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	01/30/2026

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain professional standards of practice when staff failed to ensure wound care orders were in place for one resident (Resident #123), failed to follow wound care orders for one resident (Resident #7), failed to follow orders for wrist splints to prevent or maintain contractures for one resident (Resident #19), and failed to complete neurological assessments after falls for two residents (Resident #103 and #63), out of 27 sampled residents. The facility census was 115.1. Review showed the facility failed to provide a policy that directs staff in regard to physician's orders.2. Review of Resident #123's discharge Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/12/26, showed staff assessed the resident as:-Cognitively Impaired;-Substantial/Maximal assistance with shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene;-One or more unhealed pressure ulcers (damage to skin and underlying tissue caused by prolonged pressure, friction, or shear, commonly occurring over bony prominences like heels, tailbone, or hips);-Two unstageable pressure ulcers.Review of the resident's progress notes showed staff documented the resident went to hospital on [DATE] and returned to the facility on [DATE].Review of the resident's Physician Order Sheet (POS), dated 01/22/26, did not contain documentation of a treatment order for two unstageable pressure ulcers on right lateral foot.Observation on 01/29/26 at 9:27 A.M., showed the resident had two pressure ulcers to right lateral foot.Observation on 01/29/26 at 2:45 P.M., showed resident in bed with no dressings to right lateral foot pressure ulcers.During an interview on 01/29/26 at 3:30 P.M., Licensed Practical Nurse (LPN) I said he/she was unsure if the resident's dressing has been done yet. He/She said he/she was not aware that resident does not have a treatment order for right lateral foot pressure ulcers since returning from hospital. He/She said the resident returned from hospital at the end of last week and it must have gotten missed when entering orders. He/She said the wound clinic, was here on Tuesday 01/27/26 and gave new orders for pressure ulcers but he/she is behind and had not had a chance to enter the new treatment orders into the computer. He/She said if there is no order in computer, then the nurse does not know to complete the treatment as ordered.During an interview on 01/30/26 at 5:04 P.M., the Director of Nursing (DON) said he/she expects staff to follow physician orders. He/She was not aware that the resident had no treatment orders since returning from the hospital. The DON said the wound nurse should have entered them into computer, but he/she should have checked to ensure it was done. He/She said the admitting charge nurse puts the orders in from hospital and then once they perform a readmit skin assessment they should have reached out to the wound nurse or doctor for treatment orders for the pressure ulcers.During an interview on 01/30/26 at 5:43 P.M., the administrator said he/she expects staff to follow physician's orders. He/She said he/she was not aware that the resident did not have treatment orders since returning from hospital. He/She said the admitting charge nurse, or the wound nurse should have entered the orders in. 3. Review of Resident #7's Significant Change MDS, dated [DATE], showed staff assessed the resident as:-Moderately cognitively impaired;-Required partial/moderate assistance from staff for shower/bathing and upper body dressing;-Dependent on staff assistance for lower body dressing, putting on/taking off footwear, (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and personal hygiene;-One or more unhealed pressure ulcers;-Two unstageable pressure ulcers.Review of the resident's POS, dated January 2026, showed an order to cleanse bilateral heels with wound cleanser, pat dry, apply betadine, cover with dry four by fours, wrap with kerlix (crinkle-weave gauze) and secure with tape.Observation on 01/29/26 at 10:52 A.M., showed LPN I performed a dressing change to bilateral heels. LPN I cleansed heels, patted dry, applied betadine, and wrapped heels with kerlix and secured with tape. LPN I did not cover the resident's heels with dry four by fours before wrapping with kerlix.During an interview on 01/29/26 at 3:30 P.M., LPN I said there should have been a piece of sterile gauze between the pressure ulcers and kerlix. He/She said he/she realized it after he/she wrapped the heels. He/She said he/she should have taken the dressings back off and done it correctly but did not. He/She said it is important to follow physician's orders to ensure the wound heals appropriately.During an interview on 01/30/26 at 5:04 P.M., the DON said it is important to follow physician's orders so that staff know if the treatment is working or not or if something else needs to be done.During an interview on 01/30/26 at 5:43 P.M., the administrator said he/she expects staff to follow physician's orders. He/She said if staff do not follow physicians orders the pressure ulcer could get worse. 4. Review showed the facility failed to provide a policy that directs staff on contractures, assistive devices, and/or limited range of motion.5. Review of Resident #19's significant change MDS, dated [DATE], showed staff assessed the resident as:-Cognitively intact;-Did not reject care;- Impairment of upper extremity on one side;- Dependent on staff for all mobility;- Diagnoses of arthritis, osteoporosis, and amyotrophic lateral sclerosis (ALS - a progressive neurodegenerative disease that destroys motor neurons controlling voluntary muscles, leading to muscle weakness, twitching, and eventual paralysis), and generalized muscle weakness.Review of the resident's POS, dated January 2026, showed an order dated 09/25/25, for wrist splints: on in the A.M. and off in the P.M., once a day.Review of the resident's Treatment Administration Record (TAR), dated January 2026, showed staff documented resident refused splints as ordered on 01/01/26, 01/02/26, 01/06/26, 01/11/26, 01/13/26, 01/15/26, 01/16/26, 01/17/26, 01/18/26, 01/19/26, 01/20/26, 01/22/26, 01/23/26, 01/24/26, 01/26/26, 01/27/26, 01/29/26 and 01/30/26.Review of the resident's care plan, dated 01/15/26, did not contain documentation of wrist splints or refusals of care.Observation on 01/28/26 at 8:23 A.M., showed the resident in his/her wheelchair in the assisted dining area not wearing his/her wrist splints.Observation on 01/28/26 at 8:59 A.M., showed the resident in his/her power wheelchair with his/her left hand curled in his/her lap.Observation on 01/29/26 at 8:22 A.M., showed the resident in the assisted dining room without his/her wrist splints on. Observation on 01/29/26 at 10:38 A.M., showed the resident in his/her room without his/her wrist splints on. The wrist splints sat on top of a pile of papers.Observation on 01/30/26 at 10:40 A.M., showed the resident in his/her power wheelchair in assisted dining room, without splints on his/her wrists.Observation 01/30/26 at 10:41 A.M., showed the resident's splints on top of a printer on a table in the resident's room.During an interview on 01/28/26 at 9:10 A.M., the resident said staff do not put any rolls or wash cloths in his/her hand to help with the contracture.During an interview on 01/29/26 at 10:38 A.M., the resident said staff does not ask him/her if he/she wants to wear the splints, and said he/she has not refused them, he/she would like to wear them, and the splints are newer.During an interview on 01/30/26 at 3:07 P.M., Certified Nurse Aide (CNA) N said he/she did not personally know about the splints, but said the resident does wear them to bed, and the resident will ask to put them on at night.During an interview on 01/30/26 at 3:12 P.M., CNA O said the resident wears the splints when he/she sleeps, and nurses document on the TAR when they are on the resident. During an interview on 01/30/26 at 3:15 P.M., LPN K said the resident refuses to wear the splints almost every day, they are ordered to be put on in the morning and taken off at bedtime. LPN K said the resident has good days and bad days, but never wants to wear the splints, and it should be documented if he/she refuses.During an interview on 01/30/26 at 3:27 P.M., LPN I said the resident does not wear the splints during the day, he/she wears them at night, and was not familiar with the resident's order off the top of his/her head, he/she would have to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	look at it. LPN I said the resident has a power wheelchair and manual wheelchair and is unable to steer himself/herself with the splints in place. The LPN said the order should be changed.During an interview on 01/30/26 at 4:30 P.M., the DON said he/she is not sure if the resident is supposed to be wearing splints. The DON said the resident has changed in the last few weeks, and the resident was wearing them daily all the time when he/she was first admitted . The DON said the resident's ALS is progressing and he/she has been refusing medications and other things more often.During an interview on 01/30/26 at 5:39 P.M., the Administrator said physician orders should be followed, and if the resident refuses staff should document and it should be on the care plan or progress note.6. Review showed the facility failed to provide a policy that addressed neurological checks.Review of the facility's Neurological Assessment Flowsheet, undated, showed staff are to document neurological checks as follows: initial set, then every 15 minutes times one, every 60 minutes times two, every two hours times one, every four hours times five, and every shift times four.7. Review of Resident #103's quarterly MDS assessment, dated 11/20/25, showed staff assessed the resident as:- Severely cognitively impaired;- Dependent on staff for all self-cares and mobility;- Has had falls since prior assessment; had two or more falls with no injury; had one fall with injury;- Diagnoses of Alzheimer's disease, dementia, and anxiety.Review of the resident's progress notes showed, staff documented the resident had unwitnessed fall without injury on 10/19/25. The record did not contain five of the 15 neurological checks.Review of the resident's progress notes showed staff documented the resident had an unwitnessed fall without injury on 10/24/25. The record did not contain three of the 15 neurological checks.Review of the resident's progress notes showed staff documented the resident had an unwitnessed fall without injury on 10/29/25. The record did not contain four of the 15 neurological checks.8. Review of Resident #63's annual MDS, dated [DATE], showed staff assessed the resident as:- Cognitively intact;- Used a wheelchair;- Dependent on staff to assist with coming to a standing position;- Diagnoses of anxiety disorder, depression, osteoporosis, and arthritis;- Two or more non injury falls since the prior MDS assessment.Review of the resident's care plan, dated 11/26/26, showed staff assessed the resident at risk for falling due to muscle weakness and debility.Review of the resident's nursing progress notes, dated 01/21/26, showed staff documented the resident was heard calling out for help Staff found the resident laying on floor face down next to bed. When staff asked what he/she was doing, resident stated, I don't know what I was doing, one minute I was in the chair and the next thing I know I was on the floor. Hematoma to right side of forehead, bruise to the back of right hand, and what appears to be a bruise starting to the right inner thigh. Resident complained of headache, given prn Tylenol, and vital signs completed.Review of the resident's neurological assessment flow sheet, dated 01/21/26 to 01/24/26, did not contain documentation staff assessed the resident every shift times four as directed by the neurological assessment flow sheet. The flow sheet did not contain documentation staff assessed the resident during the 6 P.M. to 6 A.M. shift on 01/23/26, and did not assess the resident on either shift on 01/24/26.During an interview on 01/30/26 at 3:15 P.M., LPN K said the charge nurse is responsible for completing the neurological checks, they are done initially, then 15 minutes times one, 60 minutes times two, every four hours times five, and then every shift for five shifts. LPN K said neurological checks are important to determine the resident's baseline, and to be able to see if there is something off or a deviation, or if they have a brain bleed, because he/she would see alterations in their status, and he/she would expect the neurological checks to be completed. LPN K said it should be a priority to complete, and should be documented for all unwitnessed falls, or any falls with involvement of the head, even if witnessed. LPN K said sometimes the resident will refuse neurological checks, and they should be reattempted, and then a progress note should be made and documented on the neurological form as well if he/she refuses.During an interview on 01/30/26 at 3:27 P.M., LPN I said whoever is the charge nurse when a resident has a fall should initiate the neurological checks and are responsible for their shift, and then the charge nurse for any other shifts should complete them. LPN I said it is important to complete neurological checks because if the resident hits his/her head they (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	could have a slight brain bleed and it may not be noticed for a while, so staff need to keep track to make sure there are not any changes of consciousness or mental status for 72 hours, and if the resident refuses, staff should try to encourage the resident and put it in a progress note that they refused. LPN I said he/she was not aware they were not being completed, and he/she tries to check to make sure the neurological checks are done completely, then staff turn them into the medical record box. He/she said the process is currently being tweaked, because there have been issues with the neurological checks being completed.During an interview on 01/30/26 at 4:30 P.M., the DON said neurological checks should be completed for any unwitnessed fall, or any witnessed fall