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	10/17/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, resident and staff interviews, and facility policy review, the facility failed to create a clean and safe environment, as evidenced by a dirty wheelchair (Resident #27) and an overbed table and bed headboard in disrepair (Resident #34) for two (2) of the 20 residents sampled. Findings Include: A review of the facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment with a revised date of August 2009 revealed that resident-care equipment, including reusable items and durable medical equipment, will be cleaned . Resident #27 On 10/15/24 at 9:20 AM, an observation revealed Resident #27 was sitting on his bed and his overbed table and headboard were noted to be in disrepair. Resident #27 was not interviewable. His overbed table had the plastic strip edging missing from all four sides and had rough jagged edges exposed. Resident #27's headboard on his bed was unsteady and the upper part of the headboard leaned inward at an eighty-degree angle over his mattress and pillow and revealed that the bed frame and bed was unsteady. On 10/16/24 at 10:39 AM, during an interview with Assistant Director of Nursing (ADON), she confirmed that the headboard on Resident #27's bed and his over bed table were in disrepair and needed attention. She confirmed the rough, jagged edges on his over bed table and revealed that this could cause lots of issues including wood splinters in the skin and skin tears. ADON also confirmed that Resident #27's headboard was unsteady, that it leaned inward over the mattress and needed to be fixed. She revealed that she was not aware of these issues, that no one had reported them to her, and that she would notify maintenance. She revealed that they had a maintenance logbook at the nurses desk and any issues they had, they documented in the book and also reported them verbally to the Maintenance Director. ADON confirmed that Resident #27's headboard nor the bedside table had been recorded in the maintenance logbook prior to her observation. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 10:46 AM, an observation and interview with the Maintenance Director in Resident #27's room revealed that he had worked there since August 2024, and that the staff usually reported to him verbally and logged any concerns or needed repairs on a Maintenance Work Order form in the maintenance logbook which he checked every morning. He confirmed that Resident #27's headboard was unsteady and was leaning inward over the mattress and needed to be fixed or replaced. He revealed that no one had reported this concern to him, and that if he didn't know about it, he couldn't fix it. Record review of the Maintenance Work Order form revealed that Resident #27's broken headboard was recorded in the maintenance logbook after the concern was identified on 10/16/24. Record review of Resident #27's Admission Record revealed an admitted [DATE]. Record review of Resident #27's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/03/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 06 which indicated that he had severe cognitive deficits. 46013 Resident #34 An observation on 10/15/24 at 10:40 AM and again at 3:00 PM revealed Resident #34 sitting in her wheelchair. A thick gray substance was noted on the frame of the wheelchair and on the spokes of the wheels. An observation and interview on 10/16/24 at 9:25 AM, revealed Resident #34 sitting in her wheelchair, which remained dirty and unchanged from the previous day. Resident #34 revealed she wasn't sure when they cleaned the wheelchairs, but it was dirty and needed to be cleaned. In an interview on 10/16/24 at 11:45 AM, Certified Nursing Assistant (CNA) #1 revealed that the night shift CNAs are responsible for cleaning the wheelchairs, but if any of us notice that they are dirty, we can also clean them off. During an observation and interview on 10/16/24 at 11:55 AM, the Director of Nurses (DON) revealed that the CNAs on the night shift and/or Sundays are responsible for cleaning the wheelchairs. She revealed, I don't have a check-off list, but the staff are responsible for cleaning them on certain days. I guess I need a check-off list to ensure they are being cleaned. She confirmed that the wheelchair had a gray substance on the frame and wheels and needed to be cleaned. During an observation and interview on 10/16/24 at 12:05 PM, the Administrator revealed that the wheelchairs are supposed to be cleaned on the night shift. They can take the equipment outside when it's warm or in the shower room when it's cold, but all equipment is to be cleaned. She confirmed Resident #34's wheelchair was not cleaned and stated, This wheelchair is not clean, and it needs to be cleaned. A record review of Resident #34's Admission Record revealed the resident was admitted to the facility on [DATE] . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the MDS with an ARD of 07/18/24, revealed Resident #34 had a BIMS score of 12, which indicated the resident is moderately cognitively impaired.