| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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<br><br>The State Agency (SA) conducted an Annual Recertification survey and eleven (11) Complaint Investigations (CI MS #26373, CI MS #26431, CI MS #26742 CI MS #26914, CI MS #27173, CI MS #27365, CI MS #27377, CI MS #27340, CI MS #27429, CI MS #27468, and CI MS #27564) at the facility from 1/06/25 through 1/09/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited M225, M610, and M1570. The SA identified non-compliance and cited M610 for failure to provide Activities of Daily Living for CI MS #27365, CI MS #26914, and CI MS #27564. The SA identified non-compliance and cited M500 regarding resident rights for CI MS #26431. The SA investigated CI MS# 26373, CI MS #26742, CI MS #27173, CI MS #27340, CI MS #27377, CI MS #27429, and CI MS #27468 with no deficiencies cited.<br><br>The census at the time of the survey was 97 and the facility was licensed for 107 beds. | M 000 | | |
| M 225 | 45.4.1 Nursing Facility<br><br>Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements:<br><br>1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. | M 225 | | 1/31/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 225 | Continued From page 1<br>2. Each facility shall have the following licensed personnel as a minimum:<br><br>a. Seven (7) day coverage on the day shift by a registered nurse.<br><br>b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility.<br><br>c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse.<br><br>d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse.<br><br>e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse.<br><br>f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse.<br><br>3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. | M 225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 225 | Continued From page 2<br><br>4. There shall be at least two (2) employees in the facility at all times in the event of an emergency.<br><br>This Statute is not met as evidenced by:<br>Level II Widespread<br>Based on staff interviews, record review and facility policy review, the facility failed to provide a Registered Nurse (RN) eight (8) hours a day for one (1) of 14 staffing days reviewed.<br><br>Findings include:<br><br>Record review of the facility policy titled, " Staffing, Sufficient and Competent Nursing" with a review date of 3-2023 revealed under "Policy Interpretation and Implementation: Sufficient Staffing...A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week..."<br><br>Record review of the Staffing Grid for the dates of 12/24/24 through 1/6/25 revealed there was no RN coverage on 12/25/24.<br><br>An interview on 1/6/25 at 11:15 AM with the Director of Nurses (DON) confirmed there was no RN coverage on 12/25/24. She stated that the RN that was scheduled did not call in or show up and no one notified her. She stated that she figured it out around noon on Christmas Day when she looked through the computer at the time clock ins. She admitted that she did not come to cover it, everyone else was on vacation and they are not allowed to use agency RN for coverage. She confirmed that the purpose of having an RN on duty is for supervision to handle emergencies or intravenous medications (IV). She admitted there were no incidents or IV | M 225 | 1.On 12/27/2024 the Administrator and Director of Nursing reviewed the resident electronic clinical records for any adverse events to include falls, hospitalization transfers, or Intravenous medications missed that may have occurred due to this deficient practice. No adverse events noted. On 12/27/2024, the Administrator conducted education with the Director of Nurses on the CMS (Center for Medicare and Medicaid Services) requirements on RN coverage in facility for eight (8) consecutive hours for seven (7) days a week.<br><br>2.All residents had the potential to be affected.<br><br>3.On 1/10/2025 the Director of Nursing initiated Inservice with all nursing staff on the licensed requirements with eight (8) hour coverage of Registered Nurse for seven (7) days a week.<br><br>4.Beginning the week of 1/10/2025, the Director of Nurses will audit daily staffing to ensure every day has a Registered Nurse for eight (8) hours. This audit will be turned in weekly to the Administrator to review for compliance for three (3) months then quarterly thereafter. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 225 | Continued From page 3<br>therapy on 12/25/24.<br><br>An interview on 1/6/25 at 2:45 PM with the Administrator confirmed there was no RN coverage on 12/25/24. She stated that the DON put an RN on the schedule that had already requested off for that day and is not sure if the DON just forgot or was not aware. She confirmed that they need an RN for at least 8 hours a day to handle emergencies and IV's. She verifies that the DON was the person that should have covered it.