STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195478	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Columns Rehabilitation and Healthcare Center	3025 Fourth Street Jonesville, LA 71343

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain a clean and sanitary kitchen to prevent the likelihood of foodborne illnesses and failed to store food in accordance with professional standards for food service safety. The facility census was 93. Findings: Review of an undated facility policy on 04/21/2026 at 8:46 a.m. titled, Sanitation Inspection revealed the following in part.It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. Review of an undated facility policy on 04/20/2026 at 2:50 p.m. titled, Date Marking for Food Safety revealed the following part .The facility adheres to a date marking system to ensure the safety of ready -to-eat, time/temperature control for safety of food. 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 5. The discard day or date may not extend the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. 6. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring and shall discard accordingly. 7. The Dietary Manager shall be responsible for checking the refrigerator daily for food items that are expiring and shall discard accordingly. Observation on 04/20/2026 at 8:32 a.m. of the facility kitchen accompanied by S3 DM revealed the following: Small Refrigerator:One gallon of remoulade sauce with an expiration date of 09/25/2025. Dry Pantry Storage:One gallon of apple cedar vinegar with expiration date of 03/26/2026.One gallon of red vinegar with expiration date of 05/12/2023.One undated, opened container of grape jelly jam.One undated, opened bag of butterscotch powdered pudding.One undated, opened bag of brown gravy. Walk-In Refrigerator:One bottle of lime juice with expiration date of 11/2025. Main Freezer:One opened cardboard box that contained: opened, unsealed, and undated plastic wrap of chicken strips (over 10 individual strips).One opened cardboard box that contained: opened, unsealed, and undated plastic wrap of dark chicken strips (over 40 individual strips).One opened cardboard box that contained: opened, unsealed, and undated plastic wrap of okra (over 100 pieces of okra).One opened cardboard box that contained: opened, unsealed, and undated plastic wrap of biscuits (over 50 individual biscuits). At the time of observation, S3 DM confirmed all of the above findings. S3 DM revealed that all dietary staff are aware of how to correctly label/store opened food items and to discard any expired food items in the kitchen. S3 DM confirmed the above listed items were expired, opened, unsealed, and/or undated and should have been handled or disposed of properly.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interview, the facility failed to ensure residents receiving a psychotropic medications had a Gradual Dose Reduction (GDR) completed for 1 resident (Resident #26) of 5 (#8, #13, #26, #40, #87) residents reviewed for unnecessary medications.Findings:Review of the facility's undated policy titled, Gradual Dose Reduction of Psychotropic Drugs, revealed in part, Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs. Review of Resident #26's medical records revealed an admit date of 06/16/2025 with the following diagnoses, including in part: Parkinson's Disease With Dyskinesia, With Fluctuations, Chronic Obstructive Pulmonary Disease, Unspecified, Alzheimer's Disease, Delusional Disorders, Depression, and Anxiety Disorder. Review of Resident #26's Physician's Orders revealed in part the following orders:Haloperidol Oral Tablet 5 MG (milligrams), Give 1 tablet by mouth at bedtime related to Alzheimer's Disease with a start date of 01/22/2026 Lorazepam Oral Tablet 0.5 MG, Give 1 tablet by mouth three times a day related to Anxiety Disorder with a start date of 11/24/2025Quetiapine Fumarate Oral Tablet 50 MG, Give 1 tablet by mouth every morning and at bedtime related to Unspecified Dementia with a start date of 06/16/2025Sertraline Oral Tablet 50 MG, Give 1 tablet by mouth one time a day for depression related to Depression with a start date of 09/18/2025 Review of Resident #26's most recent GDR dated 01/28/2026 failed to reveal Haloperidol Oral Tablet 5 MG, Lorazepam Oral Tablet 0.5 MG, Quetiapine Fumarate Oral Tablet 50 MG or Sertraline Oral Tablet 50 MG, were reviewed for an attempted GDR and a rationale was provided for continuing psychoactive medication at current dose by the Physician/Nurse Practitioner. The GDR also requested a valid Diagnosis (Dx) for Haloperidol Oral Tablet 5 MG and Quetiapine Fumarate Oral Tablet 50 MG which was left blank as well. In an interview on 04/22/2026 at 12:30 p.m., S2 DON (Director of Nursing) acknowledged Resident #26's GDR dated 01/28/2026 was not completed and signed by a physician.