

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Lake City Center for Nursing and Healing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2055 Rex Road Lake City, GA 30260	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, record review, and policy review, the facility failed to provide sufficient nursing staff to meet the needs of residents. Specifically, the facility had multiple vacant nursing positions and did not have an established, planned staffing level to determine the number and type of nursing staff needed to meet residents' needs. During the review period, residents experienced delays in activities of daily living (ADL) care, repeated delays in medication administration, and a failure to provide ordered nursing services, including enteral nutrition. The facility census was 208 residents. Findings included: 1. Resident and Staff Interviews: During an interview on 07/28/2026 at 11:12 AM, Resident (R) 8 stated that some evenings, eating in the main dining room is not an option due to no staff available to sit in the dining room with them while they ate. During an interview with Certified Nursing Assistant (CNA) GG on 07/28/2026 at approximately 11:40 AM, CNA GG stated that the facility had staffing issues, mainly during the 7:00 PM to 7:00 AM shift. CNA GG stated that residents had reported to her that, during the evening/night shift, only one nursing assistant was present to help with care, and residents had to wait hours for care and treatment. CNA GG indicated that the facility administration was aware of the staffing issues during the evening and on weekends. On 07/28/2026 at 12:20 PM, a family member of R6 expressed frustration at never being able to get through when calling the facility on the telephone. The family member stated that staff doesn't answer the telephone and added that frequently the telephone would be answered by a resident in the hall. During an interview with R3, on 07/28/2026 around 2:30 PM, R3 stated that during the evening shift several weeks ago, he lay in his own feces for over two hours waiting on staff to provide care and treatment. R3 indicated that staff came in and cut off the call light, stating they would be back. R3 stated he waited and waited, and that his buttocks got irritated during the wait. R3 stated that he felt embarrassed, upset, and belittled. R3 stated he had a history of pressure wounds. R3 stated, The facility does not have enough staff to care for us during the evening shifts, and this is why we have to wait so long. R3 indicated that this was an ongoing problem at the facility. R3 also indicated that he had informed nursing staff about staffing issues during the evening and weekend shifts, stating that there was only one nursing assistant for more than 30 residents. R3 stated it was not a great feeling to be lying in feces that long. On 07/28/2026 at 2:35 PM, R7 at night they would spend hours itching and waiting to be changed. R7 stated they recently had a really bad urinary tract infection. During an interview with CNA II and CNA JJ on 07/28/2026 at approximately 3:30 PM, both CNAs were asked whether the facility had sufficient staff to meet the needs of the residents. Both staff members indicated, We are short-staffed, but we do what we need to do to provide care for our residents. During a follow-up interview on 07/29/2026 at approximately 2:15 PM, CNA GG stated she had worked on the unit for several months. CNA GG stated that the facility needed (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administered at approximately 11:11 PM to 11:12 PM. On 07/21/2026, cyclobenzaprine, gabapentin, ascorbic acid, metoprolol, lacosamide, and apixaban scheduled for 9:00 PM were administered at approximately 1:08 AM on 07/22/2026, more than four hours after their scheduled administration times. Oxybutynin scheduled for 10:00 PM was also administered at approximately 1:08 AM. On 07/23/2026, apixaban, ascorbic acid, metoprolol, lacosamide, gabapentin, and cyclobenzaprine scheduled for 9:00 PM were not administered until approximately 5:47 AM to 5:49 AM on 07/24/2026, more than eight hours after their scheduled administration times. Oxybutynin scheduled for 10:00 PM was administered at approximately 5:49 AM. On 07/25/2026, cyclobenzaprine, gabapentin, metoprolol, ascorbic acid, and apixaban, scheduled for 9:00 PM, were administered at approximately 1:23 AM on 07/26/2026. Lacosamide, scheduled for 9:00 PM, was administered at approximately 2:48 AM on 07/26/2026. On 07/27/2026, gabapentin, lacosamide, metoprolol, ascorbic acid, cyclobenzaprine, apixaban, and oxybutynin, scheduled for the evening, were administered at approximately 4:43 AM on 07/28/2026, approximately six to eight hours after their scheduled administration times. The audit also identified significant delays during the day shift. On 07/21/2026, multiple medications scheduled for 9:00 AM were administered at approximately 12:51 PM to 12:52 PM. On 07/26/2026, multiple medications scheduled for 9:00 AM were administered at approximately 1:03 PM, approximately four hours after their scheduled administration times. 