<br><br>A follow up interview on 1/6/25 at 3:00 PM with the DON confirmed that she does the schedule, and she put an RN on the schedule that had requested off, but she was not aware of her request. She stated that after she put the schedule out that the RN called and told her that she had already requested off for that day. When asked if she expected her to come to work after that phone conversation she stated, "she never said she wasn't". When asked if she should have come in and covered, she stated, "Yes but I was not coming in to cover someone else's responsibility and miss my family." | M 225 | survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing and Administrator is responsible for monitoring and compliance. | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of | M 500 | | 1/31/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 4<br>the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; | M 500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 5<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;<br><br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by | M 500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 6<br>law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented | M 500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 7<br>by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level II<br>Based on resident and staff interviews, record reviews, and facility policy reviews, the facility failed to protect a resident from verbal abuse (Resident #60) and to honor a resident 's preferences (Resident #195) for two (2) of 23 sampled residents.<br><br>Findings Include:<br><br>Resident #60<br><br>A review of the facility's policy titled "Policy for Prohibition of Abuse, Neglect, and Misappropriation of Property" with no revision date revealed under "Intent...Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse."<br><br>Record review of the facility's investigation revealed that on 9/9/24 at 9:30 AM, Resident #60 reported that Certified Nursing Assistant (CNA) #5 made a verbal threat toward him on 9/8/24. Resident #60 stated that CNA #5 asked him to throw something in the trash, and when he refused, she responded by telling him she would run him over with her truck. This incident occurred as CNA #5 was leaving the facility. | M 500 | 1. On 1/6/2025, Certified Nursing Assistant (CNA#1) completed a shower and activities of daily living (ADL) care to including shaving, nail care, and shower for Resident #195. On 01/10/2025 RN (Registered Nurse) #1 interviewed Resident # 195 to ensure all resident preferences with ADL care were accurate and being followed. On 1/7/2024 the Administrator educated CNA#1 and CNA#2 on completion of ADL care according to residents' preferences.<br>2. The facility determined that all residents have the potential to be affected.<br>3. On 1/10/2025 an audit was completed by RN (Registered Nurse) #1 with all residents to verify the accuracy of ADL care to include showers, nail care, and shaving. The audit results were care planned by the MDS (Minimum Data Set) team to ensure staff were following the residents' preferences. This included modification of 12 (twelve) residents ADL (Activities of Daily Living) completed. On 1/10/2025 MDS (Minimum Data Set) team-initiated education with the Direct care staff on following the plan of care for resident preferences and how to utilize the Kardex, which contains the resident | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 8<br><br>Witnesses stated that CNA #5 backed up, screeched her tires, and left the parking lot. Resident #60 was behind her vehicle in his motorized wheelchair at the time. No physical contact occurred. CNA #5 was suspended pending an investigation. The facility substantiated that verbal abuse occurred.<br><br>A review of a written statement dated 9/9/24 and signed by CNA #5 revealed that she asked Resident #60 to throw something away while he was outside the facility. She stated that the resident insulted her, calling her an expletive. She responded by saying, "Stop please and move" and "chill out," to which the resident replied that he did not have to do anything for her. CNA #5 stated that she got into her truck, put it in reverse, and assumed the resident would move.<br><br>In an interview with Resident #60 on 1/6/25 at 9:00 AM, he recalled that on the morning of 9/8/24, at approximately 9:30 AM, CNA #5 asked him to throw something away but did so with an attitude. He told her he did not have to do anything for her. Resident #60 stated that CNA #5 then threatened to run him over, entered her truck, and began backing up while he was positioned behind and slightly to the left of her vehicle. She stopped, screeched her tires, and left the parking lot. Resident #60 reported feeling that CNA #5 intended to hit him but confirmed that no contact occurred.