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 _____	C 02/25/2025

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 The State Agency (SA) conducted a complaint investigations for (CI) MS#27948 and CI MS#28002 at the facility from 2/24/25 to 2/25/25. The SA determined the facility was not in compliance with the requirements of the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm related to the complaint CI MS#28002 for resident improperly restrained and cited M 500. Based on the facility's implementation of corrective actions taken on 2/18/25, prior to survey entrance, this deficient practice was determined to be Past Non-Compliance. The SA found no deficient practice for CI MS# 27948 related to quality of care/treatment. The facility had a census of 94 at the time of the survey and held a license for 120 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 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 the facility and to respect the personal rights and private property of other residents; 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	M 500		3/12/25

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 _____	C 02/25/2025

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 1 rate; 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; 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; 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	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 _____	C 02/25/2025

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 2 changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 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; 7. is free from mental and physical abuse; 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; 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 law of third-party payment contract; 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; 11. is not required to perform services for the	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 _____	C 02/25/2025

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 3	M 500		

facility that are not included for therapeutic purposes in his plan of care;

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);

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);

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);

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 by the attending physician or nurse practitioner/physician assistant in the medical record); and

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

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 _____	C 02/25/2025

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 the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Past Non-Compliance Based on staff interviews, record review and facility policy review, the facility failed to ensure that a resident was free from restraints for one (1) of three (3) residents reviewed: Resident #1. Based on the implementation of the facility's corrective actions on 2/18/25, the deficient practice was determined to be past noncompliance, and the facility was found in compliance as of 2/19/25. Findings Included: A review of the facility policy titled "Facility Policy on Personal Safety Devices (PSDs) with a revision date of 02/2025 - Enablers - Side Rails and Restraints" revealed the following: "Restraint Policy Intent: Patients/Residents have the right to be free from any physical restraint imposed for purposes of discipline or convenience..." Record review of the "Admission Record" revealed that the facility admitted Resident #1 on 12/5/24 with a medical diagnosis that included Unspecified Dementia. A record review of the facility investigation revealed that on 2/18/25, an allegation of restraint was reported to the Director of Nursing (DON). The DON was notified by Licensed Practical Nurse #1 (LPN #1) that Resident #1 was observed lying on her left side with a sheet tied across her chest to the bed frame and another sheet tied across her legs to the bed frame. It was further alleged that LPN #2 was the	M 500	Past noncompliance no POC required	

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 _____	C 02/25/2025

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	M 500		

perpetrator. It was reported that LPN #1 and Certified Nursing Assistant #1 (CNA #1) immediately went to the room and removed the bed sheets. The DON notified the Administrator (ADM) of the allegation. LPN #2 was interviewed by the ADM and was notified of suspension pending investigation. A complete body audit of Resident #1 revealed no adverse findings. Resident #1 was placed under one-on-one observation until further notice. Upon completion of staff interviews assigned to the shift on 2/18/25, it was determined that LPN #2 had secured two flat sheets across Resident #1's torso and lower extremities, tying them to the bed frame. Additionally, it was established that the resident was restrained for approximately five (5) minutes before being released. LPN #2 denied the allegations but verbally admitted to securing the sheet at two corners, stating that this was intended to prevent the resident from getting up unassisted to avoid falls and to aid with turning. In conclusion, the allegations were substantiated, and LPN #2 was terminated.

A review of a written statement dated 2/18/25 and signed by LPN #2 revealed: "Resident was up and down throughout the night, in and out of bed, using a wheelchair, and walking in the dining room. Numerous attempts to redirect and educate failed by CNA staff and the nurse. The resident continued talking to persons not present. This nurse took a flat sheet and laid it across the top of the resident, sat there, and explained the importance of not getting out of bed. The nurse reminded the resident of her last two falls and discussed the use of the sheet across the top of her as an indicator/reminder that she should not get out of bed. This nurse tucked one side of the sheet loosely under the mattress, with the other side open and resting on the floor mat. 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 _____	C 02/25/2025

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	M 500		

resident remained in bed for the rest of the night. The resident was not restrained in any way and was fully capable of movement in bed and of getting out of bed, as demonstrated earlier. The use of the flat sheet was a 'mind over matter' approach for the safety of the resident, as the resident had previously harmed herself by attempting to ambulate and transfer without assistance while refusing to call for help."

