

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255140	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2022
NAME OF PROVIDER OR SUPPLIER THE BLUFFS REHABILITATION AND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
E 000	Initial Comments *****	E 000			
E 004 SS=E	Survey conducted on 06/17/22 reveals the above facility does not meets all applicable Federal, State and local emergency preparedness requirements. Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004			7/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/05/2022

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 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.

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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide an updated emergency preparedness (EP) Plan per requirements of 42 CFR §483.73(a). Findings Include: On 6/17/22 at 10:45 AM, the facility failed to provide an updated (2021 or 2022) emergency Preparedness (EP) plan. Documentation review revealed the facility provided an EP plan dated from the year of 2019. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview on 6/17/22.	E 004	1. Emergency Preparedness Manual in place. 2. Operation not affected policy in place. 3. Record Retain manual checks for binders to ensure accuracy and up to date. 4. A Quality Assurance Performance Improvement meeting was held with the Medical Director and the Interdisciplinary team on 7/7/ 22 to discuss requirements on transfers to include resident representative notification of bed hold policy reservation agreement. Beginning on 7/6/22, the Maintenance Director will conduct an audit weekly for four (4) weeks, then monthly for three (3) months to determine for each transfer that		

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E 004	Continued From page 2	E 004	a bed hold policy reservation agreement was mailed. The Maintenance Director will report the findings to the Quality Assurance Performance Improvement committee monthly starting on 07/07/2022 for three (3) months for further recommendations. The Administrator is responsible for monitoring and compliance.¿		