<br><br>During an interview with CNA #3 on 1/6/25 at 2:40 PM, she stated that on 9/8/24 at around 9:30 AM, she witnessed CNA #5 asking Resident #60 to throw something away. Resident #60 threw the item on the ground and told CNA #5 to throw it away herself. CNA #3 reported hearing CNA #5 state, "I ought to run down your [expletive]." She | M 500 | preferences.<br>4. Beginning 1/10/2025 RN (Registered Nurse) Supervisor will observe five (5) residents' weekly observations for 4 weeks and then monthly for three (3) months to ensure staff provide care according to the care planned resident preferences. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.<br><br>On 9/09/2024 CNA #5 was terminated regarding the self-reported abuse allegation for Resident #60. On 1/10/2025 an Inservice was initiated by SDC (Staff Development Coordinator) with all staff on the Abuse and Neglect Prohibition Policy.<br><br>The facility determined that all residents have the potential to be affected.<br><br>On 1/16/2025 the AG (Attorney General) Representative held a facility wide Inservice with education on Abuse and Neglect.<br><br>Beginning 1/10/2025 the facility department heads including social services, activities, nursing leadership, and business office will conduct Nexion | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 9<br>then observed CNA #5 back up toward Resident #60, screech her tires, and leave the facility.<br><br>In an interview with the Administrator (ADM) on 1/6/25 at 3:00 PM, she confirmed that on 9/9/24, she received a report from Resident #60 about the incident on 9/8/24. The report indicated that CNA #5 was rude and verbally threatened to run over Resident #60 with her vehicle. The ADM stated that CNA #5 was immediately suspended pending investigation. She confirmed that the investigation substantiated verbal abuse by CNA #5.<br><br>A review of Resident #60's "Admission Record" revealed that he was admitted to the facility on 12/10/21 with a diagnosis of an Unspecified Injury at the T2-T6 Level of the Thoracic Spinal Cord.<br><br>A review of the Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 11/12/24 revealed that Resident #60 had a Brief Interview for Mental Status (BIMS) score of 15, indicating that he is cognitively intact. Resident #195<br><br>A review of the facility policy titled, "Resident Rights," revised 04/2017, revealed, "Residents shall: C.) Be assured of choice and share responsibility for decisions... E.) Receive care and services that are adequate and appropriate..."<br><br>An observation on 1/06/25 at 9:00 AM revealed Resident #195's hair and beard to be unkept and matted in appearance, his fingernails were observed to be approximately 1/2 inch long with a thick dark brown substance under the nail beds. In a continued interview with Resident #195, he stated he had been in the facility a little over two | M 500 | neighbor rounds with residents with BIMS (Brief Interview for Mental Status) of 12 or higher to include interviews on what abuse and neglect means, safety in facility, and who to report abuse or neglect to. This will occur weekly for four weeks then monthly for three months and quarterly thereafter. The facility department heads including social services, activities, nursing leadership, and business office will conduct Nexion neighbor rounds with residents with BIMS (Brief Interview for Mental Status) below 12 to observe for any signs and symptoms of Abuse or neglect and report findings to Abuse Coordinator immediately. These observations will occur weekly for four weeks then monthly for three months, and quarterly thereafter. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted to QAPI (Quality Assurance Performance Improvement) committee by the Administrator on 1/31/2025 for review and recommendations then monthly for three (3) months. The Administrator is responsible for monitoring and compliance.¿¿ | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 10 | M 500 | | |

weeks, and he had not received a shower, a shave, or had his hair brushed at all. He went on to state he had told someone when he was admitted that he preferred a shower and had asked the staff for one several times, they would say ok but never come back. He then stated, "I am unable to get up by myself, or I would try to shower myself."

In an interview and observation of Resident #195 on 1/6/24 at 12:10 PM with Certified Nurse Assistant (CNA) #1, she confirmed she had not attempted to give the resident a shower, and stated the facility does not have a set shower schedule for the residents. She then admitted that the resident's hair, beard and nails did not appear clean or that he had had a bath lately.