3. Missed enteral nutrition: A review of R6's physician orders revealed an order for Jevity 1.5 via PEG tube at 60 milliliters (mL) per hour for 22 hours daily, with the feeding initiated at 2:00 PM and discontinued at 12:00 PM the following day. The prescribed target volume was 1,320 mL daily. An observation conducted on 07/29/2026 at 8:40 AM revealed R6 was not connected to the enteral feeding. The feeding pump was turned off, and a bottle of Jevity 1.5 labeled 07/29/2026 at 3:00 AM was hanging at the bedside with approximately 1,300 mL remaining. According to the physician's order, the feeding should have been infusing at the time of the observation. At 3:03 PM, R6 remained disconnected from the enteral feeding. The feeding pump remained turned off, and approximately 1,300 mL remained in the bottle despite a new 22-hour feeding cycle being scheduled to begin at 2:00 PM. During an interview on 07/29/2026 at 3:15 PM, Licensed Practical Nurse (LPN) EE, who was assigned to R6, confirmed she had not connected R6's enteral feeding as ordered. LPN EE stated she forgot to connect the feeding because there were a lot of things going on. A review of additional survey findings identified delays in required ADL care. The facility failed to provide necessary ADL care for three residents reviewed for ADL care, including failure to provide timely incontinence care. During an interview on 07/30/2026 at 11:02 AM, the Director of Nursing (DON) stated the facility did not have a specific number of nursing staff established for each shift and did not have a defined planned staffing level. The DON stated the facility had a lot of open positions, including Registered Nurse (RN), LPN, CNA, and Assistant Director of Nursing positions. The DON was unable to state the number of vacant nursing positions. The DON further stated the facility's Environmental Services Director had recently resigned. When asked how the facility replaced nursing staff following callouts, the DON stated, We try to replace them the best we can. The DON acknowledged the facility had received complaints and grievances regarding insufficient staffing and delays in resident care. When asked whether she was aware of residents experiencing delays in incontinence care, bathing, call-light response, or other ADL care because staff was unavailable or attending to other residents, the DON referred to the instances identified during the survey and stated, These instances you are explaining. The DON was informed that reviews of medication administration records for multiple residents revealed a recurring pattern of scheduled medications being administered several hours after their scheduled administration times, including evening medications administered after midnight or during the following morning. The DON stated, To (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be honest, I didn't know. The DON stated the facility's acceptable medication administration window was one hour before to one hour after the scheduled administration time. When asked why medications were administered several hours after their scheduled times across multiple dates and shifts, the DON stated, The nurses either forgot to document or they were running late. When asked whether nursing staffing levels, resident assignments, workload, callouts, or use of agency staff could have contributed to the medication delays, the DON stated, It's possible. I'd have to look at it. The DON stated nursing supervisors and administration were not aware that medication passes were routinely extending several hours beyond scheduled administration times. The DON was informed that LPN EE reported failing to initiate R6's ordered enteral feeding because she forgot and there were a lot of things going on. The DON stated LPN EE's assignment was typically approximately 30 residents. When asked whether sufficient nursing staff were available on 07/29/2026 for LPN EE to complete medication administration, treatments, enteral feedings, and other assigned resident care timely, the DON stated, Should have been. When asked how the facility monitored whether nursing staffing levels were sufficient to meet residents' needs, the DON stated, We have audits and stuff. A review of the facility's Nursing Services and Sufficient Staff policy, revised March 2025, revealed it was the facility's policy to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessment and the individual plan of care. The policy directed that the facility's census, acuity, and diagnoses of the resident population were to be considered based on the facility assessment. The policy further directed the facility to provide sufficient numbers of licensed nurses and other nursing personnel, including nurse aides, on a 24-hour basis to provide care to all residents in accordance with their care plans. Providing care included assessing, evaluating, planning, implementing resident care plans, and responding to residents' needs. The policy also required licensed nurses and nurse aides to possess the competencies and skills necessary to care for residents' needs as identified through resident assessments and described in their plans of care.