with head involvement because it is important to make sure there is not a head injury or brain bleed going on. The DON said the charge nurse that is working is responsible for completing the neurological checks, and falls are discussed in clinical meetings every morning and if neurological checks were initiated. The DON said the nurse managers are supposed to audit, but ultimately it is his/her responsibility. He/she said the neurological checks are completed for 72 hours at different intervals and a paper form is used to document. He/she did not know neurological checks were not completed for the resident, and if the resident refuses staff should still assess, or try to do quick stroke questions; and if they continue to refuse staff should let the physician and himself/herself know as well as document on the paper form and progress note.During an interview on 01/30/26 at 5:39 P.M., the Administrator said neurological checks should be completed when a resident falls when unwitnessed or if the resident hit his/her head. The Administrator said the charge nurse is responsible to complete the neurological checks and ultimately it is his/her responsibility to make sure they are done. He/she said staff should document on the form and progress note if the resident refused, and they are important to do to make sure there is not a problem or a brain bleed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility staff failed to serve food in accordance with the nutritionally calculated menus to all residents. The facility census was 115.1. Review of the facility lunch menus, dated 01/28/26 (Week 1, Day 4), showed the menus directed staff to provide the residents who receive pureed diets with a: -#8 (four ounces (oz.)) scoop of pureed barbequed pork;-#8 scoop of mashed potatoes with thick gravy;-#10 (3.2 oz.) scoop of pureed spinach;-#16 (two oz.) scoop of pureed dinner roll with margarine. Observation on 01/28/26 during the lunch meal service which began at 11:24 A.M., showed staff served the residents who received pureed diets with #10 scoops of pureed barbequed pork and mashed potatoes and a #12 (2.6 oz.) scoop of pureed spinach (less than directed by the menus). Observation also showed staff did not prepare, serve or offer the pureed dinner roll with margarine as directed by the menus. Review of the facility lunch menus dated, 01/29/26 (Week 1, Day 5), showed the menus directed staff to provide the residents who receive pureed diets with #8 scoops of pureed beef tips with gravy and pureed rice pilaf. Observation on 01/29/26 during the lunch meal service which began at 11:30 A.M., showed staff served the residents who received pureed diets with a #10 scoop of pureed beef tips with gravy and a #12 scoop of pureed rice pilaf (less than directed by the menus). 2. Review of the facility lunch menus dated 01/28/26 (Week 1, Day 4), showed the menus directed staff to provide the residents who received dental soft/mechanical soft diets with a #8 scoop of ground barbequed pork with sauce and a buttered, soft dinner roll. Observation on 01/28/26 during the lunch meal service, which began at 11:24 A.M., showed staff did not prepare, serve or offer the residents who received dental soft/mechanical soft diets the buttered dinner roll as directed by the menus. Observation also showed the staff served the residents a #10 scoop of ground barbequed pork with sauce (less than directed by the menus). Review of the facility lunch menus dated, 01/29/26 (Week 1, Day 5), showed the menus directed staff to provide the residents who receive dental soft/mechanical soft diets with a #8 scoop rice pilaf and four oz. of chopped buttered carrots. Observation on 01/29/26 during the lunch meal service, which began at 11:30 A.M., showed staff served the residents who received dental soft/mechanical soft diets with a #10 scoop of rice pilaf and a #12 scoop of chopped butter carrots (less than directed by the menus). 3. Review of the facility lunch menus dated, 01/28/26 (Week 1, Day 4), showed the menus directed staff to provide the residents who receive regular diets with a dinner roll and margarine. Observation on 01/28/26 during the lunch meal service, which began at 11:24 A.M., showed staff did not prepare, serve or offer the residents who received regular diets the dinner roll and margarine as directed by the menus. Review of the facility lunch menus dated, 01/29/26 (Week 1, Day 5), showed the menus directed staff to provide the residents who receive regular diets with six oz. of beef tips with gravy and a #8 scoop of rice pilaf. Observation on 01/29/26 during the lunch meal service, which began at 11:30 A.M., showed staff served the residents who received regular diets with four oz. of beef tips with gravy and a #10 scoop of rice pilaf. 4. During an interview on 01/29/26 at 12:00 P.M., Dietary Aide (DA) NN said staff are expected to serve meals in accordance with the menus. The DA said he/she reviewed the menus prior to service for what portion sizes to serve, but he/she could not find all the right scoops to use. The DA said if he/she does not have the correct sized serving utensils, he/she is to notify his/her supervisor. The DA said he/she notified his/her supervisor prior to the meal service and the supervisor told him/her that the utensils were being washed so he/she used what was available because he/she needed to start service on time. During an interview on 01/29/26 at 12:10 P.M., the Director of Food Services said staff are expected to prepare and serve food in accordance with the nutritionally calculated menus, which would include the portion sizes listed for all diet types, and staff are trained on this requirement. The Director of Food Services said if staff cannot find the correct size of serving utensil, they should ask their supervisor for assistance to get the right one or its equivalent and not just use what is available. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Director of Food Services said staff had not notified him/her that they did not have the correct size of serving utensils and he/she did not know staff did not serve all food items as directed by the menus at the lunch meal for two consecutive days. During an interview on 01/29/26 at 4:00 P.M., the administrator said he/she did not have a policy related to the use of menus for meal service. The administrator said staff are expected to prepare and serve food in accordance with the nutritionally calculated menus, which would include the portion sizes listed for all diet types, and staff are trained on this requirement. The administrator said they have plenty of properly sized serving utensils and if staff cannot find the correct size of serving utensil, then they should notify the Director of Food Services and get one that is right and not just use what is available. The administrator said the Director of Food Services is responsible to monitor the meal services daily to ensure they are served correctly and he/she did not know did not follow the lunch menus for two consecutive days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, facility staff failed to preform hand hygiene as often as necessary using approved techniques to prevent cross-contamination. Facility staff also failed to allow sanitized dishes to air dry prior to stacking in storage and use to prevent the growth of foodborne pathogens. These failures have the potential to affect all residents. The facility census was 115.1. Review of the facility's Hand Hygiene & Glove Changes policy, dated 06/01/24, showed All staff members shall practice hand hygiene and glove changes in accordance with these procedures and applicable standards of practice to reduce the spread of infections and prevent cross-contamination. Review showed the policy directed staff to apply soap and, using friction, rub hands together for at least 30 seconds when they washed their hands and to wash their hands, at a minimum, when: -When coming on duty;-When hands are visibly soiled;-Before putting on gloves;-In between glove changes;-After taking gloves off;-Before and after eating or handling food;-Before and after assisting a resident with meals;-After handling soiled equipment or utensils;-After performing personal hygiene;-After completing duty. Review of the handwashing procedure sign posted at the handwashing sink in the kitchen, showed the sign directed staff to scrub their hands with soap for at least 20 seconds. Observation on 01/28/26 at 10:35 A.M., showed Dietary Aide (DA) OO scrubbed his/her hands with soap for five seconds when he/she washed his/her hands. Observation showed after he/she washed his/her hands, the DA put on a pair of gloves, retrieved a package of cheese from the walk-in refrigerator and delivered it to the cook and then got a cart of glasses and prepared beverages for meal service. Observation on 01/28/26 at 10:40 A.M., showed DA PP adjusted the glasses and mask on his/her face with his/her bare hands and then, without performing hand hygiene, used his/her bare hands to wrap silverware in napkins for meal service. Observation on 01/28/26 at 10:53 A.M., showed DA PP used his/her finger to pick out something from his/her ear and adjusted the glasses on his/her face. Observation showed, without performing hand hygiene, the DA then used his/her bare hands to wrap silverware in napkins for meal service. Observation on 01/28/26 at 10:56 A.M., showed [NAME] QQ entered kitchen and, when he/she washed his/her hands, he/she scrubbed his/her hands with soap for five seconds. Observation showed the cook then put on an apron and prepared cups of peaches for service to residents at the lunch meal. Observation on 01/28/26 at 10:59 A.M., showed DA PP used his/her bare hand to pull down his/her facemask to take a drink of his/her beverage and then, without performing hand hygiene, used his/her bare hands to wrap silverware in napkins for meal service. Observation on 01/28/26 at 11:11 A.M., showed DA PP adjusted the glasses on his/her face with his/her bare hands and then, without performing hand hygiene, placed insulated plate holders on a heating pad. During an interview on 01/28/26 at 11:34 A.M., DA PP said he/she had worked in the kitchen for two to three weeks and staff trained him/her on hand hygiene when he/she started. The DA said he/she should wash his/her hands between tasks and after he/she touches his/her body, glasses and facemask. The DA said he/she did not wash his/her hands because he/she just got too busy with his/her tasks. Observation on 01/28/29 at 11:39 A.M., showed when DA CC washed his/her hands, he/she scrubbed his/her hands with soap for five seconds. Observation showed the DA put on a pair of gloves and served food from the steamtable to residents at the lunch meal. Observation on 01/29/26 at 10:07 A.M., showed when DA RR washed his/her hands, he/she scrubbed his/her hands with soap for five seconds and then retrieved food from the refrigerator. During an interview on 01/29/26 at 10:08 A.M., DA RR said the facility staff did not train him/her on proper hand hygiene procedures, but he/she had worked in food service for years and had been trained before. The DA said when staff wash their hands, they should scrub their hands with soap long enough to sing the alphabet song twice. The DA said he/she did not know how long it should take to sing the alphabet song twice because it depended on how fast he/she sang it. During an interview on 01/29/26 at 10:20 A.M., the Director of Food Services said staff are trained on proper (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sanitation and infection control procedures, which includes hand hygiene, upon hire and during routine in-services. The director said staff should wash their hands when they enter the kitchen, before they handle food, before and after glove use and after they touch anything dirty, which would include their body, glasses and facemask and they should scrub their hands with soap for at least 20 seconds. The director said he/she is responsible to do quarterly hand hygiene audits, but he/she had gotten behind and had not completed a hand hygiene audit since 05/28/25. During an interview on 01/29/26 at 4:00 P.M., the administrator said staff should perform hand hygiene before and after they use gloves, after they touch anything dirty, which would include their body, glasses, and facemasks, and before they prepare food. The administrator said staff should scrub their hands with soap for at least 20 seconds when they wash their hands and all staff are trained routinely on proper hand hygiene procedures. The administrator said the Director of Food Services is responsible to conduct quarterly audits on hand hygiene to discuss at their Quality Assurance meetings. The administrator said he/she had not reviewed the Director of Food Services' quarterly audits, but the director said that he/she had completed them and he/she did not know the director had not done a hand hygiene audit since May 2025. 2. Observation on 01/28/26 at 10:45 A.M., showed 10 plastic service trays and nine Insulated plate holders stacked together wet by steamtable. Observation on 01/28/26 at 10:50 A.M. five insulated plate holders and three plates stacked together wet on the service cart by the dish storage rack. Observation on 01/28/26 at 11:11 A.M., showed 32 insulated dome plate covers stacked together wet by the steamtable. Observation on 01/29/26 at 10:05 A.M., showed staff wheeled a utility cart of sanitized dishes from the mechanical dishwashing station and placed it by the dish storage racks. Observation showed the plastic service trays on the cart were stacked together wet. During an interview on 01/29/26 at 10:05 A.M., the Director of Food Services said staff should allow clean dishes to air-dried before they are put away and staff are trained on this requirement. During an interview on 01/29/26 at 4:00 P.M., the administrator said he/she could not locate a policy related to dish washing and storage, but the Director of Food Services is responsible to monitor dish washing and storage daily when on duty and make corrections as needed. The administrator said clean dishes should be air-dried before they are put away and staff are trained on this requirement.