In an interview and record review with the shower CNA #2 on 1/06/24 at 1:00 PM, she confirmed that the facility does not have a set shower schedule for the residents letting us know when they need one. She then revealed that if a resident receives a shower by the shower staff, then it would be documented on the shower schedule forms. After record review she confirmed that Resident #195 had no documented shower since admission.

In an interview with the Director of Nursing (DON) on 1/07/25 at 10:39 AM, she confirmed that the facility did not have a shower schedule in place at this time. She stated, "we had one in place for a while, but no one was following up on it and so it was stopped." She confirmed she was aware there was a problem and should have put something in place to ensure residents received their showers. She stated that failing to provide Resident #195 showers per his preference is a failure to honor the residents' right of choice.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 500 | Continued From page 11<br><br>Record review of the January Shower Record revealed there was no documented shower for Resident #195.<br><br>Review of the "Admission Record" revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure.<br><br>Record review of Resident #195's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/24, revealed the Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. Section F0400 : Interview for Daily Preferences revealed, C. "How important is it to you to choose a bath, shower, bed bath, or sponge bath?" Coded: "Very Important." | M 500 | | |
| M 610 | 45.21.2 Activities of daily living<br><br>Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to:<br><br>1. Bath, dressing and grooming;<br><br>2. Transfer and ambulate;<br><br>3. Good nutrition, personal and oral hygiene; and<br><br>4. Toileting.<br><br>This Statute is not met as evidenced by:<br>Level II<br><br>Based on observation, resident and staff interviews, record review, and facility policy | M 610 | On 01/07/2025, Resident #17 nails were cleaned and trimmed and facial hair shaved by CNA #2 in accordance with the resident's care plan. On- 1/6/2025 | 1/31/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 610 | Continued From page 12<br>review, the facility failed to provide personal hygiene for four (4) of 29 sampled residents. Residents #17, #49, #57, and #195<br><br>Findings include:<br><br>Review of the facility policy titled "Activities of Daily Living (ADL), Supporting" with a revision date of March 2018 revealed, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. "<br><br>Resident #17<br><br>An observation and interview with Resident #17 on 1/06/25 at 9:30 AM revealed long and jagged fingernails measuring approximately one (1) inch long past the tip of the fingers with a brown substance under the nails on bilateral hands, facial hair approximately three-fourths (3/4) inch long to sporadic areas of her chin. Resident #17 stated, "I don't like these whiskers. They are very long, and they need to be cut." She revealed it's been a while since she had her fingernails cut and wanted them cleaned and trimmed.<br><br>An observation on 1/06/25 at 2:45 PM revealed Resident #17 sitting in the hallway with no change in appearance.<br><br>An observation on 1/07/25 at 8:25 AM revealed Resident #17 with no change in appearance regarding long, jagged nails and long facial hair to the chin area.<br><br>An observation and interview on 1/07/25 at 12:50 PM Certified Nurse Aide (CNA) #6 revealed she was assigned to Resident #17 today and | M 610 | Resident # 49 was shaved, and incontinence care was completed by CNA #2 in accordance with the resident's care plan. On 1/7/2025 Resident #57 nails were cleaned and trimmed along with facial shaving by CNA #2 in accordance with the resident's care plan. On 1/6/2025, Certified Nursing Assistant (CNA#1) completed a shower and ADL care to including shaving, nail care, and shower for Resident #195. On 1/7/2025 the Administrator educated CNA#1, CNA#2, CNA #7, and CNA #8 on completion of ADL care according to residents' preferences.<br><br>All residents had the potential to be affected.<br><br>On 1/15/2025 Corporate Clinical Specialist initiated in-service with in-service with Administrator and Director of Nursing on ADL Care to include resident preferences, care planning and best methods for completion. This in-service continued to all certified and licensed nursing staff by the Staff Development Coordinator to include how to read and understand the Point Click Care Kardex which shows the electronic care plan chart and provides a plan of care. On 1/10/2025 an audit of all residents was completed for activities of daily living (ADL). On 1/10/2025 Neighbor Rounds are being conducted weekly to observe for ADL completion.