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THE BLUFFS REHABILITATION AND HEALTHCARE C	2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180

(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 an annual recertification survey with four (4) complaint investigations (CI) at the facility from 10/24/23 to 10/26/23, CI MS # 22832 related to notification of change in condition and injury of unknown origin. CI MS #22896 related to resident rights, CI MS # 23102 and CI MS# 23104 related to falls. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm and cited M 625 related to range of motion and M 1570 related to infection control. There were no deficiencies cited for CI MS # 22896, CI MS #23102 or CI MS # 23104. The census at the time of the survey was 106 and the facility is licensed for 107 beds	M 000		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level III Based on observation, staff and resident interview, facility policy review, and record review, the facility failed to utilize splints for residents to maintain or prevent worsening of contractures for two (2) of 22 residents reviewed with contractures. Resident #26 and Resident #56 Findings include: Review of the facility policy titled, "Contracture	M 625	1. Resident #26 and #56 orders were reviewed by Director of Nursing and Minimum Data Set Coordinator for completion and accuracy to prevent worsening of contractures. Res #26 and #56 were assessed by Assistant Director of nursing on 10/26/2023. Issues were immediately corrected. Director of Nursing in-serviced all nursing staff on 10/26/2023 on proper utilization of splints and following orders for placing and removing	11/24/23

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M 625	Continued From page 1 Management Program", with a revision date of 1/23/23, revealed, "Intent: To have a program within the facility geared towards the prevention of new contractures and maintenance or improvement of range of motion ..." Resident #26 An observation and interview, on 10/24/23 at 3:07 PM, revealed a wrist and hand splint laying on Resident #26's bed. Resident #26 stated since he finished therapy, they don't put it on much. There were no observations during the survey of Resident #26's splint being in place. An interview, on 10/25/23 at 9:00 AM, with Certified Nursing Assistant (CNA) #2 revealed Resident #26 has a splint and he has worn it. She stated the CNA is responsible for putting it on. During an interview on 10/26/23 at 7:43 AM, Resident #26 stated that a man from therapy used to put his splint on and he took it off at night. He stated that he has not had it on any weekends. He stated that no nurse or CNA had put his splint on because they told him they didn't know how. In an interview on 10/26/23 at 7:40 AM, with CNA #1 revealed therapy was putting Resident #26's splint on, she thought he was still in therapy. She stated when the resident comes off therapy, therapy will pull whoever is working with the resident and instruct them on the splint. She stated the splint is supposed to be on the resident's care plan for the CNAs to see. An interview with the Physical Therapy Assistant (PTA) on 10/26/23 at 8:15 AM, revealed Resident #26 was not on therapy case load. He was	M 625	splints. 2. All 22 residents with orders for splints had the potential to be affected. On 10/26/2023 the Minimum Data Set Coordinator audited all residents with orders for splints that had potential to be affected for accuracy and completion. No issues found. 3. Beginning on 10/26/2023, staff were in-serviced by Director of Nursing (DON), Director of Therapy and Staff Development Coordinator on implementing splint orders. Director of Therapy will communicate need for splint orders and the Minimum Data Set Coordinator to ensure splint orders reach the Medication Administration Record (MAR). 4. On 10/26/2023 the Quality Assurance Performance Improvement Committee was held with the Medical Director and Interdisciplinary team to address issues with splint orders. Beginning 10/30/2023, an audit will be conducted weekly for four(4) weeks, then monthly for three (3) months by the Minimum Data Set Coordinator to review the comprehensive care plan and its implementation for five (5) residents with orders for splint use and Director of Nursing and Director of Therapy services will perform observation of (5) residents with orders for splint use to observe splint placement being completed as ordered for (4) weeks, then monthly for three (3) months. A report will be submitted to the Quality Assurance Performance Improvement committee on	

