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 _____	C 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUFFS, THE	3105 BLUFF CREEK DRIVE COLUMBIA, MO 65201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to ensure residents remained free of significant medication errors when staff administered Resident #2's medication to Resident #1 which resulted in Resident #1 being transported to the hospital with low blood sugar. The facility census was 116. The administrator was notified on 2/24/25 of past Non-Compliance, which occurred on 2/4/25 when staff administered the wrong medication to the incorrect resident. Staff assessed the resident, notified the residents physician, sent the resident to the hospital, and in-serviced nursing staff on medication administration. Staff corrected the deficient practice on 2/5/2025. 1. Review of the facility Medication Administration policy, dated 9/9/2022, showed nursing personnel shall ensure the safe and effective administration of medications. A physician or authorized practitioner should give all orders for medications or treatments that include medications. Prior to administration the nursing staff member administering the medication shall verify the medication is being administered to the correct resident/patient, at the proper time, in the prescribed dose and by the correct route. 2. Review of Resident #1's Admission minimum data set (MDS), a federally mandated assessment tool, dated 12/25/24, showed staff	F 760	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew L. Moore — TITLE: Executive Director — (X6) DATE: 3-4-25

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.

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F 760	Continued From page 1 assessed the resident as follows: -Cognitively intact; -Diagnoses of iron deficiency, Atrial Fibrillation (causes the heart to beat irregularly), Hypertension, and renal failure. Review of the resident's plan of care, 1/2/25, showed the care plan did not contain documentation about the resident's medications. Review of the resident's physician order sheet, dated 2/1/2025 to 2/28/25, did not show any orders for insulin or blood sugar medications. Review of the resident's progress notes, dated 2/4/24 at 8:56 P.M., showed Licensed Practical Nurse (LPN) A documented at 8:56 P.M., resident received Basaglar insulin (a long-acting insulin to control blood sugar levels) 40 units. Blood sugar was 152. Notified physician on call, waiting for to return call. Review of the resident's progress notes, dated 2/4/24 at 9:05 P.M., showed the residents blood sugar at 9:20 P.M., was 149 and at 9:40 P.M., was 142. Review of the resident's progress notes, dated 2/4/24 at 9:36 P.M., showed Licensed Practical Nurse (LPN) A documented new orders to check blood sugars every hour for 24 hours, give glucose gel for low blood sugar if needed, give glucagon (an emergency medicine used to treat severe low blood sugar) for low blood sugar if needed. Resident ate half a sandwich, juice and yogurt. Physician called back with orders to send the resident to the emergency room to monitor more closely.	F 760		

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F 760	Continued From page 2 Review of the resident's hospital records, dated 2/4/25, showed the resident admitted to the hospital for monitoring of an insulin overdose and medication error. The resident continued to have hypoglycemia (low blood sugar) ranging 60-80 for the majority of his/her stay. Review of the facility investigation, dated 2/4/25, showed LPN A administered another resident's medication to Resident #1 because Resident #1 and Resident #2 have similar names. Staff documented the review sheet and the medication administration record did not match the bed numbers. LPN A unfamiliar with residents. The resident was sent to emergency room and admitted. Review showed nursing staff in-serviced on proper medication administration on 02/5/25. During an interview on 2/24/25 at 11:14 A.M., the administrator said there was a full investigation into a medication error with the resident. The nurse gave the resident the wrong medication. The physician was contacted immediately as were the family, blood sugar checks started, snacks were given and the resident was then sent out to the hospital for monitoring. During an interview on 2/24/25 at 1:25 P.M., the resident said he/she got medications that was his/her roommate's medications and had to spend two days in the hospital because he/she is not a diabetic. He/She said the nurse did not ask his/her name and after he/she got the shot in his/her stomach, he/she asked the nurse if he/she was a diabetic now and the nurse said "I guess so." He/She said then the nurse rushed him/her to eat something and then sent him/her	F 760		

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F 760	Continued From page 3 to the hospital and he/she almost died. During an interview on 2/24/25 at 2:46 P.M., LPN A said he/she had to pass medications on a unit he/she does not normally work. He/She said he/she had the report sheet to see if the residents had any special notes he/she would need to know about. He/She said he/she followed the report sheet which showed the Resident #2 in bed A and he/she administered the insulin to that resident. After administering the insulin, the resident asked him/her if he/she was a diabetic now and he/she immediately checked the report sheet and the MAR and realized Resident #2 is in bed B and Resident #1 in bed A is not a diabetic. He/She called the physician and got new orders and tried to get the resident to eat. He/She said the physician called back and wanted the resident sent out because of the amount of insulin given. During an interview on 2/24/25 at 2:55 P.M., the Director of Nursing (DON) said he/she was contacted by LPN A that a major medication error had occurred. LPN A had given the resident his/her roommates insulin. LPN A said the bed assignments were mixed up on the report sheet. He/She said the physician and family was contacted immediately, blood sugar checks were ordered, and the resident was given snacks per physician orders, soon after the physician called back and decided to send the resident to the emergency room. MO00249963	F 760		