

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/30/2026
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)		
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. Based on observation and staff interview, the facility failed to store and serve food in accordance with professional standards for food service safety related to food items improperly stored, a dry bin left uncovered and food prepared and served in unsanitary conditions for two (2) of (2) kitchen observations. Findings Include: On 06/28/2026 at 12:12 PM, an initial tour with [NAME] #1, revealed [NAME] #2 placing a tray of sandwiches in a refrigerator. One of the sandwiches fell from the tray and landed on the floor. [NAME] #2 picked up the sandwich and placed it back on the tray of sandwiches. An observation of the food prep station revealed a pan of raw chicken sitting on the table with the lid to a jar of seasoning sitting top side down, on top of the chicken. [NAME] #2 picked up the lid and proceeded to season the chicken. An observation of the dry bins revealed the lid to the sugar was not completely on the bin, leaving the sugar exposed. An observation of the pantry revealed five (5) loaves of rye bread, boxed and sitting on a shelf, with green bio growth covering the bread. A review of the manufactures box revealed the instructions Best if used by 04/22/2027 and Keep Frozen and six containers of Ham Base with manufacturer's instructions to Keep Refrigerated for Best Quality. An interview with [NAME] #1 revealed she knows the lid to the sugar should have been securely placed on the bin to prevent something from falling into the sugar or a bug from getting in the sugar. [NAME] #1 stated the bread was bought for a one-time meal, and they did not know it was supposed to be frozen. [NAME] #1 stated the kitchen staff have always kept the Ham Base on the pantry shelf because the instructions Refrigerate for Best Quality was viewed as a suggestion. [NAME] #1 affirmed that food in the kitchen is supposed to be covered and unspoiled to prevent the residents from eating contaminated food. An interview with [NAME] #2 revealed she recalled dropping the sandwich and placing it back on the tray with the other sandwiches. [NAME] #2 further stated that she recalled leaving the lid to the seasoning sitting on top of raw chicken. [NAME] #2 affirmed that she should have thrown the sandwich away after picking it up. [NAME] #2 stated that she should not have placed the seasoning lid on top of the chicken. [NAME] #2 confirmed that in both cases there is a risk of contamination of the food. [NAME] #2 reported that another cook could come along and touch that seasoning lid and will then have residue from the raw chicken on their hands, which would have been carried to other parts of the kitchen. On 06/29/2026 at 10:34 AM, during a second visit to the kitchen, an observation of [NAME] #3 setting up food on the hot bar revealed a fly landing on the spaghetti with meat sauce. [NAME] #3 took a serving spoon, gauged where she thought the fly landed and scooped some of the sauce from the pan. [NAME] #3 proceeded to serve the spaghetti with meat sauce. An interview with [NAME] #3 revealed she continued serving the spaghetti with meat sauce because she did not have anything else to serve. [NAME] #3 stated she should have placed a lid on dish prior to walking away. [NAME] #3 noted that the hazard of having a fly in the food is that it could spread illness and could have laid eggs in the food. On 06/29/2026 at (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2:15 PM, an interview with the Administrator revealed she was made aware of the poorly stored food bread and Ham Base, exposed sugar, the seasoning lid on the raw chicken, the sandwich picked up from the floor and place back with the other sandwiches and the fly in the Spaghetti with meat sauce. The Administrator stated the hazards of these deficiencies can cause people to become sick. The Administrator noted the cook should have covered the food immediately when she placed it on the holding table. The Administrator affirmed that she should have thrown the food out once the fly was in the spaghetti with meat sauce. The Administrator noted she expects the staff to double-check dry bins when using them to make sure they are closed securely. The Administrator stated she expects the staff to pay attention and read the storage instructions on food packages.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide reasonable accommodation for a visually impaired resident by failing to consistently ensure access to a call system that accommodated the resident's disability after identifying the need and receiving complaints from both the resident and the Resident Representative (RR) for one (1) of (15) sampled residents. Resident #43. Findings Include: A record review of the facility policy Resident Rights revised and implemented on November 28, 2016, revealed, . The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. On 06/28/2026 at 1:05 PM, during an observation and interview with Resident #43 and the his wife, revealed that the staff hides his call light, often placing it out of his reach. His wife states she made a complaint last week to the facility, but nothing has improved with the call light placement. She noted Resident #43 is blind and has a hard time calling out. At this time Resident # 43's call light was observed to be tied at his right side on the bedrail. On 06/29/2026 at 11:42 AM, the Physical Therapist (PT) was observed in the resident's room adjusting Resident # 43's call light. The PT noted that the call light was wrapped around his bed rail to his right and Resident #43 asked where it was because he couldn't reach it or feel where it was in his bed. The PT then moved the call light to Resident 43's chest and attached it with a clip to his sheet and