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M 625	Continued From page 2 discharged on 10/13/23. The PTA confirmed staff should be trained when the resident is discharged from therapy. An interview on 10/26/23 at 8:17 AM, with the Certified Occupational Therapy Assistant (COTA) stated he works as needed (prn) and the therapist takes care of the orders. He stated he does train with the CNA's but cannot locate paperwork for Resident #26. He stated the facility does not have a restorative at present, so they catch the people working on the floor with the residents to teach them about the splints. Interview with the Director of Nursing (DON) on 10/26/23 at 8:35 AM, confirmed Resident #26 should have had an order in the computer for continued use of his splint after discharge from therapy. Record review of the Occupational Therapy discharge summary for Resident #26 dated 10/6/23 revealed patient will safely wear wrist cock-up splint on left hand and left wrist for up to eight hours with minimal signs/symptoms of redness, swelling, discomfort, or pain. Review of the Admission Record resident information sheet revealed Resident #26 was admitted to the facility on 3/1/22 with diagnoses that included Hemiplegia and Hemiparesis following Non traumatic Intracerebral Hemorrhage affecting left dominate side, Muscle wasting and atrophy, and Chronic Kidney Disease, Stage 5. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated	M 625	November 21, 2023, for review and recommendations then monthly for (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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Resident #26 was cognitively intact.

Resident # 56

An observation, on 10/24/23 at 11:35 AM, revealed Resident #56 had a left-hand contracture with fingers contracted but not pressed against his palm.

Observations during the survey from 10/24/23 through 10/26/23 revealed Resident #56 in his room and mobile in his wheelchair over the facility with no splint in place on his left hand.

During an interview, on 10/25/23 at 1:20 PM, with Licensed Practical Nurse (LPN) #2, she stated she had not put a splint on Resident #56. She confirmed there was an order for the splint but stated there was nowhere in the computer to document it being put on or to document the skin assessment. LPN #2 also confirmed the Medication Administration Record (MAR) for Resident #56 did not have the splint listed on it for documentation.

An observation and interview, on 10/25/23 at 1:25 PM, with the Director of Nursing (DON) and Resident #56 confirmed the DON could not locate Resident #56's splint. The DON stated that she didn't expect to find it. Resident #56 stated that it had been about a week since he had the splint on. The DON stated that this was probably because the order was put in incorrectly and did not pull over for the staff to see.

An interview on 10/25/23 at 1:55 PM, with the Director of Therapy revealed they do an evaluation on all residents who have a contracture quarterly. The Director of Therapy revealed therapy had Resident #56 for treatment

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M 625	Continued From page 4	M 625		

on service from 3/13/23 to 5/2/23 and again from 6/8/23 to 7/17/23. The Occupational Therapist would have then given instructions to the staff on the application of the splint.

Record review of the Occupational Therapy evaluation and plan of treatment form dated 10/25/23 revealed Resident #56 under clinical impression presents with left upper extremity (LUE) wrist, decreased range of motion (ROM) of elbow, wrist and digits that affects ability to wear palm splint with finger separators as part of contracture management.

An interview on 10/26/23 at 7:40 AM, with CNA #1 revealed she has not seen a splint for Resident #56 and doesn't remember seeing it on the care plan.

An interview on 10/26/23 at 8:35 AM, with the Director of Nursing (DON) and the Administrator (ADM) confirmed they have not had a Restorative Program since COVID-19 started. The process is for the order to be written on the computer for the splint, it goes to the Medication Administration Record (MAR) and the nurses are responsible for applying splints and assessing skin. The DON confirmed Resident #56's order was not on MAR and she was unable to find any documentation in the progress notes concerning the resident's splint. She stated this should be documented daily. The ADM stated she felt Resident #56's order was put in incorrectly by therapy which did not let it pull over to the MAR. The DON stated therapy can put the order in the que and nursing confirms it for accuracy and then it is pulled to the MAR for documentation. The DON stated that if the orders and treatments are not carried out for splints it could cause worsening of the contracture or skin breakdown.