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	01/30/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections, when staff failed to develop and review the program, policies and procedures annually. Facility staff failed to use enhanced barrier precautions ((EBP) - infection control intervention designed to reduce transmission of multi-drug-resistant organisms), and/or failed to have EBP signs posted, perform appropriate hand hygiene and glove changes during wound care for three residents (Resident #7, #103, and #123) out of three sampled residents, catheter care for one resident (Resident #8) of two sampled residents. Facility staff failed to ensure sanitary conditions for catheter tubing when they failed to keep the tubing off the floor for one resident (Resident #7) out of two sampled residents. Facility staff failed to ensure the two-step purified protein derivative (PPD) (skin test for tuberculosis (TB)) was completed for four (Director of Food Services, Certified Medication Technician (CMT) BB, Certified Nurse Aide (CNA) B and CNA X) out of ten employee files reviewed. The facility census was 115.1. Review showed the facility failed to provide a policy in regard to IPCP.Review showed the facility did not have documentation that a program was in place to record infection control incidents.During an interview on 01/29/26 at 2:59 P.M., the Director of Nursing (DON) said they will look at updates here and there to the IPCP as it comes up but have not done it annually. He/She said he/she knows it should be reviewed on a regular basis annually and as guidance changes. During an interview on 01/30/26 at 5:40 P.M., the Administrator said the Infection Preventionist (IP) is responsible for maintaining the IPCP. He/She said he/she thought the DON and IP were reviewing the policies and procedures annually. He/She was not aware it wasn't being done.2. Review of the facility's policy titled, Hand Hygiene and Glove Changes, dated 06/01/24, showed all staff members shall practice hand hygiene and glove changes in accordance with these procedures and applicable standards of practice to reduce the spread of infections and prevent cross contamination. Staff are directed to wash hands as follows: - When hands are visibly soiled (hand washing with soap and water); - Before and after direct resident contact or after handling a resident's belongings; - Before and after performing any invasive procedure; - Before and after entering isolation precaution settings; - Before putting gloves on; - In between glove changes; - After taking gloves off; - Before and after changing a dressing; - After handling soiled or used linens, dressings, bedpans, catheters and urinals; Staff are directed to change gloves when gloves are visibly soiled, when gloves are contaminated, and when moving between different tasks.Review showed the facility failed to provide a policy for wound care procedures. Review of the facility's EBP policy, dated 04/01/24, showed it is the policy of this facility to implement EBP. All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions, and all staff receive training on high-risk activities and common organisms that require EBP. An order for EBP will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers, and/or indwelling medical devices (e.g., urinary catheters). Implementation of EBP is to make gowns and gloves available immediately near or outside of the resident's room. EBP is only necessary when performing high-contact care activities. High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (urinary catheters), and wound care (any skin opening requiring a dressing). EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical devices that placed them at higher risk. 3. Review of Resident #7's Significant Change Minimum Data Set Assessment (MDS), a federally mandated assessment tool, dated 01/19/26, showed staff assessed the resident as:-Moderate cognitive impairment; -Partial/Moderate (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	assistance for shower/bathing and upper body dressing;-Dependent assistance for lower body dressing, putting on/taking off footwear, and personal hygiene; -One or more unhealed pressure ulcers;-Two unstageable pressure ulcers;-Indwelling catheter. Review of the resident's Physician Order Sheet (POS), dated January 2026, showed an order to cleanse bilateral heels with wound cleanser, pat dry, apply betadine, cover with dry four by fours, wrap with kerlix and secure with tape once a day.Observation on 01/27/26 at 10:45 A.M., showed the resident in bed, urinary catheter bag hung on side of bed. The resident's room did not contain posted EBP signs.Observation on 01/28/26 at 2:25 P.M., showed the resident in bed, urinary catheter bag hung on side of bed. The resident's room did not contain posted EBP signs.Observation on 01/29/26 at 10:45 A.M., showed CNA N assisted the resident with his/her shower. The CNA did not place a barrier on the resident's foot pedals before he/she rested his/her bare heels on the pedal. Observation on 01/29/26 at 10:52 A.M., showed Licensed Practical Nurse (LPN) I did not don a gown when he/she performed wound care for resident. The wheelchair foot pedal had a wet spot on it when the LPN picked up resident's right heel. LPN I did not clean the foot pedal off with an approved cleaner. During an interview on 01/30/26 at 4:18 P.M., CNA N said the foot pedals are dirty and agrees that there should have been some type of barrier between the foot pedals and the resident's heels due to risk of infection.During an interview on 01/30/26 at 11:53 A.M., LPN I said EBP is only required for open wounds. He/She said he/she did not feel the resident's wound was significant enough to warrant wearing more than gloves during care. LPN I said there is usually an EBP sign on the door that alerts staff what to put on. He/she said the risk of not using EBP is that if the resident has an infection, staff could get it, or the reverse could happen if staff have bacteria on him/her, he/she could give it to the resident. He/She said he/she should have had a barrier between resident's heels and the foot pedals and should have used a disinfecting wipe to clean wetness from foot pedal. 4. Review of Resident #103's quarterly MDS assessment, dated 11/20/25, showed staff assessed the resident as:- Severely cognitively impaired; - Dependent on staff for all self-cares and mobility; - Is at risk for pressure ulcers.Review of the resident's POS, dated January 2026, showed an order dated 01/13/26, for right great toe: skin prep and cover daily until healed, once a day.Observation on 01/27/26 at 12:23 P.M., showed the resident's room did not contain posted EBP signs. Observation on 01/28/26 at 8:20 A.M., showed the resident's room did not contain posted EBP signs. Observation on 01/29/26 at 10:23 A.M., showed the resident's room did not contain posted EBP signs. Observation on 01/29/26 at 10:24 A.M., showed LPN I did not wear a gown when he/she performed wound care on the resident. The LPN performed the resident's wound care and did not change his/her gloves before he/she applied skin prep to the resident's toe. The LPN removed his/her gloves and did not perform hand hygiene before he/she applied new gloves to place the dressing on the resident's toe. Observation on 01/30/26 at 8:46 A.M., showed the resident's room did not contain posted EBP signs. During an interview on 01/30/26 at 11:53 A.M., LPN I said EBP is only required for open wounds. The LPN said staff should wear a gown, gloves, face mask, goggles or face shield if he/she cannot wear goggles, and it is to protect staff and to not introduce anything to the resident. LPN I said he/she had received education on EBP, and it is done during monthly in-services as a refresher. LPN I said the IP would post signage outside the door. LPN I said he/she would help with posting signs if the IP is not available, otherwise the charge nurse would post them and then notify the IP. The LPN said the sign on the door alerts staff what to put on. He/she said the risk of not using EBP is that if the resident has an infection, staff could get it, or the reverse could happen if staff have bacteria on him/her, he/she could give it to the resident. LPN I said hand hygiene should be done when entering the resident's room, in between glove changes, and before leaving the room, and it should also be done when going from a dirty procedure to a clean procedure, like wound treatments. He/she said the risk of not doing it correctly could be infection for the resident. LPN I said he/she should have performed hand hygiene in between glove changes, and he/she knows when it should be done, but he/she was nervous, as the he/she did not even realize he/she had not done it during the treatment. During an interview on 01/30/26 at 4:30 P.M., the DON (continued on next page)

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	265498	A. Building B. Wing	01/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	said EBP is for urinary catheters, feeding tubes, wounds, and all wounds should have EBP. The DON said residents get signs posted and boxes of PPE as well, and his/her sign should indicate EBP, which requires gown, gloves, face masks, and/or face shield. The DON said the IP is now responsible for putting up the signs, and if a resident is admitted at night or on the weekends, the charge nurse would call him/her to let him/her know. The DON said if the resident has a chronic condition, like a long-term urinary catheter or chronic wound the signs would be posted inside his/her room. The DON said he/she did not know the resident did not have an EBP sign posted, and that gowns and gloves were not being used. The DON said he/she did not know that staff need to wear EBP for high contact care activities, and he/she thought it was only needed during wound care or catheter care, when staff would be dealing directly with the concerned area. The DON said that is on him/her, he/she did not know. During an interview on 01/30/26 at 5:39 P.M., the Administrator said he/she did not know that the resident was not on EBP, and he/she was not sure if it was required for wounds or not, but if they have a wound the resident would have EBP in that situation. 5. Review of Resident #123's Discharge MDS, dated [DATE], showed staff assessed the resident as:-Cognitively Impaired;-Substantial/Maximal assistance with toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene;-One or more unhealed pressure ulcers;-Two unstageable pressure ulcers;-Indwelling catheter.Observation on 01/27/26 at 10:18 A.M., showed the resident in bed, urinary catheter bag hung on side of bed. The resident's room did not contain posted EBP signs. Observation on 01/28/26 at 12:01 P.M., showed the resident in bed, urinary catheter bag hung on side of bed. The resident's room did not contain posted EBP signs.Observation on 01/29/26 at 8:41 A.M., showed the resident's room did not contain posted EBP signs.Observation on 01/29/26 at 9:27 A.M., showed LPN I and CNA N did not wear a gown when they assisted the resident to bed via mechanical lift. LPN I gathered the wet linens, removed gloves and did not perform hand hygiene before he/she left the resident's room. CNA A did not perform hand hygiene, apply gloves or a gown before he/she applied a gown on the resident. CNA A and CNA P did not put on a gown or perform hand hygiene before they applied gloves and assisted the resident with linens. CNA A applied lotion, covered up the resident, removed his/her gloves and did not perform hand hygiene before he/she exited the resident's room. During an interview on 01/30/26 at 11:24 A.M., CNA N said he/she is aware of EBP and said it's for residents with certain sickness like Flu or covid. He/She said he/she was not aware that residents with catheters or wounds need to have EBP during cares. He/She said he/she knows what residents are on EBP by a sign on their door, but he/she said there was no sign on resident's door. He/She said he/she should have washed hands between gloves changes and when entering and before leaving the room. He/She said it is a risk of spreading infection by not washing hands.During an interview on 01/30/26 at 4:18 P.M., CNA P said EBP is for open wounds, catheters, or any open areas. He/She said EBP should be worn with care where you are in direct contact with the resident. He/She said there is usually an EBP sign on the resident door or supplies in the room if they require EBP. He/She said he/she does not remember seeing an EBP sign on resident's door. He/She said the importance of using EBP is infection control. He/She said hand hygiene should be performed when entering a room, between glove changes, and when exiting the room to avoid the spread of infections. During an interview on 01/30/26 at 11:53 A.M., LPN I said EBP should be used whenever staff are doing catheter care, or if a resident is on isolation for any reason, and he/she thinks EBP is only required for open wounds. He/She said he/she did not wear EBP during cares with the resident because he/she was not in direct contact with the catheter. LPN I said there is usually an EBP sign on the door that alerts staff what to put on, and there should be signs in the room on how to put on and take off the PPE. He/she said the risk of not using EBP is that if the resident has an infection, staff could get it, or the reverse could happen if staff have bacteria on him/her, he/she could give it to the resident. He/She said staff should wash hands when entering a resident's room, between dirty and clean cares, and before exiting the room.During an interview on 01/30/26 at 2:55 P.M., the IP said the admitting charge nurse should put EBP signs up if a resident is (continued on next page)

