STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BLUFFS REHABILITATION AND HEALTHCARE CENTER	2850 PORTER'S CHAPEL ROAD , VICKSBURG, Mississippi, 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) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an onsite complaint investigation (CI) for CI MS # 2582568, CI MS # 2603681, and CI MS # 2617157 at the facility on 9/22/25- through 9/23/25. During the survey, the SA determined that the facility was not compliance with the requirements of participation in Medicare and Medicaid Services for CI MS # 2582568 and cited F 655 and F 689 related to accidents and hazards. The SA investigated CI MS # 2603681, and CI MS # 2617157 and no deficiencies were cited. The SA investigated staffing, quality of care, abuse, nursing services, environment, and activities of daily living. The census at the time of the survey was 96 with a bed capacity of 120 beds.	F0000		
F0655 SS = G	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F0655		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0655 SS = G	Continued from page 1 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to complete a baseline care plan that included the minimum healthcare information necessary to provide effective, person-centered care. This failure resulted in the residents' transfer needs not being identified or communicated to staff. This deficient practice was identified for one (1) of five (5) residents reviewed for baseline care plans (Resident #1). Cross-reference F689. Findings include: Review of the facility policy titled, "Care Plans-Baseline," last reviewed 6/2/25, revealed: "The baseline care plan includes instructions needed to provide effective, person-centered care of the resident	F0655		

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F0655 SS = G	Continued from page 2 that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident." Record review of the Baseline Care Plan for Resident #1 dated 9/3/25 (day of admission) revealed Self-Care: Admission Performance – Chair/bed to chair transfer was marked not assessed/no information. Record review of the Visual/Bedside Kardex Report as of 9/23/25 for Resident #1 revealed Transfer Assistance: no information listed. Record review of the Section GG Mobility form for Resident #1 dated 9/4/25 revealed chair/bed transfer coded as dependent. Record review of Resident #1's progress note dated 9/18/25 documented: "Resident obtained a laceration during transfer from bed to chair. Classified as trauma injury. Area measured 4.5 cm (centimeter) x 5.5 cm x 0.2 cm." On 9/22/25 at 3:00 PM, during an interview with the Risk Manager she confirmed Resident #1 was dependent and required a total lift for transfers. She acknowledged this information was not reflected on the Kardex and confirmed staff should have consulted the nurse supervisor for clarification. During an interview with the Minimum Data Set (MDS) Coordinator on 9/23/25 at 8:50 AM, she confirmed the baseline care plan was incomplete related to Resident #1's transfer status, and the Kardex was missing this information as well. She stated the resident was dependent and required a total lift for transfer, and staff should have clarified with the nurse supervisor when the information was not documented. Record review of the "Admission Record" revealed Resident #1 was admitted on 9/3/25 with a diagnosis of alcoholic cirrhosis of liver with ascites. Record review of Resident #1's MDS with an Assessment Reference Date (ARD) of 9/12/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F0655		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689		

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F0689 SS = G	Continued from page 3 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to ensure Resident #1 was transferred safely in accordance with her assessed needs. Staff performed a manual transfer instead of using the required total lift, which resulted in a traumatic injury to the resident's right leg. This deficient practice was identified for one (1) of three (3) residents reviewed for accident hazards (Resident #1). Cross-reference F655 Findings include: Review of the facility policy titled, "Safe Patient Handling and Moving Protocol," latest review 6/18/25, revealed: "The licensed nurse will, upon resident admission, determine the level of assistance required to safely transfer the resident, while minimizing risk to resident and staff." An observation and interview on 9/22/25 at 2:00 PM revealed Resident #1 with a large bandage to her right lateral lower leg. She stated that on 9/18/25 two staff members attempted to transfer her from the bed to the wheelchair without using a mechanical lift. She stated she told the staff she required the lift because she was very weak, but they proceeded to remove the wheelchair armrest and slide her over. She reported her legs and torso slipped downward, striking the exposed metal of the wheelchair armrest slot, causing a laceration to her right leg. In an interview with Resident #1's Representative (RR) on 9/22/25 at 2:10 PM, she confirmed that she observed the staff transfer Resident #1 without a lift on 9/18/25 after both her and the resident informed them that a lift was required. She confirmed that the resident slipped, her right leg struck the wheelchair, and a laceration occurred. Record review of the Section GG Mobility form for	F0689		

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F0689 SS = G	Continued from page 4 Resident #1 date 9/4/25 revealed chair/bed transfer coded dependent. During an interview on 9/23/25 at 8:27 AM, Certified Nurse Assistant (CNA) #2 confirmed she assisted with the transfer along with the Van Transporter (VT) for Resident #1 on 9/18/25. She stated they slid the resident into the wheelchair, and the resident's leg struck the metal frame, resulting in a tear. She confirmed the sling pad was in the wheelchair seat but stated she did not think to question why. During an interview on 9/23/25 at 8:30 AM, the VT confirmed she assisted with the transfer of Resident #1 on 9/18/25 and acknowledged the resident slipped. She admitted that she noticed the sling pad in the resident's chair but did not question it. During an interview on 9/23/25 at 8:45 AM, the Treatment Nurse stated that she assessed Resident #1's wound after the transfer on 9/18/25 and confirmed it was a trauma laceration, not a skin tear. She measured the injury at 4.5 centimeter (cm) x 5.5 cm x 0.2 cm and confirmed it occurred when staff manually slid the resident instead of using the lift. Record review of Resident #1's progress note dated 9/18/25 documented: "Resident obtained a laceration during transfer from bed to chair. Classified as trauma injury. Area measured 4.5 cm x 5.5 cm x 0.2 cm." During an interview with the Risk Manager on 9/22/25 at 3:00 PM, she confirmed Resident #1 was not transferred according to her assessed needs. She stated the resident was dependent and required a total lift for transfers. She further confirmed the transfer status was not reflected on the Kardex for staff to follow, and that staff should have consulted the nurse supervisor to clarify. She acknowledged that failing to transfer a resident properly can lead to accidents. Record review of the "Admission Record" revealed Resident #1 was admitted on 9/3/25 with a diagnosis of alcoholic cirrhosis of liver with ascites. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/12/25 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F0689		