Mississippi State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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
M0000	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, SA determined that the facility was not compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm for CI MS # 2582568 and cited M 640 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.	M0000		
M0640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Level III 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). Findings include: Review of the facility policy titled, "Safe Patient Handling and Moving Protocol," latest review 6/18/25,	M0640		

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

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M0640	Continued from page 1 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 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	M0640		

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M0640	Continued from page 2 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.	M0640		