<br><br>Beginning the week of 1/10/2025, Registered Nurse Supervisor will observe five (5) residents per week for three (3) months to ensure the completion of ADL | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 610 | Continued From page 13<br>confirmed the resident had a lot of facial hair to her chin area and the resident's fingernails were long and jagged with a brown substance under them. She revealed she couldn't cut the resident's fingernails but could have ensured they were cleaned up. Resident #13 told CNA #6 she wanted her nails trimmed and her facial hair removed.<br><br>An observation and interview on 1/07/25 at 1:00 PM, the Director of Nurses (DON) confirmed Resident #17's fingernails were long, jagged, and had a substance under them. The DON revealed that the nurses are responsible for trimming her fingernails since she is diabetic, and trimming her facial hair is part of her daily grooming when she gets a bed bath or shower. She revealed that with her fingernails, long and jagged, she could scratch herself and cause skin concerns. The DON confirmed that Resident #17 had long facial hair in her chin area and revealed that she had not been properly groomed.<br><br>During an interview on 1/07/25 at 1:47 PM, Licensed Practical Nurse (LPN) #1 revealed she cleaned and trimmed Resident #17's fingernails about a month ago. She revealed there is no set day to do nail care and there is not a reminder in the documenting system; she stated, "We just do nail care when we notice that it needs to be done. I take full responsibility for not doing her nail care."<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #17 on 11/19/2019 with medical diagnoses that included Type 2 Diabetes Mellitus, Chronic Pulmonary Edema, and Heart Failure.<br><br>Record review of Resident #17's Minimum Data | M 610 | care is being provided for dependent residents according to the plan of care to include shaving, nail care, and incontinence care. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the RN (Registered Nurse) Supervisor to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 610 | Continued From page 14<br><br>Set (MDS) with an Assessment Reference Date (ARD) of 10-29-2024 revealed, under Section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicates the resident is cognitively intact.<br><br>Resident #49<br><br>On 1/06/25 at 08:15 AM, an observation revealed a strong urine smell when standing by Resident #49's bed. CNA #7 entered the room upon the State Agent's (SA) request and pulled back the blanket covering the resident. The resident was lying on a sheet that was saturated with urine extending from the right side of the resident's waist up to his torso and extending out approximately eight (8) inches towards the edge of the bed. The saturated urine area had a brown ring around the outer edges. CNA #7 confirmed that Resident #49 was lying in a large amount of urine and stated, "You can tell he has not been changed in a while because of that brown ring around the outer edge." This observation also revealed Resident #49 with approx. ¾ inch of facial hair growth on his chin, above his lip, and on the sides of his cheeks.<br><br>During an observation and interview on 1/06/25 at 8:20 AM, LPN #1 confirmed she could smell a strong urine smell and that the urine-saturated sheet had a dried brown ring. She revealed that the urine looked like it had been there for a while and confirmed the resident was unshaven and unkempt.<br><br>During an observation and interview on 1/06/25 at 8:30 AM, the Administrator (ADM) confirmed that Resident #49 was lying on a urine-saturated sheet with a brown ring around the outer edges of the stain. She revealed that this is not acceptable | M 610 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 610 | Continued From page 15 | M 610 | | |

and confirmed that he doesn't look like he has been groomed in quite some time and has been left wet for a while.

An observation and interview on 1/6/25 at 8:35 AM CNA #7 revealed she is assigned to the resident today and made quick rounds when she came on her shift at 7 AM, just glancing in at her residents, and Resident #49 was asleep; she revealed she hadn't changed his brief this morning because she got busy assisting with breakfast. She stated the resident had not been shaved in quite some time, and "with his sheets being wet, I can tell you that the night shift did not change him like they were supposed to."