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff interviews, facility policy review, and record review, the facility failed to implement an Activities of Daily Living (ADL) care plan for one (1) of the 22 care plans reviewed. Resident #6. Findings include: A review of the facility policy, titled Care Plan-Comprehensive, revealed, It is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Record review revealed a current care plan for Resident #6 with a focus on ADL self-care performance deficit. Intervention in place revealed that the resident prefers a bed bath and requires extensive to total assistance of one (1) staff member. During observations on 10/15/24 at 11:55 AM and again at 3:30 PM revealed Resident #6 lying in bed with hair oily and disheveled, and a thick white, flaky substance was noted on her scalp. Resident #6 had facial hair approximately one (1) inch long to her chin and sporadic areas around her mouth. Her bilateral fingernails were approximately one (1) inch long with a brown substance noted under them. On 10/16/24 at 10:05 AM, during an observation and interview Certified Nursing Assistant (CNA) #2 stated that the resident's Hair looks wet and greasy, she has a lot of dandruff, her facial hair hasn't been shaved in quite some time, and her fingernails are long and dirty. It looks like it's been more than a week or so since she's been really cleaned up. CNA #2 revealed the CNA's are responsible for bathing her, which included washing her hair, trimming her facial hair, and doing her nail care since she is not diabetic. An interview on 10/16/24 at 10:45 AM, the Minimum Data Set (MDS) Coordinator revealed she is responsible for developing the care plans and revealed the purpose of the care plan is to guide and direct all staff to the individualized care needed for each resident. She confirmed according to Resident #6's care plan, she needs extensive to total assistance with her hygiene needs, and if she was not clean, her plan of care was not being followed. She confirmed that there was no documentation of refusal of care under the ADL care plan. Record review of Resident #6's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Peripheral vascular disease, Lack of coordination, and Hemiplegia and Hemiparesis following cerebral infarction affecting the right dominant side. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/02/24, revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated the resident is severely cognitively impaired.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, staff interviews, and facility policy review, the facility failed to provide personal hygiene, as evidenced by long facial hair, unkempt hair, and long nails with a brown substance under them for one (1) of 20 residents sampled. Resident #6 Findings include: Review of the facility policy titled A.M. Care (Day Tour of Duty) dated August 25, 2014, revealed under Purpose: 1. To refresh the resident. 2. To provide cleanliness, comfort, and neatness . An observation on 10/15/24 at 11:55 AM and again at 3:30 PM revealed Resident #6 lying in bed. Her hair appeared oily and disheveled, and a thick white, flaky substance was noted on her scalp. Resident #6 had facial hair approximately one (1) inch long to her chin and sporadic areas around her mouth. Her bilateral fingernails were approximately one (1) inch long with a brown substance noted under them. An observation on 10/16/24 at 8:45 AM, revealed Resident #6 lying in bed, with no change in the observation of appearance from the previous day. During an observation and interview on 10/16/24 at 10:05 AM, Certified Nurse Aide (CNA) #2 stated that Resident #6's hair looks wet and greasy, she has a lot of dandruff, her facial hair hasn't been shaved in quite some time, and her fingernails are long and dirty. CNA #2 revealed, It looks like it's been more than a week or so since she's been really cleaned up. CNA #2 revealed the CNA's are responsible for bathing her, which includes washing her hair, trimming her facial hair, and doing her nail care since she is not diabetic. CNA #2 stated, I was off work yesterday, but she still should have been cleaned up. During an observation and interview on 10/16/24 at 10:35 AM, the Director of Nurses (DON) confirmed that Resident #6's hair was greasy, with thick white dandruff on her scalp. The DON stated that she's a little hairy when referencing the resident's facial hair and confirmed that her fingernails were long and not clean. Record review of Resident #6's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Peripheral vascular disease, Lack of coordination, and Hemiplegia and Hemiparesis following cerebral infarction affecting the right dominant side. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/02/24, revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated the resident is severely cognitively impaired.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41878 Based on observation, staff interview, and facility policy review, the facility failed to ensure the proper storage of treatment medications and disinfectant wipes on the treatment cart as evidenced by an unlocked treatment cart in the residents' hallway for one (1) of three (3) survey days. Findings include: Record review of facility policy titled, Medications, Individual Medication Storage Cabinets, dated 8/25/14, revealed, Medication administration utilizing individual medication storage cabinets will meet the same criteria for timeliness, infection control, and medication safety as standard medication administration . 