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M 625	Continued From page 5 An interview on 10/26/23 at 11:53 AM, with the Occupational Therapist (OT) revealed Resident #56 had a decline in his wrist flexion from -70 in March 2023 to -88 on 10/26/23 and had a decline of the contracture to the index finger from -70 in March 2023 to -79 on 10/26/23. Record review of the OT Discharge Summary date of service 3/13/23 - 5/2/23 revealed "Short Term Goals (STG)...#2 Patient will increase AROM (active range of motion) left wrist to -40 degrees...Baseline 3/13/23 -70 degrees. Discharge 5/2/23 -30 degrees. STG #3. Patient will increase AROM left index finger PIP (proximal interphalangeal joint) extension to -45 degrees...Baseline 3/13/23 -80 degrees...Discharge 5/2/23 -45 degrees..." Record review of a Order Summary Report dated 3/27/23 revealed Resident #56 to wear left (L) resting hand splint daily in morning (am) up to four (4) hours or as tolerated. Nurse to check skin prior to applying splint and after removal of splint and report any skin changes immediately. Record review revealed a Splint and Range of Motion (ROM) Competency and Discharge Planning Form: Care Giver and /or Resident for Resident #56 dated 3/29/23. The form has instructions concerning the splint placement and is signed by the therapist, but no caregiver or resident signatures are noted upon discharge. Review of the Admission Record resident information sheet for Resident #56 revealed an admission date of 6/19/19 with diagnoses that included Unspecified Focal Traumatic Brain Injury, Stiffness of the left hand, Muscle Wasting and Atrophy.	M 625		

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M 625	Continued From page 6 Review of the quarterly MDS with and ARD of 9/14/23 revealed a BIMS score of 10 which indicated Resident #56 had moderate cognitive impairment.	M 625		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview and facility policy review the facility failed to perform hand	M1570	F880/M1570 □ Infection control 1. Respiratory Therapist (RT) was observed demonstrating tracheostomy	11/24/23

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M1570	Continued From page 7 hygiene after removing gloves during resident care for two (2) of seven (7) residents observed for staff performance of hand hygiene during resident care. Resident # 36 and Resident # 66. Findings include: Record review of facility policy "Handwashing-Hand Hygiene Policy and Procedures", with a revision date of 10/2020, revealed, "Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections...Policy Interpretation and Implementation... 7. Use an alcohol-based hand rub...for the following situations...f. Before donning sterile gloves... Applying and Removing Gloves 1. Perform hand hygiene before and after applying non-sterile gloves..." Resident #36 An observation of Resident #36 on 10/24/23 at 1:00 PM, revealed she had a tracheostomy. An attempted interview with Resident #36 revealed that she is unable to speak and does not respond to interview. A record review of Resident #36 's "Order Review History Report", revealed a physician's order, dated 9/4/23, for tracheostomy care every shift and as needed using aseptic technique. Remove inner cannula, clean with 1/2 strength hydrogen peroxide and sterile gauze and cotton swab. Re-insert inner cannula, turn to lock, clean outer cannula/stoma with sterile water, pat dry with sterile gauze. May use split sterile gauze as needed. An observation of Resident # 36's tracheostomy care on 10/25/23 at 9:00 AM, performed by the	M1570	care to resident #36 with improper hand hygiene practices. RT was immediately in-serviced on 10/24/2023 by the DON and educated on proper hand hygiene and tracheostomy care procedures. LPN #1 was observed demonstrating wound care to resident #66 with improper hand hygiene practices. LPN #1 was immediately in-serviced on 10/24/2023 by the DON and educated on proper hand hygiene and wound care procedures. Resident #36 and #45 were assessed on 10/24/2023 by Director of Nursing with no adverse findings. 2. All current residents in the facility had the potential to be affected by this deficient practice. 3. RT and LPN #1 received one on one education, in-servicing, and skills check offs on Hand washing, and infection control policy on 10/24/2023 by Director of Nursing and Administrator. All licensed nursing staff attended review of wound care policy on 10/24/2023 and will be observed for skills check off for wound care by the Director of Nursing by 11/17/2023. All RT staff attended review of tracheostomy care policy on 10/24/2023 and will be observed for skills check off for tracheostomy care by Director of Respiratory by 11/17/2023. A handwashing policy review in-service was initiated on 10/24/2023 and is ongoing at this time to ensure 100% compliance of all staff. This will be completed by Staff Development Coordinator by 11/17/2023. Hands-on skills check off for handwashing was initiated on 10/24/2023 and is ongoing at this time to ensure 100% compliance of	