told him to make sure to tell the aids to place it there, because sometimes she is not sure that he feels it where it is at his side. An interview with the PT at 12:05 PM on 6/29/26, revealed the resident was admitted on [DATE] and first evaluated by therapy on 6/20/26. She noted that the call light in this instance is recommended by therapy to be clipped to Resident # 43's chest because he can use the call light, but he has a hard time finding it when the Certified Nursing Assistants (CNA's) or other staff leave it wrapped on the bed rail, but that is how they are trained to leave it in each room. She noted that the resident has a strong voice and can yell out to get staff and she can hear him from the nearby PT room as she's observed since he's been here but agreed that the resident shouldn't have to do that to get staff in his room. She noted that the facility can get easy type call systems, but the problem with those is they have a likelihood of being pushed by accident resulting in erroneous calls to the nursing station. The PT stated that Occupational Therapy (OT) handles the referrals for call systems like that and did not recommend one on the first assessment. An interview with the Certified Occupational Therapy Assistant (COTA) on 6/29/26 at 12:20 PM, revealed the resident was deemed to be able to manipulate a call light with his right hand, but noted the resident is blind and does have deficits in his left hand making it difficult for him to locate it when it is tied and left on the right bedside rail as has been noted to be done by CNA's. He stated that the facility can order easy type call systems but has not tried one to see if it makes calling out easier for the resident. He also shared that the call light is preferred to be left clipped to the resident's gown or sheet on his chest so he can located it, but noted that staff would be more likely to leave an easy call system on his chest because it doesn't have to be clipped and can simply rest on his chest and he could set it off easier because it only has to be bumped to notify staff. An interview with Licensed Practical Nurse (LPN) #1 on 6/29/26 at 1:28 PM, she stated that most of the time when she comes into the resident' s room the call light is on his chest but at times it is lying next to him. She stated he can reach it if it's on his right side, but not if it's on the left but she stated at times it gets hidden in his bed linens and he gets frustrated and yells out Nurse, Nurse and she comes back to check on him and adjusts the call light to place on his chest again with a clip. She (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted that he is blind and in a new environment and likely cannot always feel where the light is and that he would likely benefit from an easy call system that could be laid on his chest and not lost so easily. She further stated that she was unsure why it hadn't been tried yet but had noted that the process to get it started would be that she could ask the charge nurse or Minimum Data Set (MDS) nurse to get it for the resident. An interview with the Director of Nursing (DON) at 2:31 PM, on 6/29/26 revealed the resident had been discussed recently in interdisciplinary meetings with PT and OT and they decided against it due to the fact that they thought he could use the light when he had the light in his hand and easily accessible and an easy call light system could fall off of his chest and ring the nurse's station. She noted that residents shouldn't have to yell out if the call light is working and she stated that complications of not having an adequate call system that meets resident needs based on disability could be delays in receiving care. A record review of the admission Record revealed Resident #43 was admitted on [DATE] with diagnoses that included pneumonitis. A record review of Resident #43's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/25/26 revealed a Brief Interview for Mental Status (BIMS) score of (7) which indicated the resident had severe cognitive impairment. A record review of the .Smoking and Safety assessment section dated 6/19/2026 revealed the resident had poor vision or blindness.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, record review and facility policy review the facility failed to ensure residents were afforded consistent monthly Resident Council meetings for one (1) of six (6) months reviewed. May 2026. Findings include: A review of the facility's policy, Resident Council, Reviewed 07/24/2023, revealed, .The facility supports residents' rights to organize and participate in the resident council. Policy Interpretation and Implementation.5. Council meetings are scheduled monthly. A review of the Resident Council Minutes for the previous six (6) months revealed the minutes dated 5/12/26 indicated Nursing Home Week No Meeting written across the form. On 06/29/2026 at 1:00 PM, during a Resident Council meeting Residents #26, who is the Resident Council President and Resident #49 reported the meeting for May 2026 was cancelled by the Activities Director (AD). The residents affirmed that the Resident Council members did not initiate the cancelation of the May 2026 meeting, but they were told by the AD that the meeting was cancelled due to it being Nursing Home Week. The residents stated they were not offered a rescheduled meeting for that month. On 06/29/2026 at 2:05 PM, an interview with the AD revealed the May 2026 meeting was canceled because it was Nursing Home Week. The AD stated that she asked the residents if they wanted to cancel the meeting because it was Nursing Home Week. The Activities Director affirmed that she is the one who initiated canceling the meeting. The AD noted that she made no offer to reschedule the meeting within the month of May. The AD stated that she understood that her choice of words may have led the residents to believe she was simply canceling the meeting, and they had no real choice in the matter. The Activities Director confirmed that she should have just had the meeting when it was scheduled. On 06/30/2026 at 9:10 AM, an interview with the Administrator revealed that the Resident Council Meeting belongs to the residents and it should not be canceled to accommodate another event. The Administrator stated that the Activities Director had the option of rescheduling the meeting. The Administrator confirmed that she expects the Resident Council Meeting to occur as scheduled or rescheduled with the authority of the Resident Council members. Resident #26A record review of the facility's admission Record revealed the facility admitted resident #26 on 06/10/2025 with diagnoses including Parkinson's disease with dyskinesia, with fluctuations. