STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255227	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Rehabilitation and Healthcare Center	1506 North Main Street Columbia, MS 39429

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, and interview, the facility failed to complete and submit a Minimum Data Set (MDS) discharge assessment in a timely manner in two (2) of (2) discharged residents reviewed. Findings include:On 09/11/2025 at 9:58 AM, during a record review and interview with Registered Nurse (RN) #2/ MDS nurse, it was revealed that Resident #98 was admitted on [DATE] and discharged home on [DATE]. The discharge assessment with an Assessment Reference Date (ARD) of 06/14/2025, was submitted on and accepted on 07/09/2025, which is 25 days after the discharge date . On 09/11/2025 at 2:10PM, in an interview with the Administrator, the MDS discrepancy was discussed and the Administrator verbalized understanding of the importance of getting MDS records submitted on time. On 09/11/2025 at 2:24 PM, in an interview with the Director of Nursing (DON), the MDS discrepancy was discussed. The DON stated that she was aware of the discrepancy and saw where it could be a problem.Record review of the Resident Assessment Instrument (RAI) Manual, a discharge assessment must be completed within 14 calendar days after the resident's discharge and submitted no later than 14 days after completion.Record review of the MDS Coding Policy, reviewed 6/2/25 revealed that the facility utilizes the most up to date Resident Assessment (RAI) manual for determination of coding each section of the Resident Assessment, timely and accurately.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, record reviews and facility policy review the facility failed to follow the comprehensive care plan related to Percutaneous Endoscopic Gastrostomy (peg) tube medication for one (1) of (1) peg tube medication observations. Resident #16Findings Include:A record review of the facility's Care Plans, Comprehensive Person-Centered last review date 1/2023, revealed A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident.A record review of Resident #16 comprehensive care plan created on 8/19/25 included interventions Administer (proper name of each medication) as ordered.During an observation on 09/10/25 at 9:00 AM, during morning medication administration by Licensed Practical Nurse (LPN) #2 revealed LPN#2 crushed the medications and placed each medication separately in a dispense cup with 5 cubic centimeters (cc) water. The following medications were given by peg tube Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin) , Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban Oral Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). LPN #2 administered the medications by peg tube but did not flush with water between the medications. After administering all medications, LPN#2 then flushed the peg tube with 30cc of water. In an interview on 09/10/25 at 9:59 AM, LPN #2 stated she thought she did something wrong but was not sure. She stated, I usually flush between medications, but I am not sure. In an interview on 09/10/25 at 2:20 PM, LPN #2 confirmed that she did not flush between medications as ordered by physician. She stated she forgot to flush between medications. She stated the reason for flushing is to make sure residents get all the medication and that by not flushing the peg tubing can become clogged. In an interview on 09/11/25 at 1:30 PM, with Registered Nurse (RN) #3)/ Assistant Director of Nursing (ADON) stated LPN #2 should have followed physician orders. She stated the purpose of flushing is to keep the tube patent. She stated she expects nurses to follow physician orders.In an interview on 09/11/25 at 1:38 PM, the Director of Nursing (DON) stated LPN #2 should have flushed the peg tube between medications. She stated the purpose is to make sure medications go down and make sure tube is patent. She stated the medication may not work effectively if physician orders are not followed. She stated she expects all staff to give medications correctly and way they have been trained. In an interview on 09/11/25 at 1:42 PM, Registered Nurse (RN) #2/Minimum Data set (MDS)/care plan nurse stated the purpose of the care plan is an outlook of what the residents care should be for all staff to follow. She confirmed LPN#2 did not follow the care plan. She stated she expects staff to follow the care plan.A record review of Resident #16 Physician Orders revealed crushed medications and placed each medication separately in a dispense cup with 5 cc water. The following medications were given by peg tube Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin) , Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban Oral Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). Flush with 10 cc water of water between medications.A record review of Resident #16's admission Record revealed an admission date of 1/30/25 with diagnoses that included Chronic Respiratory Failure with Hypoxia, Dyspnea unspecified, and Encounter for attention to Tracheostomy.