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M1570	Continued From page 8 Respiratory Therapist (RT) revealed that she washed her hands, applied clean gloves, removed the dressing around the tracheostomy site, removed the disposable inner cannula and her removed gloves. The RT did not perform hand hygiene after removing the dirty gloves. She then applied clean gloves, cleaned the tracheostomy site with the prescribed solution, removed her gloves, and failed to perform hand hygiene. The RT then applied sterile gloves, replaced disposable inner cannula, removed her gloves, and failed to perform hand hygiene. During an interview with the RT on 10/25/23 at 9: 20 AM, she verified that she did not perform hand hygiene after removing gloves and before applying clean gloves during tracheostomy care. She agreed that failure to perform hand hygiene could lead to the spread of infection and that she should have performed hand hygiene between glove changes. During an interview with the Administrator and Director of Nursing (DON) on 10/25/23 at 9:45 AM, they stated that the RT should have performed hand hygiene each time she removed her gloves during tracheostomy care. The Administrator and DON agreed that failure to perform hand hygiene after removing gloves could result in the spread of infection. Record review of Admission Record for Resident #36 revealed she was admitted to the facility on 6/28/2021 with diagnoses that include Chronic Respiratory Failure with Hypercapnia and Encounter for Attention to Tracheostomy. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/18/23, for Resident #36, revealed,	M1570	all staff. This will be completed by Staff Development Coordinator by 11/17/2023. 4. On 10/26/2023 the Quality Assurance Performance Improvement Committee was held with the Medical Director and interdisciplinary team to address issues of handwashing and infection control. Director of Nursing and Administrator will observe five (5) staff members perform handwashing/wound care/tracheostomy care weekly for four (4) weeks, monthly for (3) three months, and then quarterly for one (1) year. Handwashing compliance, infection control, tracheostomy care, and wound care will be reviewed, and a report will be submitted to the Quality Assurance Performance Improvement committee on November 21, 2023 QAPI meetings monthly for three (3) months and then quarterly thereafter. The Director of Nursing is responsible for monitoring and compliance.	

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under Section C Brief Interview for Mental Status (BIMS), that Resident #36 is rarely/never understood.

Resident #66
A record review of Resident # 66's "Order Review History Report" revealed a Physician's Order, dated 9/6/23, for Wound # 1 Stage four (4) pressure injury left calf, clean with wound cleaner, pat dry apply xeroform daily, cover with rolled gauze, change daily or as needed for soilage until healed.

An observation of wound care performed by Licensed Practical Nurse #1 (LPN) on 10/25/23 at 9:22 AM, revealed that LPN #1 performed hand hygiene, applied clean gloves, removed the dressing from Resident # 66's left leg, removed her gloves and applied clean gloves without performing hand hygiene. LPN #1 then cleaned the wound with wound cleanser, picked up a xeroform gauze and applied it to the wound bed, without removing gloves or performing hand hygiene. LPN #1 stated "I was supposed to change my gloves there." LPN # 1 then applied the rolled gauze around Resident # 66's left leg and secured the dressing.

During an interview with LPN # 1 on 10/25/23 at 9:28 AM, she verified that she should have performed hand hygiene each time she removed her gloves during wound care. She stated failure to perform hand hygiene after removing gloves could cause the spread of infection.

During an interview with the Administrator and DON, on 10/25/23 at 9:43 AM, they stated that LPN #1 should have performed hand hygiene each time she removed her gloves during wound care. The Administrator and DON agreed that

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M1570	Continued From page 10 failure to perform hand hygiene after removing gloves could result in the spread of infection. Record review of Admission Record for Resident # 66 revealed she was admitted to the facility on 12/15/2022 with diagnoses that include Paraplegia and Pressure Ulcer of Left Ankle. A record review of the Quarterly MDS with an ARD of 9/14/23, for Resident # 66, revealed, under Section C Brief Interview for BIMS that Resident # 66 is rarely/never understood.	M1570		