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to implement the comprehensive care plan for one of 16 residents (R) (R6) receiving enteral nutrition. This deficient practice had the potential for residents not to receive nutrition and hydration to meet their dietary needs. Findings included: A review of the facility's Comprehensive Care Plans policy, revised October 2025, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident. The policy directed that all services provided or arranged by the facility, as outlined by the comprehensive care plan, were to meet professional standards of quality. The policy further directed that qualified staff responsible for carrying out interventions specified in the care plan were to be notified of their roles and responsibilities for carrying out the interventions. A review of the electronic medical record (EMR) revealed that R6 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, anoxic brain damage, cerebral infarction, oropharyngeal dysphagia, encounter for attention to gastrostomy, tracheostomy status, myoclonus, epilepsy, and morbid obesity due to excess calories. A review of R6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R6 received 51 percent (%) or more of total calories through parenteral or enteral tube feeding and received 501 milliliters (mL) or more of fluid per day by intravenous (IV) or tube feeding during the assessment period. A review of R6's comprehensive care plan revealed R6 required enteral nutrition related to dysphagia. The care plan included interventions related to maintaining R6's nutritional and hydration status and providing enteral nutrition as ordered. A review of R6's physician orders revealed an order for Jevity 1.5 via percutaneous endoscopic gastrostomy (PEG) tube at 60 mL per hour for 22 hours daily, with the feeding initiated at 2:00 p.m. and discontinued at 12:00 p.m. the following day. The prescribed target volume was 1,320 mL daily. An observation conducted on 07/29/2026 at 8:40 AM revealed that R6 was not connected to the enteral feeding. The feeding pump was turned off. A bottle of Jevity 1.5 labeled 07/29/2026 at 3:00 AM was hanging at the bedside with approximately 1,300 mL remaining. According to the physician's order, the feeding should have been infusing at the time of the observation. An observation conducted on 07/29/2026 at 3:03 PM revealed R6 remained disconnected from the enteral feeding. The feeding pump remained turned off, and approximately 1,300 mL of Jevity 1.5 remained in the bottle. According to the physician's order, a new 22-hour feeding cycle should have been initiated at 2:00 PM; however, the feeding had not been initiated as ordered. During an interview conducted on 07/29/2026 at 3:15 PM, with Licensed Practical Nurse (LPN) EE, assigned to R6, the LPN confirmed she had not connected R6's enteral feeding as ordered. The LPN stated she forgot to connect the feeding because there were a lot of things going on. During an interview conducted on 07/29/2026 at 3:40 PM, the Director of Nursing (DON) was informed that R6's enteral feeding was not connected, and the feeding pump was turned off. The DON stated she would look into it. At approximately 4:00 PM, the DON returned and confirmed that R6's enteral feeding not being connected was an error. The DON stated the facility would initiate a 100% audit and staff education. A review of a nursing note entered on 07/29/2026 at 4:19 PM revealed R6's enteral feeding had been disconnected at the wrong time. Cross-reference F692 and F693		