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify the Ombudsman in writing of resident transfer/discharge for 1 (Resident #96) of 1 resident reviewed for transfer/discharge. The total sample size was 30.Findings:Review of the facility's undated policy titled, Transfer and Discharge (Including AMA) read in part. Policy Explanation and Compliance Guidelines: 3. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and a manner in which they can understand. The notice will include all of the following at the time it is provided: h. the name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman.Review of Resident #96's medical record revealed an admission date of 02/04/2026 and a discharge date of 03/04/2026. Resident #96 had diagnosis of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side. Review of Resident #96's Discharge-Return Not Anticipated MDS with an ARD of 03/04/2026 revealed in part.Type of discharge: unplanned. Review of the facility's March 2026 Emergency Transfer Log revealed a list of only hospitalization transfers and Resident #96's discharge was not listed.In an interview on 04/22/2026 at 2:51 p.m., S7 SSD revealed she was only aware to report hospitalizations to the Louisiana Ombudsman Program using the Emergency Transfer Log and had not reported any discharges from the facility to the Louisiana Ombudsman Program. S7 SSD confirmed she did not report Resident #96's discharge on [DATE] to the Louisiana Ombudsman Program.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record reviews, and interviews the facility failed to provide care and services that meet professional standards of quality, by failing to accurately assess 1 resident (Resident #87). The total sample size was 30 residents.Findings:Review of Resident #87's medical record revealed an admission date of 08/22/2025 with diagnoses that included in part. Alzheimer's Disease with Late Onset, Atrial Fibrillation, and Cognitive Communication Deficit. Review of Resident #87's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 03/22/2026 revealed in part a BIMS (Brief Interview for Mental Status) score of 5, indicating severe cognitive impairment. Review of Resident #87's physician orders revealed in part.Eliquis (an anticoagulant or blood thinner) Oral Tablet 2.5 MG (milligrams) Give 1 tablet by mouth every morning and at bedtime related to Unspecified Atrial Fibrillation with a start date of 08/22/2025.Monitor side effects of anticoagulant therapy.0 - .6 - Abnormal bruising, with a start date of 08/22/2025.An additional order for Weekly Skin Inspections was dated 04/01/2026. Review of Resident #87's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2026 revealed in part.Resident #87 is receiving Eliquis as ordered. Under the order to monitor side effects of anticoagulant therapy, there was no documentation of Resident #87's bruising. Resident #87's weekly skin assessments dated 04/03/2026, 04/10/2026, and 04/17/2026 also revealed no documentation of bruising. Review of Resident #87's Weekly Skin Check assessment report dated 04/17/2026 revealed no documented bruising. Review of Resident #87's current Care Plan revealed medication interventions with an initiation date of 01/07/2026, that included monitoring for bruising. In an interview and observation of Resident #87 on 04/22/2026 at 9:25 a.m., S11 LPN, revealed an observation of extensive bruising to Resident #87's left hand and fingers as well as to the right side of her neck. S11 LPN denied receiving any reports of an incident which may have contributed to bruising. S11 LPN stated the wound care or treatment nurse performs a weekly skin inspection on Resident #87. In an interview with S12 TX RN on 04/22/2025 at 12:45 p.m., S12 TX RN revealed she was familiar with Resident #87 and does perform treatments and skin assessments on Resident #87. S12 TX RN denied knowledge of extensive bruising. Observation of Resident #87 with S2 DON on 04/22/2026 at 12:45 p.m., S2 DON revealed Resident #87 did have significant bruising on her left hand and right side of her neck. S2 DON stated the bruises were in various stages of healing, which indicated some new and some older bruising. In an interview with S2 DON on 04/22/2026 at 12:50 p.m., S2 DON revealed there was no documentation in Resident #87's electronic health record of