator revealed that CNA #4 should have placed the ice scoop in its holder and not in the ice cooler. The Administrator also confirmed that CNA #4 could have caused possible cross contamination and possible infection for the residents due to not following infection control standards during the ice pass.

An interview on 5/19/22 at 11:00 AM, with the Staff Development Nurse, confirmed that CNA #4 should have used hand sanitizer or washed her hands with soap and water, between each resident during the ice pass, should not have placed the ice scoop inside the ice cooler, did contaminate the ice with the scoop being placed in the cooler, and could have possibly passed off infection to other residents.

Record review of staff in-service on hand hygiene with the date of 1/31/22 revealed CNA #4 attended the hand hygiene in-service. Record review revealed the in-service included "Infection Control/Universal Precautions ... CNA skills check-off ... handwashing." A copy of the hand washing policy was also provided as an in-service topic, that included instructions on how to use

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F 880	Continued From page 10 hand sanitizer.	F 880		