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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. Based on observations, record review, interviews, and review of facility policy, the facility failed to provide necessary activities of daily living (ADL) care for one of three residents (R)(R2) reviewed for ADL care. Specifically, the facility failed to ensure R2 received appropriate bathing services during an extended disruption in hot-water availability. Findings included: A review of the facility policy titled Activities of Daily Living (ADLs), dated October 2025, noted that the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: bathing, dressing, grooming, and oral care; and a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal oral hygiene. During an interview with R2 at 3:00 PM on 07/28/2026, R2 voiced concerns about the hot water not working for about three to four weeks during June 2026 going into July 2026. R2 stated he only received bed baths with tepid water during this period due to hot water issues, and he still felt dirty, nasty, and neglected. R2 stated he went without hot showers for at least three weeks, and no provisions were made. R2 indicated that he reported his concerns to staff regarding feeling mistreated and uncared for. A review of R2's quarterly MDS assessment, with an ARD of 05/01/2026, revealed R2 had a BIMS score of 14, which indicated intact cognition. Per the MDS, R2 required partial to moderate assistance with bathing. During an interview with CNA II and CNA JJ, on 07/28/2026 at approximately 3:30 PM, both CNAs confirmed issues with the hot water. The CNAs reported that during the hot water issues, only two residents were able to go upstairs for a shower, and the rest of the residents received bed baths with lukewarm water. The CNAs stated that the hot water issue occurred from the kitchen to the floor, and most of the residents had bed baths during that timeframe. During an interview about the hot water issue with the Director of Nursing (DON) on 07/28/2026 around 4:00 PM, the DON reported that a plan of care was provided for each resident and all the residents on the affected units should have received hot water for baths. The DON stated that individual care plans were not updated, but residents were informed that they could go up to the 200 hall for showers. During an interview on 07/29/2026 at approximately 2:15 PM, Certified Nursing Assistant (CNA) GG stated she had worked on the unit for several months. CNA GG confirmed that R2 did not receive any showers during the several weeks when the hot water was out and indicated that R2's concerns had been reported.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that one of 16 residents (R) (R6) receiving tube feeding maintained acceptable parameters related to body weight. Findings included: A review of the electronic medical record (EMR) revealed that R6 was admitted to the facility on [DATE] with diagnoses including, but not limited to, morbid obesity due to excess calories, anoxic brain damage, cerebral infarction, oropharyngeal dysphagia, encounter for attention to gastrostomy, tracheostomy status, myoclonus, and epilepsy. A review of R6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R6 received 51 percent (%) or more of total calories through parenteral or enteral tube feeding and received 501 mL (milliliters) or more of fluid per day by IV or tube feeding during the assessment period. A review of R6's care plan revealed R6 required enteral nutrition related to dysphagia. The care plan included interventions related to maintaining R6's nutritional and hydration status and monitoring for complications associated with enteral feeding. A review of R6's weight records revealed that R6 weighed: 243 pounds on 01/21/2026, 213.8 pounds on 04/20/2026, 221 pounds on 05/06/2026, 220 pounds on 06/01/2026, 212.4 pounds on 06/10/2026, and 208 pounds on 07/17/2026. R6 experienced a 35-pound, or 14.4%, weight loss from 01/21/2026 through 07/17/2026. A review of R6's physician orders revealed an order for Jevity 1.5 via PEG (Percutaneous Endoscopic Gastrostomy) tube at 60 mL per hour for 22 hours daily, with the feeding to be initiated at 2:00 PM and discontinued at 12:00 PM the following day. The order provided a target volume of 1,320 mL daily. R6 was also ordered free-water flushes at 50 mL per hour for 22 hours. A review of a Registered Dietitian (RD) Progress Note dated 06/03/2026 at 3:39 PM revealed that R6 was NPO (nothing by mouth) and received Jevity 1.5 via PEG tube at 60 mL/hour for 22 hours, from 2:00 PM until 12:00 PM the following day. The prescribed feeding provided 1,320 mL, 1,980 kilocalories, 84 grams of protein, and 1,003 mL of water. The RD calculated R6's estimated nutritional needs at 1,870-2,200 kilocalories and 76-95 grams of protein daily and recommended continuation of the prescribed enteral feeding regimen. A review of an RD note dated 06/15/2026 revealed the RD identified R6 as triggering for significant weight loss. The RD documented that R6 was NPO and enteral feeding was the resident's sole source of nutrition. The RD determined the prescribed enteral feeding provided adequate nutrition to meet R6's estimated nutritional needs and recommended continuation of the feeding regimen. A review of an RD Weight Review dated 07/28/2026 revealed the RD again reviewed R6's weight trend and nutritional requirements. The