4. The medication storage cabinet will remain locked when not in use . During an interview and observation of a treatment with Licensed Practical Nurse (LPN) #1 on 10/16/24 at 10:05 AM, the treatment cart was left in the hallway while the treatment was being done in the resident's room. Upon the exit of the resident's room, the cart was observed unlocked and unattended in the hallway. LPN #1 stated the lock on the cart had been broken for approximately a month so she was unable to secure the items in the cart. She verified that the cart was locked in the office when not being used, but confirmed when treatments were being done, the unlocked cart was in the hall and not within sight since the resident's door was closed during care. She stated this was a safety concern since a resident could gain access to the treatment items/medications/disinfectant wipes on the cart. An observation of the cart revealed drawers that contained topical medications, creams, treatment medication items such as collagen, xeroform dressings and other supplies as well as disinfectant wipes. She confirmed these treatment medications should be secured in a locked cart to ensure no one had access to these items. An observation and interview with the Assistant Director of Nursing (ADON) on 10/16/24 at 10:30 AM, revealed the cart would lock but it was difficult to position the lock handle into the locked position and it had to be jiggled and twisted until it went into the place where the lock could be secured. She demonstrated the process that was necessary to lock the cart, which consisted of several seconds of twisting and adjusting the handle and finally getting it into the appropriate spot to lock. She confirmed that not all of the staff that used this cart were notified of how to securely lock this since it had been damaged and not easily locked. During an interview on 10/16/24 at 10:30 AM, the Administrator confirmed the cart was left unlocked and unattended in the hallway during a treatment and medications used for residents' treatments were on the cart. She confirmed the facility failed to secure medications and disinfectant wipes in a locked room or locked cart to ensure no one had access to those supplies which could affect resident safety.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interviews, and facility policy review, the facility failed to ensure food items in the kitchen refrigerator, freezer, and dry storage room were dated and labeled for one (1) of two (2) kitchen tours completed. Findings Include: Review of the facility policy titled, Food Storage dated [DATE], revealed .8. All foods stored in refrigerators and freezers that have been opened, will be covered and labeled with the date and name of food if appropriate, and will be discarded within the appropriate time frame. 9. All leftover foods are to be stored in covered containers, dated, & labeled . On [DATE] at 9:45 AM, an observation during the initial kitchen tour with the Dietary Manager (DM), revealed multiple unlabeled and undated food items in the refrigerator and freezer. The unlabeled and undated foods included one-half of a five pound bag of frozen chicken strips, one-fourth of a two pound bag of frozen French fries, and one-half of a five pound bag of chicken fried steak. There was also a large bag of frozen ground beef in the freezer that had been opened and was undated and unlabeled. On [DATE] at 9:50 AM, an interview with DM revealed that she had worked there since [DATE], and the Dietary Department had been a mess. She revealed that it was everyone's responsibility to ensure opened food items were labeled and dated to make sure they didn't go over past the dates to be used. She revealed that the person who opened the food item was responsible for dating, labeling, and proper storage of the item. DM revealed that if they didn't date and label the food items when opened, they would not know how long it had been in the refrigerator or freezer and could become freezer burned or expired. DM revealed that they were supposed to use or dispose of leftover food items in the refrigerator three days after it was opened and that opened food items in the freezer were supposed to be used within six months. On [DATE] at 9:55 AM, during the initial tour of the dry storage room revealed a bag of opened vanilla wafers that were unlabeled and undated. There were approximately 30 vanilla wafers left in the bag, and it was folded down and was not sealed. There was a twenty-five pound (lb.) bag of white corn meal with the sack torn near the top and it was open to air and setting on top of an empty dry storage container. There was also an undated and opened and unsealed 5 lb. bag of yellow cake mix with approximately one and one-half cups left in the bag. On [DATE] at 9:58 AM, an interview with Dietary [NAME] revealed that the bag of corn meal was supposed to be closed and inside an air proof container. She also confirmed that the bag of corn meal, cake mix, and vanilla wafers were exposed, open to air, and were not dated or labeled. Dietary [NAME] revealed that they were supposed to make sure that any opened food items such as the cake mix, vanilla wafers, and corn meal were wrapped up in plastic and covered to help prevent contamination and prevent bugs and pests from getting inside the packages. Dietary [NAME] also confirmed that all opened food items were supposed to be dated and labeled.