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	265498	A. Building B. Wing	01/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	admitted and warrants precautions. He/She said he/she goes around every morning and ensures EBP signs are posted, and PPE supplies are available. He/She said the EBP signs must have just got missed in the process. He/She said EBP is for residents with infected wounds and catheters. He/She said staff should wear EBP when during cares when they are directly touching the resident. He/She said he/she does not think that transferring a resident requires wearing EBP, but if staff see resident is wet and soiled they would need to wear EBP to change resident. He/She said the wound nurse and providers decide if a resident needs to be on EBP. He/She said he/she is not sure what the policy says about who requires EBP. He/She said staff should wash hands when entering room, between dirty and clean cares, and before leaving the room. He/She said EBP and hand hygiene are important because if not done it's a risk for deterioration in the residents care by spreading infections or contamination.6. Review of the facility's policy titled Hand Hygiene and Glove Changes, dated 06/01/24, showed all staff members shall practice hand hygiene and glove changes in accordance with these procedures and applicable standards of practice to reduce the spread of infections and prevent cross contamination. Staff are directed to change gloves when gloves are visibly soiled, when gloves are contaminated, and when moving between different tasks.7. Review of Resident #8's quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severe cognitive impairment; -Partial/Moderate assistance for personal hygiene; -Indwelling catheter.Review of the resident's care plan, dated 10/21/25, showed the resident was at an increased risk for infection due to foley catheter and a positive urine culture for methicillin-resistant Staphylococcus aureus (MRSA) (a type of bacterium responsible for severe infections that are resistant to several common antibiotics, including methicillin, penicillin, and oxacillin).Observation on 01/30/26 at 9:22 A.M., showed CNA A entered the resident's room to provide catheter care. CNA A did not change his/her gloves after he/she raised the resident's bed, unzipped his/her jacket, removed his/her belt, pulled down his/her brief, pulled the trash can closer to the bed, or before he/she provided catheter care.During an interview on 01/30/2026 at 9:41 A.M., CNA A said it is important to keep gloves clean and not touch any dirty items before providing catheter care. He/She said not providing catheter care with clean gloves, puts resident at risk for infections such as urinary tract infections. He/She said he/she would consider touching the resident, the remote, and the trash can as an infection concern. He/She said the purpose of gloves is to manage the spread of infections.During an interview on 01/30/2026 at 9:45 A.M., the IP said it is his/her expectation that staff keep their gloves clean before providing catheter care to prevent the spread of infections. He/She said he/she considered touching clothing, remote controls, and trash cans is an infection control concern. During an interview on 01/30/2026 at 4:31 P.M., the DON said it is his/her expectation that staff change gloves and perform hand hygiene when going from a dirty to clean task. He/She said if gloves are not clean before performing catheter care there is a risk of spreading infection. During an interview on 01/30/2026 at 5:40 P.M., the Administrator said it is his/her expectation that staff wash hands and change gloves when they are dirty. He/She said staff should not touch something dirty then touch something clean. He/she said staff should not touch the trash can or remote before providing catheter care. He/She said not having clean gloves puts the residents at risk for infection.8. Review showed the facility failed to provide a policy for urinary catheter tubing.9. Review of Resident #7's Significant Change, MDS, dated [DATE], showed staff assessed the resident as:-Moderate cognitive impairment; -Dependent assistance for lower body dressing, putting on/taking off footwear, and personal hygiene; -Indwelling catheter. Observation on 01/28/26 at 11:19 A.M., showed the resident in his/her wheelchair as his/her catheter tubing touced the ground.Observation on 01/29/26 at 10:45 A.M., showed CNA N pushed the resident in his/her wheelchair as his/her catheter tubing dragged the ground.Observation on 01/30/26 at 8:40 A.M., showed the resident in his/her wheelchair in dining room as his/her catheter tubing touched the ground. During an interview on 01/30/26 at 11:24 A.M., CNA N said catheter tubing should not drag or rest on the floor at any point due to risk of infection control. He/She said did not realize the tubing was dragging the floor while pushing resident.During an interview on 01/30/26 at 11:53 A.M., LPN I (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to implement an Antibiotic Stewardship Program with antibiotic use protocols and a system to monitor and track antibiotic use within the facility. The facility census was 115.1.Review of the facility's policy titled, Antibiotic Stewardship Program, revised 10/30/18, showed the objective: to promote the highest possible quality of care by optimizing the treatment of infections while reducing unnecessary laboratory tests and antibiotic use through promotion of antibiotic stewardship principles and development of activities aimed at improving jhow antibiotics are used and prescribed. Review showed:-Policy: Antibiotic Stewardship is a set of commitments and actions intended to optimize the treatment of infections while reducing adverse events associated with antibiotic use. This policy establishes an Antibiotic Stewardship Program (ASP) as part of the infection prevention and control program (IPCP) with key directives to improve the responsible and effective use of antibiotics The Bluffs facilities. To achieve our goal, The Bluffs has established an Antibiotic Stewardship Team; adopted antibiotic prescribing processes; tracks and reports antibiotic use, infection rates, and epidemiology date; provides access to expert clinical advice and; provides education resources and materials to the care team, residents and families;-Tracking and Reporting: the ASP incorporates a range of data collection to monitor antibiotic usage, infections rates, and microbiology data;-Performance Evaluation: The performance of the ASP is evaluated by monitoring the facility's rates of antibiotic-associated adverse drug events, rates of multidrug-resistant organisms ([NAME]), rates of clostridium difficile infections, and trends in reduction of use of high-risk antibiotics. A review of the ASP is conducted annually to review the progress in expanding stewardship activities and is included in the annual review of the infection prevention and control program and updated, as necessary.2. Review of the facility's antibiotic stewardship program showed staff did not have a process in place to track and trend antibiotic usage.During an interview on 01/28/26 at 3:05 P.M., the Infection preventionist (IP) said he/she is responsible for maintaining the antibiotic stewardship Program. He/she said he/she goes over all infections and antibiotics at the end of the month, he/she fills out the tracking form and then color codes them on a facility map to track the information. He/She said tracking is important for identifying areas of concern. He/She said they use the information to see if infections are associated with one area/hall. He/She said he/she then takes the information learned through the tracking and trending and goes over the information during their QAPI meeting the next month. He/She said/she just stared as the IP in December. He/She filled out the tracking and trending for that month. He/She said he/she has not started the tracking/trending for January. He/She said someone else did the Antibiotic Stewardship before him/her and he/she is not sure about why the information is not completed previously. During an interview on 01/29/26 at 2:59 P.M., the Director of Nursing (DON) said he/she thought the antibiotic Stewardship was being completed monthly. He/She said they had another nurse doing the program before, and he/she may not have added all the documentation monthly into the Antibiotic Stewardship binder. He/She said he/she is aware that antibiotics and infections were not being tracked on paper and through graphs daily/weekly but that they do go over information and communicate in morning meetings and during interdisciplinary team (IDT) meetings. He/She said the ASP is important to prevent the overuse of antibiotics and to track infection numbers and trend locations to certain halls/units and to narrow down possible causes to things like hand hygiene practices. He/She said it is important to identify possible causes so they can implement interventions.During on interview on 01/30/26 at 5:40 P.M., the administrator said it is the responsibility of the IP to maintain the ASP. He/She said their IP is new to the position, and he/she was unaware they were not completing the ASP monthly. He/She said the ASP is important because there is a concern for antibiotic usage not being done appropriately. He/she said he/she knows they have been discussing the ASP monthly, but it is his/her expectation that the ASP is being reviewed (continued on next page)

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	265498	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	daily/weekly. His/She concern is that when the information is not being done daily/weekly and being done monthly that the information and/or concerns are too late to act on.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were offered COVID-19 (an infectious disease caused by the SARS-CoV 2 virus) vaccination, that education was provided regarding the benefits and risks of the COVID-19 vaccine and signed consent, or refusal obtained from the resident or the resident's representative, for four residents (Residents #7, #19, #21, and #28) out of five sampled residents and for three staff members (Director of Food Services, Certified Nurse Aide (CNA) B and Resident Service Assistant (RSA) C) of three sampled staff members. The facility census was 115.1.Review of the facility's policy titled, Covid 19 Vaccine Policy, revised 05/30/23, showed Covid-19 vaccine will be ordered from either our long-term care pharmacy or local or state public health agency or arrangements will be made with a vaccine provider to administer the vaccine to the staff or residents. In case of lack of availability of the covid-19 vaccine, or other issue with the availability leading to an inability to implement the Covid-19 vaccine program, the facility will demonstrate that attempts to order vaccines have been exhausted, including long term care pharmacies and the state health department. Covid-19 vaccinations will be offered to all staff and residents (or their representative if they cannot make health care decisions) per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or the individual refuses to receive the vaccine. 2. Review of Resident #7's medical record showed:-admitted to the facility on [DATE];-The record did not contain documentation the resident received education, refused, or an updated booster of the COVID-19 vaccine. 3. Review of Resident #19's medical record showed:-admitted to the facility on [DATE];-The record did not contain documentation the resident received education, refused, or an updated booster of the COVID-19 vaccine. 4. Review of Resident #21's medical record showed:-admitted to the facility on [DATE];-The record did not contain documentation the resident received education, refused, or an updated booster of the COVID-19 vaccine. 5. Review of Resident #28's medical record showed:-admitted to the facility on [DATE];-The record did not contain documentation the resident received education, refused, or an updated booster of the COVID-19 vaccine. During an interview on 01/29/2026 at 2:59 P.M., The Director of Nursing (DON) said they have not given or offered the Covid-19 vaccine in a year to any residents. He/She said the vaccine was not available for a period of time and then the person who runs the covid clinics was out on maternity leave do they have not had the vaccine to offer. He/She said the covid vaccine is important for preventative health.During an interview on 01/30/2026 at 5:40 P.M., the administrator said residents were up to date on the covid-19 vaccination until the newest version came out. He/She said it has been a year since they offered the covid-19 vaccination. He/She said he/she was told that the vaccine was unavailable. 