STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445236	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Columbia	841 W. James Campbell Blvd. Columbia, TN 38401

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions, medical record review, observation, and interview, the facility failed to ensure the prevention and spread of infection during medication administration for 3 of 7 (Resident #1, Resident #5, and Resident #51) sampled residents. The findings: 1.Review of the facility policy titled, Enhanced Barrier Precautions, dated 8/19/2025, revealed .The facility should use Enhanced Barrier Precautions (EBP).for residents with any of the following.wounds and /or indwelling medical devices.Indwelling medical device examples include.feeding tubes [a flexible feeding tube placed through the abdominal wall directly into the stomach to deliver nutrition, fluids, and medications when oral intake is unsafe].Examples of high-contact resident care activities requiring gown and glove use include.Device care or use.feeding tube. Review of the facility policy titled, Hand Hygiene, dated 10/28/2025, revealed .Associates perform hand hygiene (even if gloves are used) in the following situations.Before and after contact with the resident.After removing personal protective equipment [PPE] .gloves, gown. Review of the facility policy titled Cleaning and Disinfection of Non-Critical Patient Care Equipment, dated 7/15/2025, revealed .The following.non-critical reusable patient care equipment.is cleaned daily and before and after reuse with an .registered hospital disinfectant.examples of non-critical items include.blood pressure cuffs.pulse oximeters. Review of the facility's undated CDC Enhanced Barrier Precautions, signage revealed .Providers and staff must also.wear gloves and gown for the following high contact resident care activities.Device care or use.feeding tube. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, and Dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was cognitively intact. Resident # 1 was assessed for the use of a feeding tube. Review of the Physicians Orders dated 4/7/2026, revealed .Enhanced Barrier Precautions Diagnosis .peg tube [Percutaneous Endoscopic Gastrostomy]. Review of the Physicians Orders dated 4/4/2026, revealed .Aspirin Tablet Chewable 81 mg[milligram] Give 81 mg via [by way of] PEG-Tube one time a day. Observation during medication administration in Resident #1's room on 5/12/2026 at 10:31 AM, revealed Licensed Practical Nurse (LPN) A gathered supplies and prepared Aspirin 81 mg for administration via PEG. LPN A crushed the medication, knocked on the door and entered the room. LPN A performed hand hygiene, donned gloves, checked residual, administered the medication and flushed the tube with 15cc of water, removed her gloves, performed hand hygiene, and exited the room. LPN A failed to wear a PPE gown when accessing Resident #1's peg tube. During an interview on 5/12/2026 at 10:45 am, LPN A was asked what enhanced barriers are used for. LPN A stated, Foley catheter or feeding tubes, stuff like that. LPN A was asked what Resident #1 was in EBP for. LPN A stated, A feeding tube. LPN A was asked what do you do differently for Resident #1's EBP. LPN A stated, Wash hands extra. LPN A was asked based on the EBP signage above Resident #1's bed, should she have worn a gown when administering medications per peg tube. LPN A stated, Yes absolutely. During an interview on 5/12/2026 at 2:59 PM, the Director of Nursing (DON) was asked if a gown and gloves (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be worn during medication administration via peg tube. The DON stated, Yes. 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Diabetes, Anxiety, and Depression. Review of the Physicians Orders dated 2/3/2026, revealed .Insulin Aspart [used to decrease blood glucose] .Inject as per sliding scale.351-400= 13 units. Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 15 on the BIMS assessment, which indicated she was cognitively intact. Resident #5 received insulin 4 out of 7 days. Observation during mediation administration in Resident #5's room on 5/11/2025 at 11:35 AM, revealed Registered Nurse (RN) B gathered her supplies, cleaned the hub of the insulin pen and added a needle, performed hand hygiene, knocked on the door, entered the room, donned her gloves, and administered 13 units of Insulin Aspart into Resident #5's left thigh. RN B removed her gloves, disposed of the needle in sharps container and exited the room. RN B failed to perform hand hygiene after removing her gloves. During an interview on 5/11/2026 at 11:44 AM, RN B was asked if she should have performed hand hygiene after removing gloves. RN B stated, I should have and I did not. During an interview on 5/12/2026 at 2:59 PM, the DON was asked if she expected staff to wash their hands after removing gloves or between glove change. The DON stated, Yes. 4. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Diabetes, Hypertensive Heart, and Atrial Fibrillation. Review of the quarterly MDS assessment dated [DATE], revealed Resident #51 scored an 11 on the BIMS assessment, which indicated she was moderately cognitively impaired. Review of the Physicians Orders dated 4/19/2026, revealed .Metoprolol Tartrate Oral Tablet.Hold for SBP [Systolic Blood Pressure] less than 110 or HR [Heart Rate] less than 60.25 mg Give 3 tablets by mouth one time a day. Observation during medication administration in Resident #51's room on 5/12/2026 at 9:18 AM, revealed LPN C gathered supplies to administer medications, knocked on the door, entered the room, placed a blood pressure cuff on Resident # 51's arm and placed a pulse oximetry on her finger. The blood pressure reading was 155/78 and the heart rate was 78. LPN C placed both devices into a zippered bag, administered Metoprolol Tartrate, performed hand hygiene, exited the room, and placed the zippered bag back into the medication cart without cleaning the blood pressure cuff or pulse oximetry. During an interview on 5/12/2026 at 9:31 AM, LPN C was asked if she should have cleaned the blood pressure cuff and pulse oximetry before and after patient use. LPN C stated, Yes. I usually do but I didn't today. During an interview on 5/12/2026 at 2:59 PM, the DON was asked if she expected the staff to clean reusable equipment before and after resident use. The DON stated, Yes I do

