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	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, 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 0655 Level of Harm - Actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Actual harm Residents Affected - Few	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 [DATE] 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	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 [DATE] 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.