6. Review of the Director of Food Service's employee file showed:-Date of hire on 01/06/25;-The record did not contain documentation the staff member received education, refused, or were offered the COVID-19 vaccine. 7. Review of CNA B's employee file showed:-Date of hire on 6/24/25;-The record did not contain documentation the staff member received education, refused, or were offered the COVID-19 vaccine. 8. Review of RSA B's employee file showed:-Date of hire on 11/28/25;-The record did not contain documentation the staff member received education, refused, or were offered the COVID-19 vaccine. During an interview on 01/29/2026 at 2:59 P.M., The Director of Nursing (DON) said they have not given or offered the Covid-19 vaccine in a year to any staff. He/She said the vaccine was not available for a period of time and then the person who runs the covid clinics was out on maternity leave do they have not had the vaccine to offer. He/She said the covid vaccine is important for preventative health. During an interview on 1/30/2026 at 2:55 P.M., the infection preventionist said he/she could not find documentation of staff vaccinations for covid-19 or (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	education. He/She said to his/her knowledge, they have not offered the covid-19 vaccination to staff in the last six months. He/She said he/she started in the last 6 months and was not offered the covid-19 vaccination. During an interview on 01/30/2026 at 5:40 P.M., the administrator said staff were up to date on the covid-19 vaccination until the newest version came out. He/She said it has been a year since they offered the covid-19 vaccination. He/She said he/she was told that the vaccine was unavailable.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain resident dignity, when staff stood over four residents (Residents #58, #78, #34 and #19) of 27 sampled residents as they fed them during mealtime. The facility census was 115.1.Review of the facility's Nursing Home Residents' Rights policy, undated, showed residents have a right to a dignified existence; to be treated with consideration, resident, and dignity, recognizing each resident's individuality; quality of life maintained or improved; and a homelike environment. Review of the facility's policies showed staff did not provide policy for staff assisting residents at mealtime. 2. Review of Resident #58's Annual Minimum Data Set (MDS), dated [DATE], showed staff assessed the resident as:-Severe cognitive impairment;-Range of Motion (ROM) impairment to one side of upper extremities;-Set up assistance from staff members with eating. Observation on 01/27/26 at12:25 P.M., showed Certified Nurse Aide (CNA) R stood over the resident, picked up the resident's silverware and offered the resident bites of his/her food. The CNA took scoops of food off the resident's plate and held it to the resident's lips, until the resident opened his/her mouth for a bite. The CNA continued to feed the resident and did not engage in conversation with the resident.3. Review of Resident #78's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severe cognitive impairment;-ROM impairment to one side of upper extremities;-Supervision, or touch assistance from staff members with eating. Observation on 01/28/26 at 11:58 A.M., Certified Medication Technician (CMT) G stood over the resident as he/she fed the resident. Observation on 01/29/2026 at 11:50 A.M., showed CNA R stood over the resident as he/she fed the resident. 4. Review of Resident #34's Annual MDS, dated [DATE], showed staff assessed the resident as:-Moderate cognitive impairment;-ROM impairment to one side of upper extremities;-Set up assistance from staff members with eating. Observation on 01/29/26 at 11:50 A.M., showed CNA R stood as he/she fed the resident. The CNA continued to stand for the entire time he/she assisted the resident. During an interview on 01/29/26 at 2:02 P.M., CNA R said he/she has not been told not stand up when he/she feeds residents. The CNA said he/she stands, so he/she can get to each of the residents. The CNA said he/she knows he/she is supposed to set down, but he/she wants to help the other residents too. The CNA said if he/she sets down, he/she can only help one resident, if he/she stands, he/she can help more than one resident. 5. Review of Resident #19's Significant Change in Status Assessment (SCSA), dated 01/13/26, showed staff assessed the resident as:-Cognitively intact;-Does not reject care;-Impairment of upper extremity on one side;-Required substantial/maximal assist for eating.Observation on 01/28/26 at 12:37 P.M., showed CNA D stood over the resident with a bite of food on a fork. The CNA did not talk to the resident before putting the food into his/her mouth.6. During an interview on 01/29/26 at 2:11 P.M., Registered Nurse (RN) T said staff should be sitting adjacent to a resident when they are feeding the resident. The RN said he/she would not want staff standing over the residents. The RN said staff should not be assisting three residents at a time, that is too much of division of the staff's attention, and the resident's patience. Staff should take time with the resident at mealtime, it should be enjoyable, not a forced act. The RN said it would not be dignified for a resident to wait for bites of food, while staff leave to feed other residents. The RN said in a perfect world, one staff for each resident who needed assistance with eating. During an interview on 01/30/26 at 3:07 P.M., CNA N said it would not be appropriate to stand over a resident while assisting with feeding, it is disrespectful and would not be dignified.During an interview on 01/30/26 at 3:12 P.M., CNA O said staff should sit down when feeding a resident, it is not dignified to stand over a resident to feed them.During an interview on 01/30/26 at 3:15 P.M., Licensed Practical Nurse (LPN) K said staff should not stand over a resident while feeding them, it is intimidating and disrespectful. The LPN said staff should be sitting at the resident's level to be able to communicate face to face.7. During an interview on 01/30/26 at 3:27 (continued on next page)

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	265498	A. Building B. Wing	01/30/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P.M., LPN I said it is not appropriate for staff to stand while feeding a resident, they should sit down and be at eye level, it may make the resident feel overpowered or uncomfortable and it would not be dignified to stand over them. LPN I said staff should always try to be on the resident's level, even when just speaking or interacting with them. During an interview on 01/30/26 at 4:30 P.M., the Director of Nursing (DON) said it is not appropriate for staff to stand over residents when feeding them, staff should sit beside the resident, and it is not dignified and would be rude.During an interview on 01/30/26 at 5:39 P.M., the Administrator said staff should not stand over residents, it is not dignified, and he/she would expect staff to sit next to residents that need assistance with eating.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to document residents' code status (Do Not Resuscitate (DNR) or Full Code (Resuscitate refers to cardiopulmonary resuscitation (CPR)) consistently for two residents (Resident #2, and #100). The facility census was 115.1. Review of the facility's policies showed did not contain a policy for advance directives or resident code status. 2. Review of Resident #2's Electronic Medical Record (EMR) Face Sheet, showed the resident admitted to the facility on [DATE] with a code status as DNR. Review of the resident's Physician Order sheet (POS), dated 12/2025, showed the physician signed an order for Full Code status. Review of the resident's Care Plan, dated 12/2025, showed staff documented the resident as DNR status. Observation of the resident's door showed a red dot by the resident's name indicated a code status of DNR. Review of the facility's code status binder did not contain the residents code status for staff to use when resident's leave the building. 3. Review of Resident #100's EMR Face Sheet, showed the resident admitted to the facility on [DATE] with a DNR code status. Review of the resident's POS, dated 10/2025, showed the physician signed an order for Full Code status. Review of the resident's Care Plan, dated 10/2025, showed staff documented the resident as DNR status. Observation of the resident's door showed a green dot by the resident's name indicated a code status of Full Code. Review of the facility's code status binder showed the resident had an Outside the Hospital DNR form on file. 4. During an interview on [DATE] at 3:50 P.M., certified nurse assistant's (CNA) GG and CNA HH said they know what a resident code status is by looking at the dot on the outside of the resident's room next to his/her name. The CNAs said the red dot means Do Not Resituate and the green dot means Full Code, do everything. CNA GG and CNA HH said the nurse is responsible for sending the paperwork with the resident if they leave the facility, and believes social services put the dots on the resident's door. During an interview on [DATE] at 3:53 P.M., Licensed Practical Nurse (LPN) L said the dots outside of a resident room is for a quick reference, and they also have a binder kept at the nurse's station where they keep all residents code status in for quick access. LPN L said the green dot is for full code and the red dot is for DNR. During an interview on [DATE] at 3:59 P.M, Social Services Director (SSD) said he/she does the residents code status at admission and at that time he/she asks them to fill out the form. If there is a change in code status the nursing staff let him/her know and then he/she updates. The SSD said he/she puts the code status on the face sheet and the dots on the door of the resident's room. The SSD said the green dot is for full code and the red dot is for DNR. He/She was not aware of the code status not being consistent for either resident. The SSD said it is important to have this information correct so staff don't give CPR to a resident if they are not supposed to receive it, and the other way around. During an interview on [DATE] at 5:20 P.M., the Director of Nursing (DON) said staff know what a resident's code status shows on the ribbon at the top of their EMR, and by the red and green dots on the doors. The DON said the POS will have that information also. The concern is providing the wrong life sustaining care for the resident. The DON said SSD is responsible for adding the code status dots to the resident's room upon admission and with change. The DON said the green dot is for full code and the red dot is for DNR, staff are educated at hire. During an interview on [DATE] at 6:15 P.M., the Administrator said the residents code status can be found on the top ribbon of the matrix, or dots next to the resident name outside of their room. The SSD is responsible for the code status upon admission and places the dots outside the resident's room. The administrator said ultimately the nurse should double check the information was correct. The administrator said not having the correct resident code status can be a big deal because we don't want to do the wrong thing.