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	04/21/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, staff interviews, record reviews, facility's investigation review, and facility policy review, the facility failed to provide adequate supervision to prevent a cognitively impaired resident, from exiting the facility and entering an uncontrolled, hazardous environment without staff awareness for one (1) of three (3) residents reviewed for elopement. Resident #1. This failure resulted in the resident propelling in a wheelchair approximately one-half (0.5) mile down the facility driveway and across a busy roadway, where environmental hazards included a steep ditch and wooded area, creating a situation that was likely to cause serious injury, harm, impairment, or death. During the investigation, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 4/14/26 and existed at 42 CFR: 483.25 (d)(1)(2)- Free of Accidents Hazards/Supervision/Devices (F689) - Scope and Severity J. This situation placed Resident #1 and other cognitively impaired residents, at risk for serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 4/20/26 at 5:01 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 4/16/26, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 4/17/26, prior to the SA's entrance on 4/20/26. Findings Include: A review of the facility's policy, titled Wanderer Management, Monitoring System and Resident Elopement Protocol reviewed 3/3/26, revealed Policy, it is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. A record review of the facility's investigation, revealed on Tuesday, 4/14/26, at approximately 3:32 PM, Certified Nursing Assistant #1 (CNA), was entering her personal vehicle when a pest control representative informed her that a resident in a wheelchair was heading toward the bottom of the facility driveway. Earlier, Resident #1 had been seen sitting on the facility's front porch. CNA #1 immediately went down the driveway to assist him and found Resident #1 seated in his wheelchair across the driveway in a grassy section. She then blocked the roadway with her car and called the nurse's station to request help. CNA #1 stayed with him until additional staff arrived. Staff proceeded to assist with escorting Resident #1 into the facility. At 3:34 PM, the Human Resources Director received a call from an officer of the County Emergency Management/ Police Department, who reported that he was present with the resident and employee securing the roadway. Resident #1 was assisted back into the facility at 3:45 PM. He was alert and oriented. He denied pain or discomfort. No apparent injuries. The resident was received in a pleasant and cooperative mood. He was placed on one-on-one observation. A body audit was completed with no adverse findings. The Physician/Medical Director, Nurse Practitioner, Responsible Party were notified. An observation of the route taken by Resident #1 on 4/20/26 at 3:35 PM revealed resident propelled one-half (0.5) mile down the facility driveway and across a heavily trafficked road. Environmental hazards across the road included a steep ditch and wooded area. Record review of past weather in the area on 4/14/26 revealed a temperature between 81 and 84 degrees, with no precipitation. Record review of Nex-Wander Data Collection-V2 form, dated 11/17/25, for Resident #1 revealed a score of seven (7), indicating that the resident was a moderate risk for wandering. Interview with CNA #2 on 4/20/26 at 12:05 PM, revealed that she was assigned to (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 on 4/14/26. She stated that when she clocked out at 3:08 PM Resident #1 was sitting on the front porch. She stated he was wearing long pants, a short- sleeved shirt and non-slip shoes. She stated that he usually went outside with the smokers to drink coffee and staff were always present. She stated she was unsure of how he got outside and felt he possibly followed one of the other residents out. During an interview with the Interim Director of Nursing (IDON) on 4/20/26 at 1:00 PM she verified that the resident did not wander and had never attempted elopement in the past. Telephone interview with CNA #1 on 4/20/26 at 3:10 PM she stated she was leaving the facility, and the pest control person told her a resident was rolling down the driveway. She stated she got into her car and started driving down the driveway and saw the resident. She verified that she tried to get him to stop but he propelled his wheelchair across the street. She further stated that she blocked traffic on the street with her car and called staff to assist with getting the resident back to the facility. Record review of the admission Record revealed the facility admitted Resident #1 on 11/17/25 with diagnoses that included Cerebral Infarction and Hemiplegia and Hemiparesis affecting Right Dominant Side. Record review of the Brief Interview for Mental Status (BIMS) assessment, dated 4/14/26, revealed a score of nine (9), indicating that Resident #1 was moderately cognitively impaired. The facility implemented the following Corrective Action Plan prior to the State Agency's entrance on 4/20/26: The facility failed to provide supervision to a cognitively impaired resident. On 04/14/2026 at 3:32pm, Resident #1 was seen propelling wheelchair moving down the facility driveway. Resident #1 was observed sitting on front porch prior to incident. CNA # 1 was alerted and responded. Before CNA #1 arrived at residents' location, Resident #1 had crossed the facility drive into a grassy area. State agency provided IJ template on 4/20/2026 at 5:01 PM. Corrective Actions On 4/14/2026 at 3:08 PM, CNA #2 saw Resident #1 on the front porch in a wheelchair drinking water. On 04/14/2026 at 3:32 PM, CNA #1 was getting into her personal vehicle and was notified by pest control representative that Resident #1 was headed towards the bottom of the facility driveway. On 04/14/2026 at 3:34 PM, CNA #1 was with Resident #1, blocking road with car to secure Resident #1 safety. On 04/14/2026 at 3:35 PM, CNA #1 contacted Nurses station to obtain assistance escorting Resident #1 back into the facility. On 04/14/2026 at 3:35 PM Licensed Practical Nurse (LPN) #1 received notification to assist with escorting Resident #1 back into the facility. On 04/14/2026 at 3:35 PM, Interim DON was notified of resident location. On 04/14/2026 at 3:36 PM Local County Police officer #1 notified Human Resources (HR) that he was also with resident and blocking off roadway on opposite side. On 04/14/2026 at 3:45 PM, Resident #1 was escorted back into the facility. On 04/14/2026 at 3:45 PM, the facility initiated a one-to-one monitoring for Resident #1. On 04/14/2026 at 3:48 PM, LPN #1 conducted a head-to-toe body audit on Resident #1 to review for any skin abnormalities with no negative findings. On 04/14/2026 at 3:55 PM, the Administrator was notified of Resident #1 location and return. On 04/14/2026 at 3:55 PM, Resident #1 had a wander guard bracelet placed on his left ankle and a new wandering evaluation conducted by LPN #1. On 04/14/2026 at 3:58 PM, the Maintenance Director changed the door codes of all exit doors. On 04/14/2026 at 4:15 PM, Resident #1 Responsible Party (RP) was notified of the incident. On 04/14/2026 at 4:24 PM, the Risk Manager (RM) audited the facility; all residents were accounted for, and none were missing. On 04/14/2026 at 4:27 PM, the Nurse Practitioner (NP) was notified of resident previous location and return. On 4/14/2026 at 4:29 PM the Social Services Director (SSD) administered a Brief Interview for Mental Status (BIMS) for Resident #1, yielding a score of nine (9). On 04/14/2026 at 5:04 PM, the Staff Development Coordinator (SDC) initiated in-servicing with all direct care staff to include all Licensed Nurses and CNAs on Elopement policy and procedures along with Abuse, Neglect, and Resident Rights. No one will be allowed to work until in-serviced. On 4/15/2026 at 9:30 AM, the Administrator, Corporate Clinical Specialist (CCS), and Regional [NAME] President (RVP) discussed facility wide procedure changes initiated with residents not exiting facility with BIMS below 12 unless they are supervised and signed out along with safety vest provided. On 4/15/2026 at 11:58 AM, Resident #1 was assessed by the Social Service Director (SSD) to follow up with no signs of distress resulting. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/15/2026 at 12:30 PM, the facility NP evaluated and assessed Resident #1 and ordered labs to be obtained. On 4/15/2026 at 12:40 PM, a meeting was held with NP, the Administrator, Corporate Clinical Specialist, Risk Manager along with the Interdisciplinary Team to discuss the plan of action for Resident #1 investigation and new process that all cognitively intact residents with a BIMS score of 12 or higher must sign out when exiting and sign back in upon return. A safety vest will be provided. All residents with a BIMS of less than 12 must be accompanied by a staff or family member. On 04/15/2026 at 12:44 PM, the Interim DON notified psychiatric Nurse Practitioner to conduct and evaluate Resident #1. Addition of antidepressant to medical record. On 04/15/2026 at 1:35 PM, the Minimum Data Set (MDS) #1 updated Resident #1 care plans to reflect wander behavior along with wander guard and monitoring in place. On 4/15/2026 at 2:15 PM the Risk Manager performed an elopement drill with the day shift staff to review and discuss the elopement policies and procedures. On 4/15/2026 at 2:35 PM, a Quality Assurance (QA) Committee Meeting was held with Medical Director, Administrator, Corporate Clinical Specialist and Interdisciplinary team to discuss Resident #1 exit of facility and return. Root cause analysis along with a plan of correction and new procedures put into place. On 4/15/2026 at 3:00 PM, an audit was conducted by Medical Records (MR) on current high-risk wander patients to review orders, wander binder, wander guards, and care plans for accuracy. There are currently nine (9) high risk wandering patients. No changes were needed. On 4/15/2026 at 3:00 PM, an audit was conducted by LPN # 2 on the current resident sign out book to ensure all resident's sign out sheet is correctly color coded according to BIMS. On 4/15/2026 at 3:30 PM, a resident council meeting was held to discuss effective new procedures immediately regarding signing out with supervisor requirements prior to exit for safety. On 4/15/2026 at 4:35 PM, the Mississippi State Department of Health was notified of Resident #1 exit and return to facility. On 4/15/2026 at 5:55 PM, the Social Service Director (SSD) held a care plan conference with Responsible Party regarding Resident #1 incident along with plan of action. On 4/15/2026 at 6:43 PM, the Risk Manager (RM) performed an elopement drill with the evening shift staff to review and discuss the elopement policies and procedures. On 4/15/2026 at 7:04 PM, the RM notified the Ombudsman of Resident #1 exit and return to facility along with action plans in place. On 4/16/2026 at 9:13 PM, an electronic automatic phone system notification was utilized to alert residents' Responsible Parties and Staff members of new changes put into place regarding residents increased supervision with signing out prior to exiting facility. On 4/16/2026 at 10:00 PM, the elopement quiz along with education on the new procedures regarding residents increased supervision was placed into the orientation packet. On 04/16/2026 at 11:05 PM the Maintenance Director performed an elopement drill with the night shift staff to review and discuss the elopement policies and procedures. In order to monitor current residents for potential risk, residents will be monitored by the DON through incident report review, observations, and communication with staff. Daily checks to ensure that no residents with a BIMS score of less than 12 are out unattended will be conducted by DON for two (2) weeks, then three (3) times weekly for six (6) weeks, and then monthly for three (3) months. The administrator/designee will conduct elopement drills/scenarios quarterly for up to a year and then bi-annually thereafter. The maintenance or designee will conduct staff training elopement drill monthly with rotating shifts until all shifts are completed for three (3) months and then quarterly thereafter. The facility alleged all corrective measures were fully implemented on 4/16/2026 and the Immediate Jeopardy was removed on 4/17/2026. Validation: The State Agency (SA) validation of the Corrective Action Plan was made on-site during the Complaint Investigation (CI) #2985572 through observations, record review and interviews on 4/20/26 through 04/21/26. The SA determined all corrective actions were completed on 4/16/26 and the IJ was removed on 4/17/26 prior to the SA entrance into the facility.