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 08/27/2025

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 two (2) Complaint Investigations (CI) MS #491260 and CI MS #2585966 at the facility from 8/26/25 through 8/27/25. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA investigated CI MS #491260 related to discharge rights and quality of care and cited F689. The SA investigated CI MS #2585966 related to resident neglect and quality of care related to pain medication and cited F755. The census at the time of the survey was 52 with a license for 55 beds.	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to adequately supervise residents during smoking breaks which allowed residents to smoke marijuana for two (2) of three (3) residents reviewed for smoking. Resident #1 and #2 Findings include: Record review of facility policy titled, “Resident Smoking” dated 10/24/22, revealed, “It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including	F0689		

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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F0689 SS = D	Continued from page 1 safety as related to smoking… 8. Any resident who is deemed safe to smoke will be allowed to smoke under supervision in designated smoking areas..." During an interview on 8/26/25 at 3:35 PM, Resident #1 revealed he was a smoker and would smoke during scheduled smoke breaks. He stated he was outside smoking with other residents and Resident #2 was smoking marijuana and gave the joint to him to smoke. He stated he had a drug problem in the past and did not refuse the joint even though he knew he should not have smoked it. He revealed the facility should have kept it out, so he was not tempted to use it. Attempted to interview Resident #2 on 8/26/25 at 4:05 PM, resident was alert and able to nod head to answer questions, but speech was limited at the time of interview. Nodded yes to the question of whether he was a smoker and was able to smoke during the scheduled times. When asked about an incident involving marijuana, he smiled but did not respond in any other way. During an interview with Certified Nursing Assistant (CNA) #1 on 8/27/25 at 10:50 AM, it was revealed that she and CNA #2 were outside supervising the smoking residents, and she smelled marijuana. She saw Resident #2 passing a joint to Resident #1 who put it to his mouth and took puffs of it. She did not see how Resident #2 lit this since his back was towards her. CNA #2 stated that she went inside to immediately to report this incident. An interview with CNA #2 on 8/27/25 at 11:00 AM revealed she and CNA #1 were outside with the smokers and she smelled marijuana. She saw Resident #2 passing the marijuana to Resident #1, but since Resident #2's back was towards her, she did not see him light this. She stated she went inside to report and have additional staff in the area, and they convinced Resident #2 to give the joint to them. During an interview on 8/27/25 at 9:45 AM and an interview and observation on 8/27/25 at 1:30 PM, the Administrator revealed that Resident #1 and Resident #2 were smoking marijuana during smoke break and from questioning the residents and staff and watching camera footage, it was determined that Resident #2 had the marijuana joint and lit it from his cigarette and he shared this with Resident #1 who took several puffs of it. Resident #1 told her he was an addict, and he would take what was offered to him. She stated from the camera view, only Resident #2's back was showing, so they could not see what he was doing in front of him,	F0689		

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F0689 SS = D	Continued from page 2 but they were able to see that Resident #2 passed the lit joint to Resident #1 and Resident #1 put it to his mouth and took a few puffs from it. The staff members then approached those residents and Resident #2 gave it to them. During the smoke break observation, the Administrator pointed out that Residents #1 and #2 were on the far end of the smoking area with Resident #2 positioned facing the parking lot with his back towards the other residents, staff, and camera. Resident #1 was on the side and facing Resident #1. The staff were positioned in the center of the area and only had a view of Resident #2's back. The Administrator confirmed the staff should have been positioned on each end of the rectangular area to offer a better view of all of the residents to ensure safety. She confirmed the facility failed to provide adequate supervision during smoking break and due to this a resident was able to light a marijuana joint, smoke it, and pass it to another resident who also smoked it. Review of Resident #1's "Safe Smoking Evaluation" dated 3/21/25, 4/10/25, and 6/6/25 revealed the box by "Resident is safe to smoke unsupervised at this time" was not checked. Record review of Resident #1's "Admission Record" revealed he was admitted to the facility on 3/1/23 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction and pain. Record review of Resident #1's Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 6/16/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Review of Resident #2's "Safe Smoking Evaluation" dated 4/10/25, 8/14/25, and 8/27/25 revealed the box by "Resident is safe to smoke unsupervised at this time" was not checked. Record review of Resident #2's "Admission Record" revealed resident was admitted to facility on 3/3/25 with diagnoses that included cerebral infarction. Record review of Resident #2's MDS Section C with ARD of 6/4/25 revealed a BIMS score of 14 which indicated the resident was cognitively intact.	F0689		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F0755		

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F0755 SS = D	Continued from page 3 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to provide an ordered pain medication for a resident who had pain for one (1) of four (4) residents reviewed. Resident #1 Findings include: Record review of facility policy titled, “Pharmacy Services” dated 3/14/24, revealed, “It is the policy of this facility to ensure that pharmaceutical services, whether employed by the facility or under an agreement, are provided to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice”. Record review of facility policy titled, “Medication	F0755		

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F0755 SS = D	Continued from page 4 Shortages/Unavailable Medications" with revision date of 1/1/13, revealed, "Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from Pharmacy…2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose…". During an interview and observation on 8/26/25 at 3:35 PM, Resident #1 appeared comfortable in his room lying in his bed. He stated he had pain in his back and his feet, but was comfortable at that time. He stated he recently requested pain medication for the pain in his back and feet and he was told by the nurse that he did not have pain medication and he would have to wait until it arrived at the facility. During a phone interview on 8/27/25 at 11:15 AM, Licensed Practical Nurse (LPN) #1 revealed she was working the medication cart on the evening that Resident #1 requested pain medication, and it was unavailable. She informed him that the medication was unavailable, and he could not receive it at that time, but he did receive his other medications as scheduled. She stated she had another resident with a medical concern and got distracted by that issue and failed to follow through with obtaining the medication as needed and ordered. She acknowledged she "dropped the ball" and that it was "my mistake" and took full responsibility for not obtaining the medication as needed. Interviews with the Administrator on 8/27/25 at 9:45 AM and at 1:30 PM revealed the facility had a procedure in place to ensure each resident received the medications needed and ordered, but this procedure was not followed by LPN #1. She stated the resident had an active prescription and the nurse should have contacted the pharmacy for a code to the medication dispensing system to obtain the medication to administer to the resident. She confirmed the facility failed to provide an ordered pain medication for a resident who had pain. She confirmed the medication system was in place, but the staff member did not follow the procedure, therefore, the medication was not administered. Record review of Resident #1's "Order Summary Report" revealed an order for Hydrocodone-Acetaminophen tablet 7.5-325 milligrams – give one tablet by mouth every four hours as needed for severe pain. Record review of Resident #1's "Controlled Substances	F0755		

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F0755 SS = D	Continued from page 5 Proof of Use" with received date of 6/19/25 revealed resident completed a card of Hydrocodone 7.5-325 on 8/9/25 at 8:48 PM. Record review of Resident #1's "Controlled Substances Proof of Use" with received date of 8/12/25 revealed the facility received Hydrocodone 10-325 on that date. Record review of Resident #1's Electronic Medication Administration Record (EMAR) for August 2025 revealed resident received his as needed Hydrocodone on 8/9/25 at 8:48 PM then did not receive again until 8/11/25 at 12:50 PM. Record review of Resident #1's "Admission Record" revealed he was admitted to the facility on 3/1/23 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction and pain. Record review of Resident #1's Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 6/16/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F0755		