STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675996	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbus Oaks Healthcare Community	300 North St Columbus, TX 78934

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 3 (Resident #5) reviewed for pharmaceutical services.-The facility failed to ensure Resident #5's medications on 01/13/2026 were documented as given during the night shift. -Resident #5 did not receive pain medication on 03/05/2026 at 8:00p.m. per physician orders.This failure could cause residents to have unnecessary and avoidable pain. Record review of Resident #5's medical records revealed, she was a [AGE] year-old female originally admitted on [DATE] with diagnoses including hypertension (high blood pressure), type 2 diabetes mellitus (high blood sugar, dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life), atherosclerotic heart disease of native coronary artery without angina pectoris (a type of heart disease where plaque buildup narrows the coronary arteries but does not cause chest pain), fibromyalgia (a chronic condition involving widespread body pain and fatigue), generalized anxiety disorder (prolonged periods of excessive anxiousness and worry), major depressive disorder (chronic feelings of sadness and hopelessness), insomnia (inability to sleep), Parkinson's Disease (a progressive neurological disorder that primarily affects movement, including causing slow movement, tremors and balance problems, along with sleep and sensory disturbance), and low back pain.Record review of Resident #5's progress notes , on 11/28/2025 the ADON documented Resident #5 had a BIMS score of 14, indicating high cognitive intactness. Record review of Resident #5's care plan last updated 01/23/2026 revealed, she was care-planned for the following:-11/5/25-Resident had potential for pain with interventions including observing and documenting for side effects of pain medications.-11/5/25- Resident had hypertension with interventions including give anti-hypertensive medications as ordered and monitor for side effects such as orthostatic hypotension (low blood pressure when going from standing to sitting or sitting to standing) and increased heart rate.-11/5/25 -Resident was on anticonvulsants therapy for Parkinson's Disease with interventions including giving medications as ordered and reporting seizure activity.-11/5/25- Resident used anti-anxiety medications with interventions including administering anti-anxiety medications as ordered.-11/5/25- Resident was on melatonin for insomnia with interventions including administering medications as ordered.Record review of Resident #5's Physician Orders, she had an active order with a start date of 02/13/2025 for hydrocodone-acetaminophen oral tablet 5-325 mg, give 2 tablet by mouth four times a day related to fibromyalgia. Record review of Resident #5's January [DATE] had the following medications was left blankfor 01/13/2026: -Atorvastatin Calcium Oral Tablet 20mg-give 1 tablet by mouth at bedtime related to age-related osteoporosis (bone density loss due to age) at 9p.m.-Donepezil HCl Oral Tablet 10 mg -give 1 tablet by mouth at bedtime related to anxiety disorder at 9p.m.-Duloxetine HCl Oral capsule - Give 2 capsule by mouth at bedtime related to major depressive disorder at 9p.m.-Melatonin Oral Tablet 5mg - give 2 tablet by mouth at bedtime related to insomnia HS (at bedtime).-Trazadone HCl Oral Tablet 100mg - give 2 tablet by mouth at bedtime related to major depressive disorder at (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8p.m.-Buspirone HCl oral Tablet 30 mg - give 1 tablet by mouth two times a day related to generalized anxiety disorder at 9p.m.-Divalproex Sodium Oral Capsule 125 mg - give 1 capsule by mouth two times a day related to dementia at 9p.m.-Losartan Potassium oral Tablet 50mg - give 1 tablet by mouth two times a day related to hypertension at 9p.m and to hold if SBP (top number indicating the pressure in the arteries when the heart contracts) was less than 110 and pulse was less than 60. Blood pressure and pulse also not documented.-Nifedipine ER oral tablet extended release 24-hour 30 mg-give 1 tablet by mouth every 12 hours related to hypertension at 9.p.m.-Pregabalin oral capsule 50 mg - give 1 capsule by mouth two times a day related to fibromyalgia (nerve pain) at 9p.m.