the bruising that was revealed to be on Resident #87 during the observation with this surveyor. S2 DON confirmed neither the hall nurses nor treatment nurses had been accurately documenting on the condition of the resident's skin as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infection. The sample size was 30. The facility failed to ensure: Enhance Barrier Precautions (EBP) were implemented and utilized for Resident #10; andProper hand hygiene and gloving were performed throughout Resident #10's wound care treatment.Findings: Review of an undated facility policy on 04/21/2026 at 4:22 p.m. titled, Clean Dressing Change revealed the following in part .It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross contamination. Physician's orders will specify the type of dressing and frequency of changes. 9. Loosen the tape and remove the exiting dressing. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered. Pat dry with gauze. 14. Wash hands and put on clean gloves. 15. Apply topical ointments or creams and dress the wound as ordered. Review of an undated facility policy on 04/21/2026 at 9:26 a.m. titled, Enhanced Barrier Precautions revealed the following in part .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 2. Initiation of Enhanced Barrier Precautions: b. an order for Enhanced Barrier Precautions will be obtained for residents with any of the following: i. wounds (ex. chronic wounds such as pressure ulcers). 4. High contact resident care activities include: d. providing hygiene, f. changing briefs or assisting with toileting, h. wound care: any skin opening requiring a dressing. Review of Resident #10's medical record revealed an admission date of 01/26/2026 with diagnoses, which included Alzheimer's Disease, Mild Protein-Calorie Malnutrition, Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, and Adult Failure to Thrive. Review of Resident #10's admission MDS with an ARD of 02/01/2026 revealed a BIMS score of 11, which indicated moderate cognitive impairment. Resident #10 required substantial/maximum assistance with toileting hygiene and was dependent on staff with personal hygiene and toilet transfers. Resident #10 had multiple pressure injuries ranging from stage 1- stage 3, required pressure injury care, and applications of ointments/medications/nonsurgical dressings to areas of the body other than to the feet. Resident #10 also required hospice care services. Review of Resident #10's current physician's orders revealed the following in part .-Cleanse an unstageable pressure ulcer to the coccyx with normal saline or wound cleanser, pat dry. Apply santyl to the wound bed, cover with calcium alginate, and cover with a dry dressing. Perform daily or as needed for soiled or missing dressing every day shift for wound healing. (Start date: 04/01/2026).-Admit to hospice with a diagnosis of Alzheimer's (Order Date: 01/26/2026). Further review of Resident #10's current physician's orders revealed no orders for EBP related to her unstageable coccyx pressure ulcer. Review of Resident #10's skin issues assessment for the following dates revealed .-03/26/2026: Location: coccyx; Skin issue: pressure ulcer/injury; Pressure ulcer staging: unstageable pressure ulcer/injury; Acquired: present on admission; Exudate amount: moderate; and Exudate type: serosanguineous- mixture of serous and sanguineous fluid, typically, pale, red, and watery. -04/09/2026: Location: coccyx; Skin issue: pressure ulcer/injury; Pressure ulcer staging: unstageable pressure ulcer/injury; Unstageable ulcer due to: slough and/or eschar; Acquired: present on admission; Exudate amount: moderate; and Exudate type: serosanguineous- mixture of serous and sanguineous fluid, typically, pale, red, and watery. -04/16/2026: Location: coccyx; Skin issue: pressure ulcer/injury; Pressure ulcer staging: unstageable pressure ulcer/injury; Unstageable ulcer due to: slough and/or eschar; Acquired: present on admission; Exudate amount: faint; and Exudate type: serosanguineous- mixture of serous and sanguineous fluid, typically, pale, red, and watery. Review of Resident #10's current care plan (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the following in part . (Date Initiated: 02/02/2026) Focus: I have the following pressure ulcers: 01/26/2026 stage 3 to coccyx (restaged to unstageable pressure ulcer on 02/12/2026). Interventions: Wound care provided as ordered. Further review of Resident #10's current care plan revealed no care plan for EBP related to her unstageable coccyx pressure ulcer. Review of a facility staff in-service conducted