RD documented R6's prescribed enteral feeding met the resident's estimated nutritional needs. The RD documented R6 had a Body Mass Index (BMI) of 33.6 and considered the resident's weight loss beneficial due to obesity. During an observation conducted on 07/29/2026 at 8:40 AM, R6 was not connected to the enteral feeding, and the feeding pump was turned off. A bottle of Jevity 1.5 labeled 07/29/2026 at 3:00 AM was hanging at the bedside with approximately 1,300 mL remaining. According to the physician's order, the feeding should have been infusing at the time of the observation. A review of an RD Weight/PAR Review entered on 07/29/2026 at 11:03 AM revealed the RD documented R6 continued to receive enteral feeding as ordered meeting estimated nutritional needs. The RD again documented that R6's weight loss was considered beneficial due to the resident's BMI and obesity. During an observation conducted on 07/29/2026 at 3:03 PM revealed R6 was again not connected to the enteral feeding. The feeding pump was turned off, and approximately 1,300 mL of Jevity 1.5 remained in the bottle. According to the physician's order, the feeding should have been infusing at the time of the observation. During an interview conducted on 07/29/2026 at 3:40 PM, the Director of Nursing (DON) (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Lake City Center for Nursing and Healing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2055 Rex Road Lake City, GA 30260	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was informed that R6's enteral feeding was not connected and the feeding pump was turned off. The DON stated she would look into it. At approximately 4:00 PM, the DON returned and confirmed that R6's enteral feeding was not connected and that this was an error. A review of the facility's Nutritional Management policy, undated, revealed that a systematic approach was to be used to optimize each resident's nutritional status, including identifying and assessing nutritional status and risk factors, evaluating/analyzing assessment information, developing and consistently implementing pertinent approaches, monitoring the effectiveness of interventions, and revising them as necessary. The policy directed staff to evaluate the care plan to determine if current interventions were being implemented and were effective. The care plan was to be updated as needed when interventions were determined to be ineffective or when new causes of nutrition-related problems were identified. The physician was to be notified of significant changes in weight, intake, or nutritional status.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that one of 16 residents (R) (R6) who required enteral nutrition through a gastrostomy tube received the tube feeding in accordance with the physician's orders. Specifically, the facility failed to ensure R6's prescribed Jevity 1.5 was administered at 60 milliliters (mL) per hour for the ordered 22-hour duration when the feeding was disconnected and the feeding pump was turned off during the prescribed administration period. This deficient practice resulted in R6 not receiving the prescribed enteral feeding and required practitioner intervention, including orders for additional, immediate enteral nutrition. Findings included: A review of the facility's Care and Treatment of Feeding Tubes policy, revised October 2024, revealed that feeding tubes were to be utilized according to physician orders, including the type of feeding, caloric value, volume, duration, mechanism of administration, and frequency of flushes. The policy directed staff to ensure administration of enteral nutrition was consistent with and followed the practitioner's orders. The policy further directed staff to periodically evaluate the amount of enteral feeding formula being administered for consistency with the practitioner's orders. A review of the electronic medical record (EMR) revealed that R6 was admitted to the facility on [DATE] with diagnoses including, but not limited to, anoxic brain damage, cerebral infarction, oropharyngeal dysphagia, encounter for attention to gastrostomy, tracheostomy status, myoclonus, epilepsy, and morbid obesity due to excess calories. A review of R6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that R6 received 51 percent (%) or more of total calories through parenteral or enteral tube feeding and received 501mL or more of fluid per day by intravenous (IV) or tube feeding during the assessment period. A review of R6's care plan revealed R6 required enteral nutrition related to dysphagia. The care plan included interventions related to enteral feeding, maintaining nutritional and hydration status, aspiration precautions, monitoring for tube dysfunction and complications, and gastrostomy tube site care. A review of R6's physician