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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, interviews, record reviews and facility policy review the facility failed to administer medications by Percutaneous Endoscopic Gastrostomy (peg) tube according to physician orders for one (1) of four (4) medication observations. Resident #16.Findings Include:A record review of the facility's Administrating Medication through an Enteral Tube last reviewed date of 6/2025 revealed .General Guidelines.3. Administer each medication separately and flush between medications.On 09/10/25 at 9:00 AM, during an observation morning med administration by Licensed Practical Nurse (LPN) #2 revealed LPN#2 crushed the medications and placed each medication separately in a dispense cup with 5 cubic centimeters (cc) water. The following medications were given by peg tube Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin) , Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban Oral Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). LPN #2 administered the medications by peg tube but did not flush with water between the medications. After administering all medications, LPN#2 then flushed the peg tube with 30cc of water. On 09/10/25 at 9:59 AM, in an interview LPN #2 stated she thought she did something wrong but was not sure. She stated, I usually flush between medications, but I am not sure. On 09/10/25 at 2:20 PM, in an interview LPN #2 confirmed that she did not flush between medications as ordered by physician. She stated she forgot to flush between medications. She stated the reason for flushing is to make sure residents get all the medication and that by not flushing the peg tubing can become clogged. On 09/11/25 at 1:30 PM, in an interview with Registered Nurse (RN) #3)/ Assistant Director of Nursing (ADON) stated LPN #2 should have followed physician orders. She stated the purpose of flushing is to keep the tube patent. She stated she expects nurses to follow physician orders.On 09/11/25 at 1:38 PM, in an interview the Director of Nursing (DON) stated LPN #2 should have flushed the peg tube between medications. She stated the purpose is to make sure medications go down and make sure tube is patent. She stated the medication may not work effectively if physician orders are not followed. She stated she expects all staff to give medications correctly and way they have been trained. A record review of Resident #16 Physician Orders revealed orders for Amiodarone HCl Oral Tablet 400 MG (Amiodarone HCl, Aspirin Oral Tablet Chewable 81 MG (Aspirin),Clopidogrel Bisulfate Oral Tablet 75 MG (Clopidogrel Bisulfate), Apixaban Oral Tablet 2.5 MG (Apixaban), Furosemide Oral Tablet 20 MG (Furosemide), lansoprazole Oral Tablet Delayed Release Disintegrating 30 MG (Lansoprazole),Potassium Chloride Oral Solution 20 MEQ/15ML, Fish Oil Oral Capsule 1000 MG (Omega-3 Fatty Acids, Vision Formula/Lutein Oral Tablet (Multiple Vitamins w/ Minerals). Flush with 10 cc water of water between medications.A record review of Resident #16's admission Record revealed an admission date of 1/30/25 with diagnoses that included Chronic Respiratory Failure with Hypoxia, Dyspnea unspecified, and Encounter for attention to Tracheostomy.A record review of Resident #16's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates the resident was cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to provide daily oral care for over three weeks for a resident who was totally dependent on staff for personal hygiene and oral care. This failure resulted in visible plaque buildup and placed the resident at risk for oral infection, discomfort, and diminished quality of life for one (1) of five (5) residents reviewed for activities of daily living (ADLs). Resident #43. Findings include: A record review of the facility policy Activities of Daily Living (ADL) Supporting revised 3/2018 revealed, Policy Statement .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene On 9/8/25 at 1:07 PM, during an observation and interview with Resident #43, he communicated that it had been over three weeks since his teeth had last been brushed. He communicated a desire to have his teeth brushed at least once per day and revealed that he required staff assistance to complete this task. Observation revealed significant plaque buildup on both his upper and lower teeth.On 9/9/25 at 8:59 AM, during a follow-up observation and interview with Resident #43, he communicated that his oral care had still not been provided. Observation revealed plaque remained visibly built up on both his upper and lower teeth.On 9/9/25 at 2:38 PM, an interview and in-room observation were conducted with the Registered Nurse (RN) Supervisor #1, who confirmed the resident's teeth appeared as though they had not been brushed in some time. She stated that oral care should be provided daily as part of the resident's assigned ADL care.On 9/9/25, at 2:41 PM, the RN Supervisor, State Agency (SA), and Certified Nursing Assistant (CNA) #1 entered the resident's room. CNA #1 acknowledged that she was assigned to Resident #43 on both the current and previous day. She admitted that she had not brushed the resident's teeth on either day and confirmed that daily oral care was required as part of her responsibilities, given the resident's inability to perform the task independently.During an interview with the Director of Nursing (DON) on 9/11/25 at 1:41 PM, she explained that oral care is a part of the daily ADL care that the CNAs perform and that she expects them to perform it as required.A record review of the admission Record revealed the resident was admitted on [DATE] with diagnoses including Hemiplegia and Hemiparesis following cerebral infarction affecting the left non-dominant side and Aphasia.