STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265498	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluffs, The	3105 Bluff Creek Drive Columbia, MO 65201

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 - 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** 43024 Based on interview and record review, facility staff failed to provide a proper mechanical lift transfer for one resident (Resident #1) in a manner to prevent accidents when staff failed to lower the resident appropriately in the shower chair which resulted in a compression fracture (a break in a vertebra, or bone in your spine, causes it to collapse) the resident's spine. The facility census was 115. 1. Review of the facility's use of lift machine policy, dated 11/25/2019, showed the purpose of the policy is to help lift residents who otherwise may not be transferred manually, promote comfort and maintain good body alignment while resident is being moved, to position the resident in desired location, and use controls to slowly lower resident to that location. 2. Review of Resident #1's five day Minimum Data Set (MDS) a federally mandated assessment tool, dated 7/1/24, showed staff assessed the resident as follows: -Cognitively intact; -Required substantial maximal assistance for toileting, showers, and transfers; and -Impairments to both lower extremities. Review of Resident #1's Baseline Care plan, dated, 6/25/24, showed staff assessed the resident as required two-person assistance with bed mobility and toileting. The resident utilized a power wheelchair. Review of the facility's investigation, dated 7/6/24, showed staff documented the resident requested to be transferred to the shower chair via mechanical lift. While being assisted by two staff members with the use of the mechanical lift, the lifts knob released too quickly and the resident was abruptly lowered into the shower chair. The resident complained of pain afterwards and staff called an ambulance. Resident sent to the hospital. (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

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	Review of the resident's nurse notes, dated 7/6/24 at 7:06 P.M., showed Registered Nurse (RN) A documented two staff members assisted the resident into his/her chair with the mechanical lift. Review showed after transfer was completed patient stated to Certified Nursing Assistant B he/she was sat down too hard and was now hurting and uncomfortable. The staff then transferred resident to his/her bed. Staff called 911 to go to hospital for back pain. Nurse went to room and resident said he/she did not need a nurse assessment he/she knew he/she was going no matter what because he/she was afraid of a back injury. The resident was transported to the hospital. Review of the resident hospital records, dated 7/18/24, showed the resident had a recent history of lower back region of the spine laminectomy (surgery where part or all of the bone is removed) and bilateral discectomy (surgical procedure to remove a section of two intervertebral discs to treat severe lower back pain) in April 2024 and a revision surgery on June 2024. He/She presented to the emergency department on 7/6/24 with low back pain after being lowered too quickly at his/her skilled nursing facility. Computed tomography of the lumbar spine in the emergency department showed L1-L2 compression fracture (a break in a vertebra, or bone in your spine, causes it to collapse) which is new, and neurosurgery consulted. He/She taken to the operating room [ROOM NUMBER]/16/24 for L2-L3 fusion, L2 hardware removal, facet fusion of L1-2 and L3-4. During an interview on 1/13/24 at 10:11 A.M., the administrator said the resident was in the facility because he already had a surgery to the spine, the resident was a two person mechanical lift, he/she said he/she was sat down too hard in the shower chair and staff went to get nurse and the resident called 911 and left, he/she never came back and he/she was not certain what happened to the resident. During an interview on 1/13/24 at 12:03 P.M., the administrator said after reviewing additional hospital records it looked like the resident had new damage to his/her spine. During an interview on 1/15/24 at 12:36 P.M., RN A said he/she can remember the aide on duty came to him/her and said the resident said his/her back hurt really bad. He/She said the resident called to go to the hospital for the back pain because the resident said he/she had been dropped too hard into the shower chair. The resident declined for the nurse to assess him/her. RN A said he/she questioned the aides on duty who said there were two aides present and there was no malfunction to the lift. He/She said the resident never came back to the facility. During an interview on 1/23/25 at 4:57 P.M., Certified medication technician (CMT) A said he/she was on the medication cart that day and was asked by CNA B to spot him/her on the mechanical lift. He/She said CNA B let the resident down too quick which caused the resident to drop down into the shower chair from the mechanical lift and the resident was really upset and complained about immediate back pain. MO000247806