orders revealed an order for Jevity 1.5 via percutaneous endoscopic gastrostomy (PEG) tube at 60 mL per hour for 22 hours daily, with the feeding to be initiated at 2:00 PM and discontinued at 12:00 PM the following day. The order provided a target volume of 1,320 mL daily. R6 was also ordered free-water flushes at 50 mL per hour for 22 hours. A review of a Registered Dietitian (RD) Progress Note dated 06/03/2026 at 3:39 PM revealed R6 was NPO and enteral nutrition was the resident's sole source of nutrition. The RD documented that R6 received Jevity 1.5 via PEG tube at 60 mL per hour for 22 hours, from 2:00 PM until 12:00 PM the following day, and recommended continuation of the prescribed enteral feeding regimen. During an observation conducted on 07/29/2026 at 8:40 AM, R6 was not connected to the enteral feeding. The feeding pump was turned off. A bottle of Jevity 1.5 labeled 07/29/2026 at 3:00 AM was hanging at the bedside with approximately 1,300 mL remaining. According to the physician's order, the feeding should have been infusing at the time of the observation. A review of an RD Weight/PAR Review entered on 07/29/2026 at 11:03 AM revealed the RD documented R6 continued to receive enteral feeding as ordered, meeting estimated nutritional needs. During an observation conducted on 07/29/2026 at 3:03 PM, R6 remained disconnected from the enteral feeding pump. The feeding pump remained turned off, and approximately 1,300 mL of Jevity 1.5 remained in the bottle. According to the physician's order, a new 22-hour feeding cycle should have been initiated at 2:00 PM; however, the feeding had not been initiated as ordered. During an interview conducted on 07/29/2026 at 3:15 PM with Licensed Practical Nurse (LPN) EE assigned to R6, LPN EE confirmed she had not (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	connected R6's enteral feeding as ordered. She further added that she was unsure who had disconnected the feeding and that she didn't think it [the enteral feeding] was connected when I got here. LPN EE added that she started her shift at 7:00 AM. LPN EE stated she forgot to connect the feeding because there were a lot of things going on. During an interview conducted on 07/29/2026 at 3:40 PM, the Director of Nursing (DON) was informed that R6's enteral feeding was not connected, and the feeding pump was turned off. The DON stated she would look into it. At approximately 4:00 PM, the DON returned and confirmed that R6's enteral feeding had not been connected and that this was an error. Cross-reference F692		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure that medications were secured and inaccessible to unauthorized individuals during one of three medication administration observations. During the affected observation, Licensed Practical Nurse (LPN) EE left the medication cart unlocked and unattended at 8:35 AM and again at 8:45 AM. Findings included: On 07/29/2026 at 8:35 AM, during medication administration observations, LPN EE prepared medications for Resident (R)19. LPN EE left the medication cart to enter R19's room and administer the medications. While LPN EE was in R19's room, the medication cart remained unlocked in the hallway and was outside of LPN EE's line of sight. At 8:45 AM, LPN EE exited R19's room and stated she would be right back. LPN EE then took an oxygen cylinder down the hallway to replace it, leaving the medication cart unlocked and unattended. The medication cart remained outside of LPN EE's line of sight while she was away from the cart. During an interview on 07/29/2026 at 8:57 AM, LPN EE stated the medication cart should be locked when left unattended. When asked about leaving the medication cart unlocked during the medication administration observations, LPN EE stated, I normally lock it, but I didn't that time. LPN EE acknowledged the medication cart should have been secured before she walked away from it. During an interview on 07/29/2026 at 10:25 AM, the Director of Nursing (DON) stated that medication carts were expected to be locked whenever they were left unattended or were outside of the nurse's line of sight. The DON stated nursing staff should lock the medication cart before entering a resident's room or leaving the immediate area of the cart to prevent unauthorized access to medications. After the surveyor described the observations involving LPN EE at 8:35 AM and 8:45 AM, the DON stated the medication cart should have been locked on both occasions and that leaving the cart unlocked and unattended was not consistent with the facility's expectations for medication security. During the interview, the DON was asked to provide a copy of the facility's policy related to medication storage and security. The requested policy was not provided before the exit of the survey on 07/30/2026.		