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to notify the physician or registered dietician of the refusal of nutritional supplements for one resident (Resident #44), and failed to obtain a nutritional supplement in a timely manner for one resident (#61), out of 27 sampled residents. The facility census was 115.1. Review of the facility's policies did not contain a policy to direct staff on when to notify the physician or dietician if a resident refuses prescribed supplements or a policy on when to obtain a physician's order for supplements.2. Review of Resident #44's quarterly Minimal Data Set (MDS), a federally mandated assessment tool, dated 12/10/25, showed staff assessed the resident with impaired cognition, and weight loss of five percent or more in the last month or loss of 10 percent or more in the last six months.Review of the resident's care plan, dated 03/23/25, showed the resident has experienced weight loss, has a med pass 2.0 nutritional supplement (shake) ordered three times a day (TID), has protein shakes ordered twice a day (BID), and for staff to encourage oral intake of food and fluids.Review of the residents Physician Order Sheet (POS), dated January 2026, showed an order for Med Pass 2.0 give 60 milliliters (ml) TID and ordered on 09/06/24, and protein shakes BID and ordered on 04/17/24.Review of the resident's Medication Administration Record (MAR), dated November 2025, showed staff documented resident refused Med Pass 2.0 nutritional supplement 81 times and refused protein shakes 54 times.Review of the resident's MAR, dated December 2025, showed staff documented the resident refused Med Pass 2.0 nutritional supplement 84 times and refused protein shakes 56 times.Review of the resident's MAR, dated January 2026, showed staff documented resident refused Med Pass 2.0 nutritional supplement 77 times and refused protein shakes 49 times.During an interview on 01/30/26 at 11:40 A.M., Certified Medication Technician (CMT) EE said Med Pass 2.0 would be provided by a nurse and the protein shakes would be provided by the kitchen during mealtimes. CMT EE said the CMT's are responsible for observing whether a resident drinks their supplements or not and responsible for documenting it in the MAR. CMT EE said he/she was aware the resident has been refusing both of his/her nutritional supplements for a long time and said he/she has communicated this to the nursing staff, but was not sure which staff member he/she told and could not recall the last time he/she told anyone in nursing. CMT EE said he/she is not sure why the resident still has an order for both supplements if the resident almost always refuses them and said the resident's refusals of the supplements should have already been communicated to the resident's physician and the facility's registered dietician.During an interview on 01/30/26 at 11:47 A.M., the Dietary Manager (DM) said the resident's protein shake is on the resident's meal ticket and is provided with the resident's meal. The DM said he/she was not aware the resident consistently refuses the protein shakes. The DM said nursing staff should have communicated this to him/her so he/she could notify the registered dietician. He/She said that is important in order to re-evaluate what types of nutritional supplements the resident may consume.During an interview 01/30/26 at 2:42 P.M., Licensed Practical Nurse (LPN)/Charge Nurse AA said the resident receives a Med Pass 2.0 nutritional supplement and protein shakes. LPN AA said he/she was not aware the resident was consistently refusing both nutritional supplements. The LPN said if a resident refuses medications or nutritional supplements two to three days in a row, nursing staff would be expected to notify the resident's physician and the registered dietician.During an interview on 01/30/26 at 5:04 P.M., the Director of Nursing (DON) said he/she was not aware the resident was refusing his/her nutritional supplements and said if a resident is refusing a physician's order for a few days in a row, he/she would handle that like the order was not being followed. The DON said if the resident has been consistently refusing both of his/her nutritional supplements, he/she would expect the charge nurse to notify him/her and to contact the resident's physician or registered dietician to discontinue the supplements. The DON said notifying the residents physician or (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	registered dietician is important in order to determine another type of nutritional supplement the resident may like.During an interview on 01/30/26 at 5:39 P.M., the Administrator said he/she would expect the charge nurse to communicate a resident's consistent refusal of a physician's order to the DON, the resident's physician, and registered dietician. The Administrator said this is important so the resident can be re-evaluated to see if the resident would try a different nutritional supplement. 3. Review of Resident #61's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact with diagnoses of hyperlipidemia, and diabetes mellitus.Review of the resident's care plan, dated 03/23/25, showed the resident requires a therapeutic diet for a diagnoses to include diabetes, gastroesophageal reflux disease, hyperlipidemia, and hypertension.Review of the resident's POS, dated 12/01/25, showed an order on 10/17/2025 for brand specific protein shake BID at breakfast and lunch cannot be supplemented with other protein shakes as they do not meet the nutritional needs per the resident's bone doctor.Review of the resident's MAR dated 12/01/25, did not contain documentation staff administered brand specific protein shake as ordered and staff documented it was unavailable 42 out of 62 times.Observation on 01/27/26 at 12:35 P.M., showed the staff did not provide the resident's specific protein shake. Observation on 1/28/26 9:45 A.M., showed the staff did not provide the resident's specific protein shake. Observation on 01/30/26 at 8:50 A.M., showed the staff did not provide the resident's specific protein shake. During an interview on 01/30/26 at 8:56 A.M., the resident said the facility does not provide the type of protein shake he/she wants to drink and said his/her son provides the protein shakes. The resident said he/she is unsure about the last time his/her son brought the protein shakes. The resident said he/she believed the shakes helped him/her but it's been a long time since he/she's received them. During an interview on 01/30/26 11:34 A.M., CMT EE, said he/she informed the nurse the resident's been out of his/her shakes, but he/she is unsure if the nurse called the resident's son. The CMT said he/she is unsure if he/she documented he/she notified the nurse the resident did not have any protein shakes. During an interview on 01/30/26 2:43 P.M., LPN AA said we are responsible to notify the family and reach out when the resident is out of his/her protein shakes. The LPN said we would notify the family, the pharmacy, the doctor if the resident did not receive his/her protein shake. The LPN said the resident should not be without his/her protein shake more than a couple of shifts. The LPN said prior to today, he/she was not aware the resident was out of his/her protein shakes. He/She said he/she would notify the whole team about the resident's shakes not available. During an interview on 01/30/26 at 5:04 P.M., the DON, said he/she expects his/her staff to follow the resident's physician orders. The DON said he/she is responsible to ensure everything is done to follow the resident's physician orders. The DON said the charge nurse puts the orders in the system. He/She is in charge to follow up to ensure the care plans are followed up. He/She said the charge nurse needs to contact the doctor to follow up on the order, if the resident is out of his/her supplement. He/She said if the nurse informs the supplement missing, he/she would inform the physician. The DON said he/she was not aware the resident was out of his/her protein shakes. During an interview on 01/30/26 at 5:39 P.M., the Administrator said he/she would expect staff to follow up on the resident's protein shakes and said the facility is responsible for making sure the resident has his/her protein shakes.

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	265498	A. Building B. Wing	01/30/2026

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, facility staff failed to screen five employees (Director of Food Services, Resident Service Assistant (RSA) D, RSA C, Dietary Aide (DA) CC and Licensed Practical Nurse (LPN) FF) out of ten new employees prior to employment to determine if the employees had any indicators on the Certified Nurse Aide (CNA) Registry. The facility census was 115. 1. Review of the Facility's policy titled, Abuse & Neglect, dated 05/31/24, showed the facility will not employ individuals who have had a finding entered the Missouri CNA Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. The facility will report to the state nurse aide registry or any other licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. 2. Review of the Director of Food Services' personnel record showed: -Hire date of 01/06/25;-Did not contain documentation a CNA Registry check was completed. 3. Review of Resident Service Assistant (RSA) D's personnel record showed: -Hire date of 11/12/25;-Did not contain documentation a CNA Registry check was completed. 4. Review of RSA C's personnel record showed: -Hire date of 11/28/25;-Did not contain documentation a CNA Registry check was completed. 5. Review of Dietary Aide (DA) CC's personnel record showed: -Hire date of 12/23/25;-Did not contain documentation a CNA Registry check was completed.6. Review of Licensed Practical Nurse (LPN) FF's personnel record showed: -Hire date of 01/09/26;-Did not contain documentation a CNA Registry check was completed. During an interview on 01/29/26 at 3:54 P.M., the Human Resource Director said he/she could not provide CNA Registry checks for the mentioned staff. The Human Resource Director said he/she did not do CNA Registry checks on positions that are not CNAs, because he/she did not know it was necessary if the position the staff had been hired for, was not a CNA. During an interview on 01/30/26 at 3:43 P.M., Director of Nursing (DON) said he/she just found out, all staff should be run through CNA registry, he/she had not been aware. The DON said the Human Resource Director is responsible to do the CNA Registry checks on new hires. During an interview on 01/30/26 at 3:57 P.M., the administrator said the Human Resource Director does the background stuff. The administrator said everyone should be checked on the CNA Registry. The administrator said he/she is responsible to make sure the Human Resource Director does the CNA Registry checks.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the plan of care with changes in the residents' needs for six residents (Resident #7, #8, #19, #61, #78 and #103) out of 27 sampled residents. The facility census was 115.1. Review showed the facility failed to provide a policy that directs staff when to review or revise care plans. 2. Review of Resident #7's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/12/26, showed staff assessed the resident as:-Moderate cognitive impairment;-One or more unhealed pressure ulcers;-Two unstageable pressure ulcers. Review of the resident's progress notes, dated 12/02/25, showed staff documented the resident seen by wound clinic for two unstageable pressure ulcers to bilateral heals.Review of the resident's care plan, revised 1/20/26, showed it did not contain documentation in regard to the resident's bilateral heal unstageable pressure ulcers.During an interview on 01/30/26 at 12:18 P.M., Licensed Practical Nurse (LPN) I said he/she does not add anything to resident's care plans. He/She said he/she gives the wound clinic nurse notes to the MDS coordinator each week, so they can update the care plan. He/She said any kind of significant change should be updated on care plans.During an interview on 01/30/26 at 3:15 P.M., the MD coordinator said he/she updates care plans after morning meetings, Medicare meetings, and gathering information from staff to add to care plans. He/She said every three months he/she gets all the provider notes and updates care plans. He/She said if there is a new wound, the wound nurse will give her a printout of the wound clinic rounds every Tuesday, or wounds are discussed during morning meetings or interdisciplinary team (IDT) meetings. He/She said wounds should be on the care plan. He/She is unsure why Resident #7's pressure ulcers are not on his/her care plan. He/She said all nurses can make edits to care plans, but most staff just give the information to him/her so it can be updated. He/She said the importance of care plans to ensure staff knows what's going on and what is expected. He/She said the care plan is a blueprint for what resident's needs are and how to care for them. 3. Review of Resident #8's quarterly MDS, dated [DATE], showed staff assessed the resident as:- Cognitively impaired;- No behaviors or rejection of care over the past seven days;- Diagnoses of post-traumatic stress disorder, depression, and non-Alzheimer's dementia.Review of the resident's nursing progress notes showed staff documented the following:- On 09/04/2025, weekly meeting to discuss recent fall, resident is having behaviors, refusing care at times. He/She appears not to have a good support system r/t refusal to allow others to be proactively involved in his care and life;- On 09/05/2025, it was reported to this nurse by the Certified Medication Technician (CMT) that resident hit her and slapped the eye drops from her hand. When the next eye drops was due this nurse went to administer, and resident became angry and stated he would not take the eye drops and they are making his eyes worse anyway.