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment. Section GG Oral Care indicated the resident was totally dependent on one staff member for all personal hygiene and oral care tasks.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and facility policy review the facility failed to ensure that food was palatable, attractive, and served at a safe and appetizing temperature for five (5) of (5) sampled food items. Specifically, the facility failed to ensure that meals were maintained at appropriate temperatures prior to service, which had the potential to affect the taste, safety, and nutritional value of meals served to residents.Findings include:A record review of the facility policy titled Food: Quality and Palatability, dated 2/2023, revealed .Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature.Definitions.Proper (safe and appetizing) temperature. Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction.On 9/8/25 at 11:49 AM, temperatures of food items on the steam table were recorded as follows: chicken breast 109 Fahrenheit (F), pureed noodles 100 F, pureed peas 101 F, and pureed chicken 119 F. Only the chopped chicken reached a temperature of 148 F.On 9/8/25 at 12:01 PM, during an observation conducted with the Dietary Manager (DM), food items were observed being placed from the oven onto the steam table. The dietary staff then plated the food, placed onto carts, and served to residents in the dining hall at the temperatures documented as above. The DM acknowledged that steam table foods should reach and maintain at least 135 F to ensure proper holding temperature. She further confirmed that the kitchen's window air conditioning unit blows directly over the steam table, contributing to premature cooling of the food items. Despite knowing this, she stated the facility had not implemented any corrective action or reliable protocol to maintain safe, warm, and appetizing food temperatures prior to meal service.On 9/9/25 at 7:47 AM, observation revealed the window air conditioning unit was again running and blowing directly onto the steam table. Temperature checks at that time revealed scrambled eggs at 108 F and pureed eggs at 100 F. The State Agency (SA) observed during this time food being plated, placed onto carts and being served to residents in the dining hall.

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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 observations, interviews, record reviews and facility policy review, the facility failed to administer medication in a manner to prevent infection for one (1) of four (4) medication administrations observed. Resident #99. Findings Include:A record review of the facility's Infection Prevention and Control Program with a revision date of 6/30/25 revealed An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection .On 09/10/25 at 8:25 AM, revealed Licensed Practical Nurse (LPN)#1 administered morning medication consisting of: Renvela Oral Tablet 800 milligrams (mg), Aspirin Enteric Coated (EC) Tablet Delayed Release 81 mg, B-Complex/Folic Acid/Vitamin C Oral Tablet Extended Release (B-Complex w/ C & Folic Acid),Clopidogrel Bisulfate Tablet 75 MG, Hydralazine HCl Oral Tablet 100 MG by mouth and Combigan Ophthalmic Solution 0.2-0.5 % (Brimonidine Tartrate-Timolol Maleate) one drop in each eye. LPN#1 gathered the medications and entered Resident #99's room. Resident #99 poured his medication on the overbed table and picked up one pill at time and placed it in his mouth. Resident #99's breakfast tray was still on the table and three pills rolled under his tray. LPN#1 moved the tray back and picked up the pills with her bare hands and placed them back on Resident #99's overbed table. Resident #99 continued to take the medications one at a time. LPN #1 sanitized her hands and applied gloves and administered Resident #99's eye drops. LPN#1 removed her gloves and the resident stated You put the gloves on too late. You should have put them on before picking my pills up in your hands.On 09/10/25 at 8:45 AM, in an interview with LPN #1 she confirmed she was not supposed to pick up pills with her bare hands. She stated it is an infection control issue.A record review of Resident #99's Order Summary Report revealed physician orders for Renvela Oral Tablet 800 mg, Aspirin EC tablet delayed release 81 MG, B-Complex/Folic Acid/Vitamin C Oral Tablet Extended Release (B-Complex w/ C & Folic Acid),Clopidogrel Bisulfate Tablet 75 MG, Hydralazine HCl Oral Tablet 100 MG, all the above medications were by mouth and Combigan Ophthalmic Solution 0.2-0.5 % (Brimonidine Tartrate-Timolol Maleate) one drop each eye.A record review of Resident #99 admission Record revealed an admission date of 9/5/25 with diagnoses that included Peripheral Vascular Disease, Unspecified Anemia, Chronic Kidney Disease, and Primary open-angle Glaucoma, bilateral severe stage. On 09/11/25 at 1:27 PM, in an interview Registered Nurse (RN) #3/ Infection Preventionist/Assistant Director of Nursing (IP/ADON) revealed LPN #1 should not have touched the medication with her bare hands. She should have let the resident pick them up by moving tray so the resident could get the medication. She stated that it is an infection control issue.On 09/11/25 at 1:35 PM, in an interview the Director of Nursing (DON) stated that LPN #1 should have washed her hands before picking up pills with her bare hands off the table. She stated that it is infection control issue.