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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47157 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) 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.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47157 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. 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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47157 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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: [NAME], [NAME] 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 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. 45598