STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255283	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vaiden Community Living Center	868 Mulberry Street Vaiden, MS 39176

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure the safety of one (1) of four (4) residents reviewed for safe transport (Resident #1), when staff failed to secure the resident's wheelchair with the appropriate safety belts while being transported in the facility van. This failure resulted in the resident sustaining a sternal fracture and a head laceration with bleeding after her unsecured wheelchair tipped over during transport, causing her to fall to the floor of the van. Resident #1 Due to corrective actions implemented prior to State Agency (SA) entrance on 6/18/25, this was determined to be Past Non-Compliance as of 4/30/25. Findings Include: Review of the facility policy titled How to Properly Secure a Wheelchair for Transportation signed and dated by Certified Nurse Assistant (CNA) #1 on 01/03/2025 read . Wheelchair securement systems allow the wheelchair user to drive or ride in a vehicle as safely as anyone else. Securement systems lock the wheelchair in place either with tie-down straps or a mechanical docking device. Securement systems are primarily used in wheelchair accessible vans to safely secure the user in his power chair or wheelchair while the vehicle is in motion. The policy contains a picture diagram of the lap and cross body safety belts and the floor anchorages and pictured the proper way to fasten the residents in the van.´ The policy included diagrammed instructions for securing residents in the van. Review of the facility policy titled Fleet Safety Policy signed by CNA #1 and dated 01/03/2025 revealed, The purpose of this policy is to ensure the safety of those individuals who drive company vehicles. Vehicle accidents are costly to our company, but more importantly they may result in injury to you or others. It is the driver's responsibility to operate the vehicle in a safe manner and to drive defensively to prevent injuries and property damage . (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 6/18/25 at 10:15 AM, the Administrator (ADM) confirmed Resident #1 was being transported to a medical appointment on 4/28/25 when the wheelchair flipped in the van, throwing the resident to the floor. The van driver pulled to the side of the road and called 911. The van driver (CNA #1) did not notify the facility. The facility was alerted by the emergency room (ER) when Resident #1 arrived with injuries. Resident #1 sustained multiple head lacerations requiring staples and a nondisplaced sternal fracture, per the ER report dated 4/28/25. The facility ADM and the Director of Nursing (DON) attempted to call the van driver on her cell phone on numerous occasions in the afternoon of 4/28/25 and received no contact with the van/bus driver. At approximately 4:00 PM on 4/28/25 the van/bus driver returned to the facility in the van/bus. CNA #1 then gave a written statement to the ADM and DON and confirmed that she had not properly fastened the wheelchair to the van/bus safety belts and had not positioned the wheelchair properly inside the van/bus. CNA #1 was terminated from employment for not following the facility policy for van/bus safety that caused the fall with injuries to Resident #1. Record review of the typed statement of the facility Administrator (ADM) dated 4/28/25 revealed: Administrator (name of ADM) interviewed employee (name of CNA #1) van driver regarding incident that occurred in the van. (CNA #1) stated I buckled her at the bottom, but I didn't put the seatbelt on. An attempted phone interview on 6/18/25 at 12:30 PM with CNA #1 resulted in no answer and no voice mail. Record review of the handwritten statement of CNA #1 dated 4/28/25 revealed: I (name of CNA #1) was transporting a pt. (patient) to an appt. (appointment) at 1:15 PM on hwy (Highway)82. I heard her yell I pulled over once I found a safe place. Pt. wheelchair had flipped over. I called 911, put a diaper under her head to stop the bleeding. Police and EMT's (Emergency Medical Technicians) arrived I waited I followed them to the hospital. Signed by (name of CNA #1). Record review of the ER report dated 4/28/25 at 2:12 PM documented a 3 (three) cm (centimeter) occipital scalp laceration (closed with four staples), a second 2 (two) cm laceration (closed with two staples), and a confirmed sternal fracture. Resident #1 was hospitalized for additional medical conditions and passed away on 5/03/25 due to acute renal failure, per the death certificate. Record review of the death certificate of Resident #1 dated 5/3/25 and signed by the corner on 5/6/25 listed cause of death in the hospital as Renal Failure. An interview and observation on 6/18/25 at 11:00 AM with CNA #2 loading Resident's #2, #3 and #4 into the van for transportation to dialysis confirmed that CNA #2 properly affixed lap and floor belts on three dialysis residents and demonstrated knowledge of policy-compliant securement procedures. Interviews with Residents #2, #3, and #4 confirmed consistent and safe practices during van transportation. An interview on 6/18/25 at 11:30 AM with the Maintenance Director stated that he inspected the van after the incident and found that the floor stabilizers had not been affixed and the lap belt had not been used. He confirmed that CNA #1 had been previously trained and provided his weekly safety check documentation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the Quality Assurance Committee (QA) meeting's sign-in sheet dated 4/29/25 revealed that all members were present at the QA meeting on 4/29/25 to review the incident that occurred on 4/28/25. Record review of the admission Record of Resident #1 revealed that the facility admitted the resident on 3/18/25 with medical diagnoses that included Heart Failure, Chronic Obstructive Pulmonary Disease (COPD) and Chronic Kidney Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/15/25 revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that the resident was cognitively intact. The State Agency (SA) validated through interview and record review on 6/18/25 that the facility began with immediate action of van safety in-service for all authorized drivers, van and seat belt safety inspection, conducted a full investigation and terminated CNA #1. Monitoring to be performed by the ADM and DON to ensure Wheelchair Securement System in proper working order 2 times a week for 2 weeks, then 1 time per week for 2 weeks, then monthly for 3 months. This deficiency was cited as Past Noncompliance at actual harm level, corrected prior to the survey entrance.