

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>255140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>09/09/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>THE BLUFFS REHABILITATION AND HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>2850 PORTER'S CHAPEL ROAD VICKSBURG, MS 39180</b>	
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 0880  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Many	<b>Provide and implement an infection prevention and control program.</b>  Based on observations, record review, staff interviews, and the facility protocol entitled, COVID-19: Screening Checklist - for Visitors and Staff, the facility failed to screen accordingly one (1) of one (1) visitor, who entered the facility and had potential access to 83 of 83 residents, and facility staff. The failure occurred during a COVID-19 pandemic. The findings include: During a concurrent observation and interview on 09/08/2020 at 3:29 p.m., Hospitality Aide (HA) #1 allowed visitor access into the building, and did not screen according to the facility's protocol. Review of the facility screening protocol revealed, the HA was supposed to screen if the visitor had worked in facilities or locations with recognized COVID-19 cases. The HA stated, It was an oversight on my part. The HA acknowledged an awareness of the COVID-19 pandemic and the importance of screening accordingly. During an interview on 09/08/2020 at 3:35 p.m., the Director of Nursing stated she expected each question to be asked per the COVID-19 screening protocol. Review of the facility records provided by the facility, revealed, there were four (4) residents confirmed positive for COVID-19. Review of the facility's protocol revealed, several screening questions were to be completed by the screener; to include question 3B which read, .Ask if they have worked in facilities or locations with recognized COVID-19 cases? If yes, ask if they worked with a person(s) with confirmed COVID-19? .		

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

TITLE

(X6) DATE

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.