-On 09/11/2025, resident declined to participate in scheduled assessment. Resident verbalized refusal despite education on purpose of assessment;- On 09/24/2025, overhead resident speaking in an elevated voice, sounding irritable and speaking quickly. Resident stating that his urologist is trying to kill him because he is a Vet, resident also stated that he wants to go to Veteran's Home in Mexico, Missouri. Resident not agreeable to going anywhere with staff and seemed to grow more agitated with the request to walk together. Staff stepped away, continued to listen to situation from nearby office;-On 11/21/25, the resident irritated he/she has had two episodes of loose stool. Staff attempted to assist resident in the bathroom, but he/she began to yell, telling staff it was their fault he/she has loose stools. Staff was not able to assist resident as resident continue to yell and stated staff did not know what they were doing;-On 12/11/25, the resident refusing medications today, and med tech states he/she refused his/her medications yesterday as well;-On 12/18/25, the resident has been refusing medications for the past three days, resident appears quite upset, delusional and paranoid this morning. Resident is being very (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uncooperative despite multiple attempts to calm, distract, explain, etc .;- On 12/21/25, the resident has been verbally aggressive towards staff today. Resident approached this nurse aggressively yelling. This nurse was in the middle of taking care of a resident and he/she followed me back down the hall getting loud about his/her rights, he/she then approached a Certified Nursing Assistant (CNA) and began yelling. The resident is now sitting in the common area talking to him/herself about random things.Review of the resident's care plan, dated 11/27/26, did not contain documentation of the resident's aggressive behaviors or refusals of care.During an interview on 01/30/26 at 4:43 P.M., the MDS/Care Plan Coordinator said he/she is responsible to update resident care plans. The MDS/Care Plan Coordinator said he/she did not view the residents' aggressive behaviors and refusals as a pattern, but more isolated incidents, so he/she did not include it on the resident's care plan. He/She said if a resident does have a pattern of aggressive behaviors and/or refusals, he/she would be expected to identify that on the resident's care plan and include interventions, so staff understands how to approach the resident.During an interview on 01/30/26 at 5:04 P.M., the Director of Nursing (DON) said if a resident is having aggressive behaviors and refusing care, he/she would expect it to be on the resident's care plan.During an interview on 01/30/26 at 5:39 P.M., the Administrator said if a resident is showing a pattern of behaviors and refusing care, he/she would expect it to be on the resident's care plan. The Administrator said the importance of the care plan is to ensure staff knows how to care for residents.4. Review of Resident #19's Significant Change MDS, dated [DATE], showed staff assessed the resident as:- Cognitively intact;- Does not reject care;- Had impairment of upper extremity on one side;- Dependent on staff for mobility;- Diagnoses of arthritis, osteoporosis, and amyotrophic lateral sclerosis (ALS - a progressive neurodegenerative disease that destroys motor neurons controlling voluntary muscles, leading to muscle weakness, twitching, and eventual paralysis); dysarthria (motor speech disorders characterized by weak, slow, or difficult to understand speech), and generalized muscle weakness.Review of the resident's POS, dated January 2026, showed an order dated 09/25/25, for wrist splints: on in the A.M. and off in the P.M., once a day.Review of the resident's Treatment Administration Record (TAR), dated January 2026, showed staff documented resident refused splints as ordered on 01/01/26, 01/02/26, 01/06/26, 01/11/26, 01/13/26, 01/15/26, 01/16/26, 01/17/26, 01/18/26, 01/19/26, 01/20/26, 01/22/26, 01/23/26, 01/24/26, 01/26/26, 01/27/26, 01/29/26 and 01/30/26.Review of the resident's care plan, dated 01/15/26, did not contain documentation staff applied splints or resident's refusals.Observation on 01/28/26 at 8:23 A.M., showed resident in his/her manual wheelchair in the assisted dining area. Observation showed he/she did not have his/her wrist splints on. Observation on 01/28/26 at 8:59 A.M., showed resident in his/her power wheelchair with his/her left hand curled in his/her lap.Observation on 01/29/26 at 8:22 A.M., showed resident in the assisted dining room without his/her wrist splints on.Observation on 01/29/26 at 10:38 A.M., showed resident in his/her room and without his/her wrist splints on. Observation showed his/her wrist splints on top of a pile of papers on a table.Observation on 01/30/26 at 10:40 A.M., showed resident in his/her power wheelchair in assisted dining room, without his/her wrist splints on.During an interview on 01/28/26 at 9:10 A.M., the resident said staff do not put any rolls or wash cloths in his/her hand to help with the contractures.During an interview on 01/30/26 at 11:53 A.M., LPN I said staff discuss care plans in the interdisciplinary team meetings, and that he/she does not add to or edit the care plans, the MDS Coordinators are responsible for that. LPN I said any kind of splints or assistive devices should be on the care plan, and if a resident refuses that should be on there as well. During an interview on 01/30/26 at 3:07 P.M., CNA N said he/she did not personally know about the splints, but said the resident does wear them to bed, and the resident will ask to put them on at night. The CNA said splints should be on the care plan, so staff know the resident needs them and when to put them on. CNA N said he/she thinks the charge nurse or MDS coordinator is the person that updates them, or the nurse manager.During an interview on 01/30/26 at 3:12 P.M., CNA O said the resident wears the splints when he/she sleeps, and nurses document on the TAR when they are on the resident. The (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA thinks that splints should be on the care plan and believes the nursing department updates the care plans. During an interview on 01/30/26 at 3:15 P.M., LPN K said the resident refuses to wear the splints almost every day, they are ordered to be put on in the morning and taken off at bedtime. LPN K said the resident never wants to wear the splints, and it should be documented if he/she refuses. LPN K said the use of splints should be on the care plan and any refusals of cares so that staff know. He/she believes the MDS Coordinator is responsible for updating the care plans, he/she was never told that charge nurses can update the care plans.During an interview on 01/30/26 at 3:27 P.M., LPN I said the resident does not wear the splints during the day, he/she wears them at night, and was not familiar with the resident's order off the top of his/her head, he/she would have to look at it. The LPN said the order should be changed, and it should be on the care plan.During an interview on 01/30/26 at 4:30 P.M., the DON said he/she is not sure if the resident is supposed to be wearing splints. The DON said the resident has changed in the last few weeks, and the resident was wearing them daily all the time when he/she was first admitted . The DON said the resident's ALS is progressing and he/she has been refusing medications and other things more often, and it should be on the care plan for splints or if he/she is refusing cares. The DON said the MDS Coordinator is responsible for updating the care plans.During an interview on 01/30/26 at 5:39 P.M., The Administrator said splints should be on the care plan and refusals of care. The Administrator said physician orders should be followed, and if the resident refuses staff should document and it should be on the care plan or progress note, and the MDS Coordinator is responsible for updating the care plans. 5. Review of Resident #61's quarterly MDS, dated [DATE], showed staff assessed the resident as:-Cognition intact;-Diagnoses of anxiety disorder, depression, hyperlipidemia, hypertension, and diabetes mellitus;-Not on a therapeutic diet while a resident.Review of the resident's registered dietician progress notes, dated 12/09/25, showed the resident with a regular diet order.Review of the resident's POS, dated January 2026, showed the resident prescribed a regular diet.Review of the resident's care plan, dated 03/23/25, showed the resident requires a therapeutic diet due to his/her diabetes, gastroesophageal reflux disease, hypertension, and hyperlipemia.During an interview on 01/27/26 at 11:36 A.M., the resident said he/she is on a regular diet and not a therapeutic diet.During an interview on 01/30/26 at 4:43 P.M., the MDS/Care Plan Coordinator said he/she was attempting to show the resident's comorbidities under the nutrition section of the care plan. He/She said she's responsible to update the care plan. He/She said he/she was not aware of the resident's change in diet September of 2025. During an interview on 01/30/26 at 5:04P.M., the DON said he/she is in charge to ensure the care plans are followed up. The DON said we meet weekly to discuss the resident's care plan needs and any issues to follow up with weekly. The DON said he/she was not aware the resident's care plan was not updated.During an interview on 01/30/26 at 5:39 P.M., the Administrator said the importance of the care plan is to ensure staff know how to care for residents. He/She expects the change to be on the resident's care plan. He/She expects his/her staff to follow the care plan. The Administrator said overall, he/she is responsible to ensure the staff follow the resident's care plan. 6. Review of Resident #78's quarterly MDS assessment, dated 11/05/25, showed staff assessed the resident as:- Severe cognitive impairment;-Received Antipsychotic medication for seven of the seven day look back period;-Significant weight loss.Review of the resident's POS, dated January 2026, showed an order dated 12/10/25, Quetiapine (antipsychotic mood stabilizer) 50mg, one tablet at bedtime.Review of the resident's electronic medical record (EMR), showed staff documented the resident weighed 131 lbs. (Pounds) on 08/04/25, 112 lbs. on 08/11/25 and 110 lbs. on 09/01/25.Review of the resident's care plan, dated 12/23/25, did not contain documentation related to the resident's use of Antipsychotic medications, or interventions to monitor for related behaviors and potential adverse effects to the medication. The care plan did not contain documentation related to the resident's significant weight loss, or the interventions to direct staff for the resident.During an interview on 01/30/26 at 10:20 A.M., CNA R said the resident's care plan should include weight loss if the resident has significant weight loss. The CNA said he/she is pretty sure antipsychotic (continued on next page)

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	265498	A. Building B. Wing	01/30/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications, and their effects should be on the resident's care plan. During an interview on 01/30/26 at 10:30 A.M., CMT U said significant weight loss should be on the resident's care plan and interventions for the weight loss should be on the care plan. The CMT said antipsychotic medications should be on the care plan, so staff know what to look for and report to the nurse. During an interview on 01/30/26 at 10:33 A.M., Registered Nurse (RN) T said antipsychotic medications and what to look for should be on the resident's care plan. The RN said weight loss and interventions should be on the care plan. During an interview on 01/30/26 at 12:30 P.M., the MDS Coordinator said typically significant weight loss and interventions should be on a resident's care plan. The MDS Coordinator said he/she missed those on the resident's care plan, it is on him/her 100%. Antipsychotic medication should be care planned with monitoring for side effects and behaviors, he/she has not updated the resident's care plan in a while. During an interview on 01/30/26 at 3:43 P.M., DON said weight loss should be on the care plan with updated interventions. The DON said antipsychotic medications and their effects should be care planned. The DON said the MDS coordinator is responsible to update the care plan. The DON said he/she is responsible to make sure the MDS Coordinators get them care planned. During an interview on 01/30/26 and 3:57 P.M., the administrator said weight loss and interventions should be care planned. The administrator said antipsychotics and the adverse effects should be care planned. The administrator said the MDS Coordinator is responsible for updating the care plans, and he/she is responsible to make sure the MDS Coordinator is updating the care plans. 7. Review of Resident #103's quarterly MDS assessment, dated 11/20/25, showed staff assessed the resident as:-Severe cognitive impairment;-Dependent on staff for care and mobility;-At risk for pressure ulcers;-Diagnoses of Alzheimer's disease, dementia, and anxiety.Review of the resident's POS, dated January 2026, showed an order dated 01/13/26, for right great toe: skin prep and cover daily until healed, once a day.Review of the resident's care plan, dated 11/21/25, did not contain documentation of the wound to the resident's right toe and the need for Enhanced Barrier Precautions (EBP).During an interview on 01/30/26 at 11:53 A.M., LPN I said that EBP, and pressure ulcers or wounds should be on the care plan. LPN I said he/she gives the MDS Coordinator a copy of the wound report each week and they should update the care plan with that information.During an interview on 01/30/26 at 3:07 P.M., CNA N said wounds should be on the care plan so staff know what interventions should be in place. During an interview on 01/30/26 at 3:15 P.M., LPN K said the resident's toe wound should be on the care plan, it is important to know about all skin changes, and he/she would communicate if there were changes or refusals.During an interview on 01/30/26 at 4:30 P.M., The DON said wound care notes are reviewed at the weekly interdisciplinary team meetings, and wound care rounds are completed on Tuesday, so that information should be on the care plan once it is identified. The MDS Coordinators usually update the care plans, and it is his/her responsibility to oversee that it gets done. The DON said it is important so that everyone knows how to take care of the residents, and he/she did not know it was not being done.During an interview on 01/30/26 at 5:39 P.M., the Administrator said wounds should be on the care plan, the MDS Coordinator is responsible for updating care plans. He/she was not aware the resident's care plan did not address his/her wound or need for EBP, but if a resident has a wound, they should have EBP.