STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255140	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bluffs Rehabilitation and Healthcare Center	2850 Porter's Chapel Road Vicksburg, MS 39180

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 47158 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 Include: 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 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. (continued on next page)

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.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.