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, National Pressure Ulcer Advisory Panel (NPUAP) Position Statement review, medical record review, observation and interview, the facility failed to ensure that residents had a thorough assessment and documentation while receiving wound care treatments for 1 of 3 (Resident #42) sampled residents reviewed for pressure ulcers. The findings include: 1.Review of the facility policy titled, Skin Integrity and Pressure/Ulcer Injury Prevention, dated 6/11/2025, revealed .Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury. Complete wound assessment/documentation, and provide treatment and care of skin and wounds.a skin assessment/inspection should be performed weekly by a nurse. 2. Review of the undated article titled The Facts about Reverse Staging in 2000 The NPUAP Position Statement, revealed . Staging is an assessment system that classifies pressure ulcers based on anatomic depth of soft tissue damage .Pressure ulcers heal to progressively more shallow depth, they do not replace lost muscle, subcutaneous fat, or dermis [the deeper connective tissue layer of the skin that provides structural support, elasticity, and strength to the skin] .Instead, the ulcer is filled with granulation (scar) tissue .If a pressure ulcer re-opens in the same anatomical site [location on the body], the ulcer resumes the previous staging diagnosis (i.e once a Stage IV always a Stage IV) . 3. Review of the medical record review revealed Resident #42 was admitted to the facility on [DATE], with diagnoses of Psychosis, Schizophrenia, Dementia, Diabetes, and Morbid Obesity. Review of the quarterly Minimum Date Set (MDS) assessment dated [DATE], revealed Resident #42 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #42 had severe cognitive impairment. Resident #42 was assessed as being at risk for pressure ulcers. Review of a Progress Note dated 4/13/2026, revealed .area to the left knee reopened .MD (Medical Doctor) made aware. Previous tx [treatment] restarted. Review of the Physician's Order dated 4/13/2026, revealed .Cleanse left knee with normal saline, skin prep intact skin, apply [named brand] honey to wound bed, cover with foam dressing. Change 3 x [times] a wk [week] and as needed. Review of the Care Plan dated 5/4/2026, revealed .The resident has an open wound Left Anterior (inner) Knee. Review of the medical record revealed a chronic stage 4 pressure area to Resident #42's left anterior knee reopened on 4/13/2026. The first documentation of an assessment or measurements of the wound was dated 5/4/2026. Review of the facility's .Wound Observation Tool. dated 5/4/2026, revealed Resident #42's left anterior knee wound measurements were 1.0 x 1.0 x 0.3 cm [centimeters]. It was identified as a pressure injury, Stage 4, a past chronic wound. Review of the Progress Note dated 5/6/2026, revealed Resident has a chronic Stage 4 pressure injury (PI) to the anterior left knee, first noted in 2022 .The wound has a history of repeated resolution and reopening at the same site, suspected to be related to weakened tensile [can be stretched or elongated] strength, resident picking at the area, and body alignment. The PI was last documented as resolved in December 2025 .staging has since been confirmed .as a chronic Stage 4 pressure injury . During an interview on 5/12/2026 at 11:59 AM, Licensed Practical Nurse (LPN) F was asked can you provide any documentation describing the wound or wound measurements on 4/13/2026. LPN F confirmed the wound is a chronic area that is classified as a Stage 4 when it opens up. LPN F stated, No I cannot, LPN F was asked how often the wound should be documented and measured once it turned into a pressure ulcer. LPN F stated, It should be done weekly. LPN F was asked should there have been an initial assessment and measurements when the wound reopened. LPN F stated, Yes. Observation in the resident's room on 5/12/2026 at 2:28 PM, revealed Resident #42 sitting on the side of the bed with her left knee exposed. Licensed Practical Nurse (LPN) F was next to the resident, squatting and measuring the wound. Measurements were 0.8 x 0.6 x 0.1 cm. During an interview on 5/12/2026 at 2:55 PM, the Director of Nurses (DON) was asked if there was an assessment or measurement on the pressure ulcer to the left knee that opened on 4/13/2026. The DON stated, I do not see a measurement. The (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON was asked would you expect to see documentation when it was found. The DON stated, Typically yes. The DON was asked how often wounds should be assessed and measured. The DON stated, Weekly. The DON was asked would you have expected missing documentation and measurements on this wound. The DON stated, No.