During an interview on 1/6/25 at 8:55 AM, the DON confirmed that Resident #49 had long facial hair and revealed she wasn't sure when he was last properly groomed. She revealed there was no excuse for the resident to be found lying in urine and stated, "We obviously have an issue with care not being done."

Record review of the Admission Record revealed Resident #49 was admitted to the facility on 08/07/2024 with diagnoses that included Unspecified Dementia, Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis.

Resident #57

An observation on 1/06/25 at 8:00 AM revealed Resident #57 lying in bed with facial hair growth on his chin, above his lip, and on the sides of his cheeks that was approximately 1 inch long. Resident #57's fingernails were approximately one-half (1/2) inch long, jagged and had a brown substance underneath them on both hands.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 610 | Continued From page 16<br><br>During an observation and interview on 1/06/25 at 8:10 AM, LPN #1 confirmed Resident #57 was unshaven with fingernails that were long and jagged, with a brown substance under them. She revealed she wasn't sure when the resident was shaven, but it looks like it has been a while. She revealed it is the nurses' responsibility to do his nail care since he is diabetic and revealed we do it whenever we notice they are getting long. She confirmed it had been about a month since the resident's nails were trimmed.<br><br>During an observation and interview on 1/06/25 at 8:20 AM, CNA #8 revealed she was assigned to the resident today and wasn't sure what day the resident was supposed to get his showers. She revealed we take them when they need to be cleaned up or give them a bed bath. She revealed that it looked like the resident hadn't been shaven in a long time, and his nails were very long and dirty.<br><br>During an observation and interview on 1/06/25 at 8:30 AM, the DON confirmed that Resident #57 was unshaven, and his fingernails were long, jagged, and dirty. She revealed that the resident could scratch himself and possibly cause an infection. The DON stated, "The CNA's are responsible for making sure residents are properly groomed, and it honestly looks like it's been a while since that has happened."<br><br>Record review of the Admission Record for Resident #57 revealed he was admitted to the facility on 02/21/22 with diagnoses that included Need for Assistance with Personal Care and Type 2 Diabetes Mellitus.<br><br>Resident #195 | M 610 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 610 | Continued From page 17<br><br>An observation and interview on 1/06/25 at 9:00 AM revealed Resident #195's hair and beard to be unkept and matted in appearance, his fingernails were observed to be approximately 1/2 inch long with a thick dark brown substance under the nail beds. Resident #195 stated he had been in the facility for a little over two weeks and had not received a shower, a shave, or even had his hair brushed. He then stated that his nails had also not been trimmed or cleaned since he was admitted. Resident #195 stated he had asked for a shower several times and the staff would say ok but would never come back to give him a shower, and stated, "I am unable to get up by myself, or I would try to do it myself."<br><br>In an observation of Resident #195 on 1/6/24 at 12:10 PM with CNA #1 assigned to the resident, she confirmed that the resident's hair and beard were unkept and did not appear clean. She then stated he did not appear that he had received a shower lately and confirmed the resident's nails were dirty, long, and jagged with some type of brown substance under his nail beds. She then confirmed she had not attempted to do nail care on the resident or give him a shower. CNA #1 then revealed the facility did not have a shower schedule in place letting the staff know when the residents are to be bathed and stated that nail care should be provided as needed.<br><br>In an interview with the shower CNA #2 and record review on 1/06/24 at 1:00 PM, she confirmed the facility did not have a set shower schedule for the residents. CNA #2 then revealed that when a resident receives a shower by the shower team that it would be documented on the shower schedule. She then confirmed she was unable to find any documentation of showers for Resident #195. | M 610 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 610 | Continued From page 18<br><br>During an interview with the DON on 1/07/25 at 10:39 AM, she confirmed that the facility did not have a shower schedule at this time. She stated "The facility had one in place for a while, but no one was following up on it, so it was stopped." She confirmed she was aware there was a problem with residents not receiving showers and confirmed she should have put something in place before now. She then stated concerns from failing to provide a resident with their showers and personal hygiene, is it could cause skin irritation, infection control issues, and dignity concerns.<br><br>Review of the "Admission Record" revealed Resident #195 was admitted by the facility on 12/21/24 with a diagnosis of Acute Kidney Failure.<br><br>Record review of Resident #195's Admission MDS with an ARD of 12/27/24, revealed the BIMS score was 13, indicating the resident was cognitively intact. Section GG0130: Self Care, revealed, E.) Shower/bathe: coded requires substantial/maximal assistance ... I.) Personal Hygiene: coded requires supervision or touching assistance. | M 610 | | |