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, facility staff failed to ensure medications were stored in a safe and effective manner when staff failed to discard expired medications/supplies for two out of five medication carts, and one of three medication storage rooms. The facility census was 115.1. Review of the facility's Storage and Labeling of Drugs Policy, dated 12/02/13, showed nursing staff shall check all stock medications routinely (no less than monthly) for expired medications the need for restocking and that the stock be rotated. Central supply staff or Director of Nursing (DON) Designee is responsible for checking expiration dates of all stock medication at least monthly. As new stock medications are brought in, stock is rotated to ensure oldestsamples are at the front. Expired medications are to be destroyed through use of drug buster. When a multi-dose medication vial is opened, the date opened is written on the vial or box. The vial is disposed within 30 days after it is opened. 2. Observation on 01/27/26 at 2:02 P.M., showed the Cherry hall medication cart contained:-Two bottles of Naxolone Hydrochloride (HCL) (used to reverse opioid overdose) 4 Milligram (MG) spray with an expiration date of 09/25; and-One eye drop bottle with an expiration date of 09/25. 3. Observation on 01/27/26 at 2:47 P.M., showed the Elm hall nurse's medication cart contained:-One flex touch insulin pen, opened and undated;-One Insulin Lispro pen, opened and undated;-One insulin safety syringe with an expiration date of 11/30/24;-One Luer-Lok Tip Syringe with an expiration date of 5/31/23;-One Safety Needle with an expiration date of 03/22;-One box of Prochlorperazine (Used to treat severe nausea/vomiting/vertigo/schizophrenia and anxiety) Suppositories 25 mg, with an expiration date of 03/31/25;-One tube of Clotimazole (antifungal used to treat various infections caused by fungus and yeast) cream one percent 30 gram (GM), opened with an expiration date of 12/25;-One tube of Preparation H one percent cream opened with an expiration date of 02/25;-One tube of Triamcinolone Acetonide Cream (used to treat inflammation, allergies and skin conditions) 0.5 %, opened with an expiration date of 07/25;-One bottle of Ketoconazole Shampoo (broad spectrum antifungal medication) two percent, opened with an expiration date of 06/25;-One bottle of Clobetasol Propionate topical Solution (corticosteroid used to treat severe skin conditions), opened with an expiration date of 07/25;-One tube of Lidocaine anesthetic cream (used to relieve pain or numb tissues) four percent, opened with an expiration date of 04/25; and-One tube of Hemorrhoidal Ointment, opened with an expiration date of 03/24. 4. Observation on 01/28/26 at 8:31 A.M., showed the Elm hall medication storage room contained:-One box of Bismuth Subsalicylate (used to treat temporary upset stomach, heartburn, indigestion, gas, nausea and diarrhea) chewable tablets opened with an expiration date of 06/25;-One Sterile Medium tip foam swab, with an expiration date of 06/30/25;-One straight tip self-catheter, with an expiration date of 12/22/25;-Three specimen collection swabs with vials, with an expiration date of 08/19/25;-One disposable syringe needle, with an expiration date of 02/15/24. During an interview on 01/28/26 at 8:54 A.M. Registered Nurse (RN) KK said the facility may have a policy, but he/she is not sure when medication carts and storage rooms should be checked for expired medications and supplies. The RN said he/she doesn't know if there is an assigned staff to check for the expired. The RN said the Central Supply Coordinator does the supplies and over-the-counter medications, he/she goes through and checks the medication storage rooms and pulls the expired ones. 5. Observation on 01/28/26 at 9:04 A.M., showed Cherry hall medication storage room contained:-One wound dressing change kit, with an expiration date of 09/15/25;-One Hypodermoclysis (subcutaneous fluid administration, often used to treat dehydration) kit, with an expiration date of 09/30/25;-60 vials of Albuterol (used to dilate bronchial and open airways) solution 2.5 mg/3mL, with an expiration date of 05/25;-21 vials of Albuterol solution 2.5 mg/3mL, with an expiration date of 09/30/25;-27 packets of Budesonide Inhalation Suspension (used to treat Asthma and allergies) 0.25 mg/2 mL, with an expiration date of 12/25;-19 vials of Ipratropium (continued on next page)

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	01/30/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bromide (used to treat breathing problems, by dilating the bronchial) 0.5 mg and Albuterol Sulfate 3 mg in halation solution, with an expiration date of 06/24. 6. During an interview on 01/28/26 at 9:20 A.M., RN MM said it looks like staff are not doing first in first out policy with medications and supplies. During an interview on 01/28/26 10:26 A.M., Licensed Practical Nurse (LPN) LL said the Central Supply Coordinator does the stocking, and makes sure all expired medications and supplies are taken out, and stored appropriately. During an interview on 01/29/26 at 2:11 P.M., RN T said for medication and supply storage we have a system that is setup to check carts and room for expired medications. There is a central supply person who stocks the medication rooms. The RN said he/she personally does not check for expired medications. The supply person checks the expirations when they get in new stock, and stock it. The RN said staff should date insulin, when staff put open the insulin and put it on the medication cart. The RN said staff should destroy the insulin if it does not have an open date. During an interview on 01/30/26 at 12:05 P.M., the Central Supply Coordinator said he/she stocks the over-the-counter medications and supplies in the Walnut medication storage room, he/she does not stock the other storage rooms, nurses just come and get what they need from the Walnut medication storage room and take it back to their medication storage rooms. The Central Supply Coordinator said he/she checks treatment supplies for expiration, every six months or so. The Central Supply Coordinator said someone from the pharmacy comes in every month to check the medications on the medication carts for expiration. The Central Supply Coordinator said he/she is not aware of the expired medications and supplies. During an interview on 01/30/26 at 3:43 P.M., the Director of Nursing (DON) said Central Supply is supposed to be taking the expired supplies and medications out, he/she is supposed to do all the medication rooms. The DON said the Certified Medication Technicians (CMT)s are supposed maintain the medication carts and Nurse Managers are supposed to do audits to checks the medication carts for expired medications. The DON said he/she is responsible to make sure the Nurse Manager are completing the audits. During an interview 01/30/26 at 3:57 P.M., the administrator said he/she would expect the CMT, or nurse to remove expired over the counter medications and supplies, but it is all his/her responsibility, to ensure it gets done.

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F 0689 Level of Harm - Minimal harm or potential for 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, interview, and record review, facility staff failed to ensure the residents' environment remained free of accident hazards when staff failed to properly store medications in the memory care unit bathroom and left medications in one resident's bathroom (Resident #62). The facility census was 115.1.Review showed the facility failed to provide a policy to direct staff on medication storage safety. 2. Observation on 01/29/26 at 8:35 A.M., showed the whirlpool bathroom on the memory care unit unlocked, with the door propped open, and the following sitting out:-Nystatin (Antifungal) topical 100,000 unit/gram powder labeled with a resident's name;-Triad hydrophilic wound dressing pansement hydrophilic (a sterile, zinc-oxide based paste designed to manage light-to-moderate wound exudate by creating a moist, healing environment);-Calmoseptine ointment (a multipurpose, over-the-counter moisture barrier designed to treat skin irritations, diaper rash, incontinence, and minor wounds);-A&D ointment.3. Observation on 1/29/26 at 2:33 P.M., showed the whirlpool bathroom on the memory care unit unlocked, with the door propped open, and the following sitting out:-Nystatin topical 100,000 unit/gram powder labeled with a resident's name;-Triad hydrophilic wound dressing pansement hydrophilic;-Calmoseptine ointment;-A&D ointment.During an interview on 1/29/2026 at 2:33 P.M., Resident Service Assistant (RSA) DD said the whirlpool bathroom is usually kept unlocked for residents to use, but no items should be out where residents can get to them. He/She was unaware the items were out. He/She said they get the supplies out when they toilet residents every two hours, but supplies should be put back. He/She said it is dangerous to leave medications and ointments out where residents can ingest them, because they have a lot of confused residents on the unit.During an interview on 1/29/2026 at 2:40 P.M., the Director of Nursing (DON) said it is important to keep medications and ointments out of the reach of residents. He/She said there are residents that wander on the unit and who are not cognitive who could get ahold of and possibly ingest the ointments and medications. He/She said all medications and ointments should be kept locked in the medication carts. He/She was not aware staff were leaving ointments and prescribed medications in the whirlpool bathroom with the door open and unattended.During an interview on 1/30/26 at 11:37 AM, the administrator said is his/her expectation that any ointments and/or medications are kept behind locked doors or cabinets when it is not in use. He/She said it is especially important for safety on the locked memory care unit. He/She said he/she would expect prescriptions to be placed in the treatment cart and not left out. He/She said the residents are on the memory care unit because they wander, some are mobile, and they have cognitive impairment. He/She said items left out could care harm if ingested.4. Review of Resident #62's Comprehensive Minimum Data Set (MDS), dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as severe cognitive impairment and a diagnosis of dementia.Review of the physician order sheet (POS), dated January 2026, showed an order to check wander guard placement every shift.Observation on 01/27/26 at 10:55 A.M., showed the resident wore a wander guard on his/her left ankle.Observation on 01/28/26 at 9:46 A.M., showed the resident's bathroom contained three tubes of A&D ointment and Selan plus Zinc oxide barrier cream.Observation on 01/29/26 at 8:41 A.M., showed the residents bathroom contained three tubes of A&D ointment, Selan plus Zinc oxide barrier cream.Observation on 01/29/2026 at 8:48 A.M., showed the resident wandered into the whirlpool bathroom.During an interview on 1/29/26 at 2:33 P.M., RSA DD said the ointments should not be left where residents can get to them. He/She said they have confused residents who may rub it on their skin or try to ingest it. He/She was not aware the ointments where in the resident's room, he/she said it was a safety concern.During an interview on 1/29/26 at 2:40 P.M., the DON said the resident is not cognitive and wanders. He/She said ointments and medications should not be left out where the resident can get a hold of them. He/She said items left out can be a safety risk for the resident. He/She said it is (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her expectation that staff place ointments/creams in locked medication carts when they are not in use. He/She was not aware of the issue.During an interview on 1/30/26 at 11:37 AM, the administrator said he/she was not aware medications and ointments were on the counters in the resident's room again. He/She said the resident is not cognitive, is mobile, and does wander. He/She said this is a safety concern, and these items could be dangerous if ingested.