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/05/2025 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of (15) indicating the resident was cognitively intact. Resident #49 A record review of the facility's admission Record revealed the facility admitted Resident #49 on 09/09/2025 with diagnoses including heart failure. A record review of the Quarterly MDS with an ARD of 06/10/2026 revealed the resident had a BIMS score of (15) indicating cognitively intact.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview, record review and facility policy review, the facility failed to ensure that appropriate medical evaluations were conducted in accordance with the physician orders, specifically failing to perform the necessary Hemoglobin (HbA1c) test for one (1) of (15) sampled Residents. Resident #3. Findings include: A record review of the facility policy Physicians Orders, dated 4/13/21, revealed, Policy Statement: It is the policy of this facility that resident's medication and treatments are ordered by a licensed physician or other licensed health care professional as permitted by state law Physicians' orders are carried out. During an interview with the Director of Nursing on 6/30/26 at 9:05 AM, she emphasized that getting blood work done on time is crucial for keeping residents safe from chemical imbalances and dangerous drug reactions. She admitted she was aware that Resident #3 missed a scheduled HbA1c blood sugar test in April. She explained that regular tracking is vital to make sure the resident's kidneys are functioning properly, warning that skipping these routine tests can lead to serious health complications. A record review of the facility's admission Record revealed the facility admitted the resident on 07/19/2023 with diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/18/2026 revealed the Resident #3 had a Brief Interview Mental Score (BIMS) of (15) indicating the resident is cognitively intact. A record review of the Order Summary Report revealed an order dated 2/11/25 .Hemoglobin (HGA1C) every three months (Q3) January, April, July, and October. A record review of the clinical record revealed there was no documentation that the physician ordered Hemoglobin A1c scheduled for April 2026 was obtained.		

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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** Based on observation, interview, record review, and facility policy review, the facility failed to follow infection prevention and control practices by failing to perform hand hygiene between glove changes during wound care for one (1) of (1) resident observed for wound care. Resident #47. Findings include: A review of the facility policy Hand Hygiene Policy and Procedure dated 12/2025 revealed, Policy: Hand Hygiene will be performed by all staff consistent with accepted standards of practice, to reduce the spread of infections and prevent cross contamination. At 11:27 AM on 6/30/26, Resident #47 was observed for wound care provided by Registered Nurse (RN) #1. RN#1 removed the resident's shoe and sock while wearing gloves and revealed a right foot wound with no dressing in place. She then removed her gloves, applied new ones and cleansed the wound bed without performing hand hygiene. She then removed her gloves again and applied new ones without performing hand hygiene and applied a clean dry dressing. An interview with RN # 1 at 11:54 AM on 6/30/26, she confirmed that she did not perform hand hygiene between glove changes during care. She stated the reason why was she was not sure if she could leave the room to get hand sanitizer after she had applied her gown due to cross-contamination concerns. She stated that changing gloves does not negate the need to perform hand hygiene to remove contaminants from the hands and prevent infection spreading to other residents or cross contamination. An interview with the Director of Nursing (DON) at 11:56 AM on 6/30/26, revealed her expectation of staff is that they will perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) infection prevention guidelines to prevent infection spreading among residents from staff members. She noted that in this instance the nurse should have cleansed her hands each time gloves were removed during care and once it was completed. She noted that complications of not cleansing hands according to CDC guidelines can result in wound infection including sepsis for the residents. A record review of resident # 47's Order Listing Report revealed an order dated 6/19/26, Wound care: clean right plantar foot with wound cleanser, pat dry, apply collagen to wound bed, cover with border gauze daily. A record review of the admission Record revealed Resident #47 was admitted on [DATE] with diagnoses that included chronic diastolic congestive heart failure. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/26 revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of (13) which indicated the resident was cognitively intact.		