

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH08VC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/05/2023
NAME OF PROVIDER OR SUPPLIER VAIDEN COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 868 MULBERRY STREET VAIDEN, MS 39176		
(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, MS #22549, on 9/5/23. The SA investigated MS #22549 for Quality of Care/Treatment related to the resident having body odor, Quality of Care/Treatment related to the resident not being groomed adequately, and Resident/Patient/Client Assessment related to resident not receiving care for a medical change in status. During the survey the SA determined the facility was in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with no deficiencies cited. The facility is licensed for 60 of beds and at the time of the survey the census was 56.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/12/23