on 03/04/2026 revealed the staff were educated on signage for residents, which included EBP symbols and signage. EBP posted signage would be identified by a symbol of a pair of gloves and a check mark. S5 CNA was documented as present during the in-service. Treatment observation on 04/21/2026 at 8:55 a.m. revealed S4 TX RN perform Resident #10's unstageable coccyx pressure injury care, with S10 CNA, who assisted with brief care and turning/repositioning of Resident #10. Observed S4 TX RN perform hand hygiene and apply gloves prior to beginning wound care. S4 TX RN and S10 CNA (both with only gloves on) repositioned/turned Resident #10 and exposed the resident by removal of her incontinence brief. S4 TX RN removed the dirty wound dressing and described the pressure injury drainage as moderate serosanguineous drainage, with the wound bed as having slough and eschar. S4 TX RN disposed of the dirty wound dressing and then, without hand hygiene or glove change, touched the clean supplies and cleaned the coccyx wound bed. S4 TX RN began to put her same contaminated/dirty gloved finger in a cup of santyl and applied the ointment to Resident #10's coccyx wound bed, with her pointer finger. With the same contaminated/dirty gloves, S4 TX RN applied calcium alginate and covered the coccyx wound bed with a dry dressing. S4 TX RN completed the treatment at 9:08 a.m. and disposed of all supplies in a red biohazard bag. S4 TX RN performed hand hygiene after disposal of biohazard waste. At the time of the treatment observation, S4 TX RN revealed Resident #10 admitted to the facility with multiple skin issues/pressure ulcers and required hospice services. S4 TX RN described Resident #10's coccyx pressure ulcer as actively draining and had deteriorated into an unstageable due to eschar and slough present in the wound bed. S4 TX RN revealed the unstageable pressure ulcer was very slow to heal due to the resident's end of life disease process. In an interview on 04/21/2026 at 9:08 a.m., S4 TX RN confirmed all the above findings during the treatment observation. S4 TX RN revealed she did not know why she only completed hand hygiene and a glove change prior to starting the treatment. S4 TX RN confirmed she should have performed hand hygiene and glove changes between each task of the treatment, but did not. S4 TX RN revealed Resident #10 did not require EBP procedures and did not know why the resident didn't require EBP. In an interview and record review on 04/21/2026 at 9:11 a.m., S2 DON/IP revealed she expected S4 TX RN to perform hand hygiene and glove changes between each task of Resident #10's wound care treatment. In a record review, at the time of interview, S2 DON/IP revealed Resident #10 did not have orders for EBP procedures. S2 DON/IP revealed she was filling in as the facility Infection Preventionist and stated, I don't know why Resident #10's is not on EBP. S2 DON/IP revealed that as the facility DON/IP, she should be aware if Resident #10's unstageable coccyx pressure ulcer required EBP procedures. S2 DON/IP confirmed Resident #10 should have had EBP procedures due to the resident having a slow to heal, draining, unstageable coccyx pressure ulcer, and required hospice services, but did not. In an interview on 04/22/2026 at 12:19 p.m., S5 CNA revealed she was assigned to Resident #10 and required total care with most ADLs (Activities of Daily Living). S5 CNA revealed she provided incontinent care, a bath, repositioning/turning, and dressed the resident this morning while only wearing gloves. S5 CNA revealed Resident #10 did not require EBP procedures. Observation on 04/22/2026 at 12:25 p.m. revealed EBP signage posted on the doorframe of Resident #10's room. In an interview on 04/22/2026 at 12:31 p.m., S6 LPN revealed she was assigned to Resident #10 and aware of the resident's skin issues, including the coccyx pressure ulcer. S6 LPN revealed the resident admitted to the facility with this pressure ulcer, it had since deteriorated into an unstageable due to her disease process and worsening condition. S6 LPN described the coccyx pressure ulcer as slow to heal due to the resident's disease progression. S6 LPN revealed Resident #10 had a history of receiving antibiotic therapies due to an infection of the coccyx wound and had recently completed the antibiotic cycle. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note: After surveyor notification of all of the above issues in Resident #10's pressure injury investigation, the facility updated her record to reflect the implementation of EBP procedures on 04/21/2026.