

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  255283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2026
NAME OF PROVIDER OR SUPPLIER  Vaiden Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on record review, interview, and facility policy review the facility failed to provide written notice of an involuntary discharge including appeal rights prior to refusing readmission from the hospital for one (1) of three (3) resident reviewed. (Resident #1). Findings Included:Record review of the facility policy titled, Transfer Form, revealed Policy Statement, It is the policy of this facility to provide a completed and accurate transfer form to residents transferred or discharged from this facility .Record review of the facility policy titled, Appealing a Transfer or Discharge Notice revealed Policy Statement, Residenta have the right to appeal transfer or discharge notices.2. Upon notice of transfer or discharge, the resident will be provided with a statement of his or her right to appeal the transfer or discharge.Record review of Progress Notes dated 12/31/25, revealed Resident #1 left the facility at 2:30 PM by facility van to be admitted to [Proper name for psychiatric hospital] for evaluation.Record review of Progress Notes for Resident #1, dated 1/6/26, revealed resident had been discharged from the facility due to aggressive behavior. Further review revealed per conversation with [Proper name for psychiatric hospital], the Administrator and Social Services Director would assist in finding placement for the resident as well as home health if needed. Documentation further indicated that due to threats made, the facility stated it was unable to meet the resident's needs.Record review of Progress Notes for Resident #1, dated 1/6/26, revealed the facility communicated with the resident's family regarding not allowing the resident to return to the facility.Record review of Progress Notes for Resident #1, dated 1/6/26, and interview with the Administrator on 03/24/26 at 10:00 AM, revealed she spoke with the Geri-psych facility on 01/06/26, and they agreed to assist with finding the resident alternative placement. The Administrator revealed she spoke with the resident's family and informed them the resident would not be able to return to the facility. The Administrator verified that the resident and family were not provided a formal involuntary discharge notice and were not provided rights to appeal. The Administrator further verified she could not locate a physician order for discharge. The Administrator stated the formal notice and right to appeal should have been provided and the facility should have obtained a physician order prior to discharge.Record review of the admission Record revealed that the facility admitted Resident #1 on 12/14/21 with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction.</p>

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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