A review of a written statement dated 2/18/25 and signed by CNA #3 revealed that during rounds, she witnessed Resident #1 tied in two (2) places to her bed with sheets-one across the legs and the other across the abdomen.

A review of an undated witness statement signed by CNA #4 revealed that LPN #2 stated she had tied Resident #1 up. The assigned agency CNA checked the resident and reported that she was restrained.

During a telephone interview with LPN #1 on 2/24/25 at 3:41 PM, she stated that when she returned from lunch between 2:00 AM and 2:30 AM, CNA #4 informed her that Resident #1 was tied to the bed. LPN #1 went to the room and observed a sheet over the resident's torso, tied under the bed, and another sheet over the resident's legs, also tied under the bed. She stated that the resident was asleep and in no distress. She immediately removed the sheets, evaluated the resident, and noted no injuries. She then notified the DON.

In an interview with the ADM on 2/24/25 at 11:00 AM, the ADM confirmed that on 2/18/25, she received a report that Resident #1 had been restrained to her bed with sheets by LPN #2. She verified that the investigation revealed that

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 _____	C 02/25/2025

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 Resident #1 was seen by staff lying on her left side with a sheet tied across her chest to the bed frame and another sheet tied across her legs to the bed frame. Staff immediately removed the sheets and evaluated the resident, who was found to have no injuries. She stated that on 2/18/25, LPN #2 was suspended pending investigation and subsequently terminated when the investigation substantiated that she had restrained Resident #1. The ADM further stated that on 2/18/25 at 7:30 AM, the Risk Manager initiated an update of the care plan for Resident #1. The Staff Development Coordinator provided education to all staff on abuse prohibition, resident rights, the Vulnerable Adults Act, the Restraint-Free Facility Initiative, and a physical abuse competency quiz. A head-to-toe body assessment was conducted by the Registered Nurse Supervisor, with no negative findings. The Medical Director was notified, and Resident #1 was placed on one-on-one monitoring. A telehealth visit with a Psychiatric Nurse Practitioner, along with the Assistant DON and Resident #1, resulted in no negative findings. The DON notified Resident #1's resident representative. Record review revealed that on 2/18/25 at 10:30 AM, life satisfaction rounds were conducted with residents scoring 12 or higher on the Brief Interview for Mental Status (BIMS) test to determine any knowledge of the perpetrator, witness accounts, or experience of abuse. Peer reviews were also initiated with staff to assess any knowledge of the perpetrator or abuse incidents. A physician assessed Resident #1, noting no negative findings. The Social Services Director conducted a trauma assessment on the resident.	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 _____	C 02/25/2025

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 Record review revealed that at 2:30 PM on 2/18/25, an ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held to assess the situation, establish a timeline of events, discuss immediate and systemic actions, and develop monitoring plans related to Resident #1's restraint incident. On 2/19/25 at 4:15 PM, a Resident Council Meeting was held to inform residents of the incident, discuss the suspension of the perpetrator, and provide education on different forms of abuse, including restraints and reporting procedures. The facility committed to conducting abuse drills for three (3) months, then quarterly. Random resident interviews and body audits will be conducted weekly for four (4) weeks, biweekly for eight (8) weeks, and then monthly for three (3) months. Findings will be reviewed by the QAPI Committee for further action. In a further interview on 2/25/25 at 8:45 AM, the ADM reiterated that the facility maintains a restraint-free policy and that it was her expectation that LPN #2 would not have restrained Resident #1. Validation: On 2/25/25, the State Agency (SA) validated through interviews and record reviews that all corrective actions had been implemented as of 2/18/25, and the facility was in compliance as of 2/19/25, prior to the SA's entrance on 2/24/25.	M 500		