-Primidone oral tablet 50 mg - give 1 tablet by mouth three times a day related to Parkinson's Disease. Further review of Resident #5's January MAR for 2026 reflected her blood pressure for January 2026 did not exceed limits set by her physician's orders. Record review of Resident #5's March [DATE] revealed: Hydrocodone order had a start date of 02/13/2026 and an end date of 03/07/2026. Resident #5 was not administered the pain medication 03/05/2026 at 8:00pm. It was signed AN! indicating the sign-off for Agency Nurse. Resident #5 pain levels were not checked. Record review of Resident #5's March progress notes revealed, LVN B signed for Hydrocodone pulled from e-kit on 03/05/2026 at 10:26am and 03/05/2026 at 4:12pm. An agency nurse documented on 03/05/2026 at 11:49pm that Hydrocodone was ordered. There was no documentation that Hydrocodone was given that shift.Observation and interview with Resident #5 on 01/23/2026 at 9:48am, Resident #5 appeared to be in a pleasant mood and did not appear to be in pain. Resident #5 said the facility used many agency nurses and she felt she had not gotten medications right when they were working. She said her blood pressure had been high two weeks ago. She said she sometimes got her medication late because the facility did not reorder them in time but did not list her pain medication Hydrocodone. Resident #5 said she was not in any pain. Interview with MA J on 01/23/2026 at 1:16pm, she said she passed out regular medications and documented medication administration in the MAR. MA J said Resident #5 received all her blood pressure medications and if she did not then she would have high blood pressure.Interview with LVN M on 01/23/2026 at 1:30pm, she said Resident #5 received her pain medications that were scheduled and as needed. LVN M said some nurses did not sign on the MAR. LVN M said there were some agency nurses that worked on the night shift and that nurses would have given Resident #5 her medications on days it was not documented. LVN M said if residents did not get their blood pressure medications they could have a stroke. Interview with the DON on 01/23/2026 at 2:01pm, she said medications should have been documented in resident records. Resident #5 was alert and would have been able to say that she did or did not get medications. The DON was able to determine an agency nurse worked and dispensed medications on 01/13/2026 in the evening. The DON said all staff were trained in medication administration. If medications were not documented, then residents could have said they did not get the medication, and the facility would not be able to say they gave it. Interview with LVN G on 01/23/2026 at 3:19pm, she said she passed out Resident #5's medication and she did not document it but thought the medication aide would have documented it. LVN G said she documented the scheduled pain medications but other medications like blood pressure would have been documented by the medication aide. LVN G said she received training on medication administration through her agency. LVN G said she worked 01/14/2026 and not 01/13/2026. Interview with LVN B on 04/01/2026 at 9:28am, she said she worked with Resident #5 sometimes. LVN B could not remember the date, but she did have to get Resident #5's pain medication from the e-kit before the pharmacy delivered it on night shift. LVN B said the facility did reorder the medication. LVN B told the incoming nurse that the medication was on the way but she did not remember the nurse. LVN B said she did tell the DON and management staff. LVN B was not aware of any medication delays.Interview with OP S on 04/01/2026 at 12:43pm, OP S said that Resident #5 had two doses of Hydrocodone 1 tablet each time authorized from the e-kit on 03/05/2026 at 10:18am and 03/05/2026 at 3:48pm. OP S said there was a delivery to the facility for Resident #5's Hydrocodone on 03/06/2026 at 12:06pm which was signed by a nurse. OP S said it (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could take 5 to 6 hours to deliver medications when the pharmacy closes at 6p.m. since the pharmacy was located in the middle of a neighboring state. OP S said if there was a delay staff could request medications through the e-kit machine.Interview with the DON on 04/01/2026 at 10:20am, the DON said she talked and in-serviced staff on 03/31/2026 at night regarding having access to the e-kit machine. One nurse reported to the DON that she did not have access to the e-kit and the DON said she had to request access the next day with the ADON. The DON confirmed that agency staff did not have access to the machine, but they could have asked someone. No one told the DON that Resident #5's medications were out. The nurses should have let the physicians know of the missed dose. The DON said Hydrocodone was always available in the e-kit. The DON said she talked to Resident #5 about her pain, and she said it was okay. In a later interview on 04/01/2026 at 2:36pm, the DON said she was not aware Resident #5 missed any medications, but they should not have been missed. She said Resident #5 would tell the DON when she missed doses.Interview with NP C on 04/01/2026 at 1:34pm, she said she would call back to answer questions regarding Resident #5. There were no return calls as of exit .Record review of the facility's policy on Administering Medications last revised April 2019, it read in part, Medications are administered in a safe and timely manner, and as prescribed.The individual administering the medication electronically signs or signs with initials on the residents MAR/EMAR after giving each medication and before administering the next ones.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement.-The facility failed to ensure residents' lunch was served at a safe temperature on 3/31/2026. These failures could place residents who ate food from the kitchen at risk of foodborne illness and disease. In confidential interviews with residents in the facility, residents stated food was always cold when it arrived and they would prefer food to be warmer. Observation and interview with the Dietary Manager on 3/31/2026 at 12:30pm revealed, she took the temperature of the mixed vegetables consisting of peas and carrots which was 114.6F. The Dietary Manager brought a second bowl of mixed vegetables which she measured at 105.8F. The Dietary Manager said the temperature was not in range to be served to residents, the most the food temperature should have gone down to 135F holding temperature from the steam table to when it got to residents. The Dietary Manager said if food was not the right temperature for residents, they could get sick. Interview with the Administrator and DON on 03/31/2026 at 2:36pm, the DON said that the Dietician came in and audited the kitchen and found full compliance, including with food temperatures. The Administrator said food came out on carts directly to the halls. Record review of the facility's policy titled Taking Temperatures last revised June 1, 2019, read in part, The facility realizes the critical nature of serving foods at the correct temperatures to ensure the health of its residents. The facility will take and record the temperatures of all foods prior to service. Foods not at the correct temperature will be corrected or discarded as necessary. The policy did not cover specific food temperatures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and transmission of communicable diseases and infections for 1 of 3 residents (Resident #4) observed for infection control.-The facility failed to ensure CNA GG washed her hands or used hand sanitizer after doffing gloves during incontinent care observation on 3/31/26.These failures could place the residents at risk of cross-contamination and development of infection. Record review of Resident #4's face sheet dated 04/01/2026 reflected an [AGE] year-old female was admitted on [DATE] and diagnoses include Alzheimer's disease (is a progressive neuro degenerative disorder that causes disorientation and behavioral changes, and obstructs memory, thinking and judgment), shortness of breath, hypotension (low blood pressure) and muscle wasting and atrophyRecord Review of Resident's #4's quarterly MDS assessment dated [DATE] reflected the Resident #4's BIMS score was 04, reflected cognition was severely impaired. Resident #4's was incontinence of bladder and bowel.Record Review of Resident's #4's care plan dated 11/24/2025 reflected:-I have ADL self-care performance deficit and totally dependent on staff for all ADLs. I will remain clean, dry, without odor and comfortable every shift on a daily basis, with all needs to be anticipated and met by staff through the next 90 days.Observation of incontinent care on 3/31/26 at 7:12PM to Resident #4, resident was on the wheelchair from the nurse's station to her room by C NA GG, then transferred Resident #4 from her wheelchair to the bed for incontinent care with CNA CC assisting. CNA GG don a clean glove, unfastened Resident 4's soiled brief to perform incontinent care, doffed gloves without washing hands, did not use hand sanitizer, donned a clean glove, picked up wet wipes cleaned Resident #4's right groin then folded the same wipe and used it to clean the left groin. CNA CC was advising CNA GG not to fold wet wipes cleaning Resident #4's groin. CNA GG doffed gloves, without washing hands or using hand sanitizer she donned a clean glove, repositioned Resident #4's to her left side, she used the wet wipes to clean in-between the buttock and around the buttocks then picked up clean brief and placed on Resident #4 and positioned on her back. CNA GG doff soiled gloves, without washing hands or using hand sanitizer she went to the clean linen and got top cover sheet for Resident #4,Interview on 3/31/26 at 7:27PM CNA CC regarding incontinent care, she said CNA GG should only use wet wipes to clean the groin one time and it should not be folded and did not wash hands or use hand sanitizer. CNA CC said not washing hands or using hand sanitizer, after changing gloves doing incontinent care would cause cross contamination and infection. CNA CC said she had in-service bi-weekly. CNA CC said she had in-service for incontinent care and skilled check.Interview with DON 4/6/26 at 2:51 PM regarding incontinent care and hand washing, she said CNA's were in-serviced to wash hand or use hand sanitizer after changing gloves, to prevent infection and the staff had in-services on infection control. Record review of the facility Infection Control Guidelines for all Nursing Procedures (Revised August 2012): Purpose: To provide guidelines for general infection control while caring for residents.4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations:a. Before and after direct contact with residents.b. Before donning sterile glovesc. Before performing any non-surgical invasive procedures.g. After contact with a resident's intact skin.j. After removing gloves.