| M1570 | 48.58.1 Infection Control<br><br>The following infection control standards shall be met:<br><br>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. | M1570 | | 1/31/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 |
|---|---|---|---|---|
| M1570 | Continued From page 19<br>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.<br><br>3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.<br><br>This Statute is not met as evidenced by:<br>Level II Pattern<br>Based on observation, staff interviews, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by failing to utilize proper hand hygiene for one (1) of five (5) resident direct care observations. Resident #37<br><br>Findings include:<br><br>Review of the facility policy titled, "Handwashing-Hand Hygiene Policy and Procedures" with a revised date of 10-2020 revealed, "This facility considers hand hygiene the primary means to prevent the spread of infections." ... 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...g. Before handling clean or soiled dressings, gauze pads, etc...; k. After handling used dressings ..." | M1570 | On 1/8/2025 Resident #37 was reviewed and assessed by the Director of Nursing for any adverse reactions due to failure to prevent the possibility of infections by failing to utilize proper hand hygiene during a direct care observation on 1/8/2025 by state surveyor. No adverse reactions were found. On 1/8/2025 the Assistant Director of Nurses was educated by the Director of Nursing on proper hand hygiene and completed a wound care skilled check off to include the monitoring of infection control practices and hand hygiene. No issues were found.<br><br>All residents have the potential to be affected.<br><br>On 1/9/2025 the Director of Nurses in-serviced nursing staff on the infection control practices to include hand hygiene | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 75VT | A. BUILDING: _____ B. WING _____ | 01/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| 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 |
|---|---|---|---|---|
| M1570 | Continued From page 20<br><br>An observation and interview on 1/8/25 at 9:50 AM with Registered Nurse (RN) #1 providing wound care for Resident #37 with the Director of Nurses (DON) present revealed RN #1 washed her hands, applied clean gloves after removing the residents wound bandage. RN#1 then cleaned Resident #37's sacral wound, patted the wound bed with a dry gauze and then applied Santyl ointment to the wound without changing her soiled gloves, washing her hands, and applying clean gloves. RN #1 confirmed she had not washed her hands and changed her gloves between the dirty and clean procedures and acknowledged that not practicing proper infection control measures could potentially cause an infection in the wound.<br><br>An interview on 1/08/25 at 2:34 PM with the DON confirmed proper hand hygiene was not performed during the wound treatment for Resident #37 and confirmed their policy is to make sure to change gloves and wash hands between dirty and clean wound treatment. She revealed that not doing so is an infection control issue and could delay healing.<br><br>A record review of Resident #37's Admission Record revealed the resident was admitted to the facility on 09/17/2024 with diagnoses that included a Pressure Ulcer of the Sacral Region, Stage 4. | M1570 | during all direct resident care. On 1/9/2025 skilled wound care check offs were initiated on all licensed nurses to ensure accurate infection control practices were followed during direct care to include wound care.<br><br>On 1/10/2025 the Infection Preventionist will make observation rounds on three (3) resident wound care treatments to ensure that accurate infection control practices were followed during direct care. These observations will occur weekly times four (4) weeks and then monthly for three (3) months. On 1/10/2025 a QAPI (Quality Assurance Performance Improvement) meeting was held with the Interdisciplinary team to discuss the survey results. A report of audit findings will be submitted by the Infection Preventionist to QAPI (Quality Assurance Performance Improvement) committee on 1/31/2025 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance. | |