STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115535	A. Building B. Wing	04/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake City Center for Nursing and Healing LLC	2055 Rex Road Lake City, GA 30260

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(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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of the facility's policy titled Food Receiving and Storage, the facility failed to ensure food safety protocols and maintain sanitary conditions for two of two resident refrigerators on Hall 100 and Hall 800 and failed to discard expired food in the dry storage area. The deficient practices had the potential to place 201 residents (R) who received an oral diet from the kitchen at risk of contracting a foodborne illness.Findings Include:Review of the facility's policy titled Food Receiving and Storage, issued April 2025, documented: POLICY: Foods shall be received and stored in a manner that complies with safe food handling practices. GUIDELINES: .6. Dry foods that are stored in bins will be removed from original packaging, labeled, and dated. Such foods will be rotated using a first in first out system. 7. All foods stored in the refrigerator or freezer will be covered, labeled, and dated.During the initial tour of the kitchen on 04/17/2026 at 8:05 AM with the Certified Dietary Manager (CDM), the dry storage area contained five plastic bins of cereal with expired dates of 02/20/2026, 02/27/2026, and 02/28/2026. Additionally, 73 bowls of preˆpackaged cereal were stored without labels or dates. The CDM confirmed the cereal was expired and acknowledged that staff should have discarded it.During the initial tour on 04/17/2026 at 8:20 AM, the Dietary Aide (DA) AA confirmed that the food items in the refrigerator on Hall 800 (West Wing) were unlabeled and undated, and that some food items were molded. DA AA stated nursing was responsible for the Hall refrigerators.Interview on 04/17/2026 at 8:25 AM with Certified Nursing Assistant (CNA) BB on Hall 800 (West Wing) confirmed the presence of unlabeled and undated food items, including a 2 lb (pound) 6 oz (ounce) veggie tray with a fuzzy green substance, a leftover cooked chicken plate with unidentifiable food items due to fuzzy green substance, and three unlabeled and undated peanut butter and jelly sandwiches. Interview on 04/17/2026 at 8:35 AM with the Unit Manager (CC) on Hall 800 (West Wing) confirmed that the undated food items-including the 2 lb 6 oz veggie tray with a fuzzy green substance, the leftover cooked chicken plate with unidentifiable food items due to fuzzy green substance, and the three unlabeled and undated peanut butter and jelly sandwiches-should have been thrown away. She stated that nursing staff were expected to discard food items after three days.Interview on 04/17/2026 at 8:45 AM with Unit Manager (DD) on Hall 100 (East Wing) confirmed the presence of unlabeled, undated, and leftover chicken, rice, an egg roll, a small plastic container of greens, and a leftover plate of unidentifiable food items due to fuzzy green substance, which was covered with a paper towel and wrapped in a brown plastic bag. Unit Manager DD confirmed that the food items in the refrigerator should have been labeled, dated, and discarded within three to five days. She stated that it was the nursing staff's responsibility to ensure this was done.Interview on 04/19/2026 at 8:25 AM with the CDM and Administrator revealed that their expectation was for staff to date and label all open food items with both an open date and an end date. The CDM stated that they would continue providing education for staff regarding this requirement.Interview on 04/19/2026 at 10:20 AM with the Certified Dietary Manager (CDM) and Dietitian Manager (JJ) reviewed pictures of unlabeled and expired cereal, as well as old food items that were not labeled or dated. They confirmed that the refrigerators on Hall 100 and Hall 800 were found to be in an unsanitary condition. Both individuals (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated that the condition of the food items and the sanitation of the refrigerators were unacceptable.Interview on 04/19/2026 at 11:55 AM with the Administrator revealed that she did not have a Performance Improvement Plan (PIP) in place to address the food storage, labeling, and unsanitary condition of the residents' refrigerators located on Hall 100 and Hall 800.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and record review, the facility failed to ensure that nail care was provided for one resident (R) (R92) of 35 sampled residents. This failure could lead to skin impairment resulting from toenail overgrowth.Findings include:Review of the electronic medical record (EMR) revealed R92 was admitted to the facility on [DATE] with diagnoses that included but was not limited to spinal stenosis, cervical region and type 2 diabetes mellitus with diabetic chronic kidney disease. Review of the orders revealed Podiatry/Oral/Dental Care as needed with a start date of 01/21/2025.During an interview and observation on 04/17/2026 at 12:40 PM, R92 reported that staff were not cutting toenails.During an interview and observation on 04/18/2026 at 8:43 AM, R92 reported that his toenails and fingernails were as long as they will get. R92 further reported that if someone offered to cut his toenails he would allow it. The toenail on the left great toe was jagged with the other nails curling over the toes due to length.During an interview on 04/18/2026 at 9:06 AM with Social Services Assistant (SSA) it was reported that podiatry was last scheduled in the facility on 04/07/2026 and is scheduled again for 04/30/2026.During an interview and observation on 04/19/2026 at 10:02 AM with Licensed Practical Nurse (LPN) HH 800 Hall, she reported that nurses were responsible for nail care, but podiatry typically cuts toenails. LPN HH reported that Podiatry services come once or twice each month, but the nurse had to notify Social Services to put a resident's name on the list. LPN HH confirmed the long toenails for R92 and reported that she would notify Social Services.During an interview on 04/19/2026 at 12:58 PM the Director of Nursing (DON) reported that SSA will add R92 to the podiatry list and the next appointment is scheduled for 04/30/2026. The DON explained that podiatry services prior to 11/01/2025 are no longer being used and a new podiatrist just started April 2026 and the SSA was unsure of the last time R92 was seen by podiatry.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review and staff interview, the facility failed to ensure a medication error rate was less than five percent during medication administration review. Three errors were identified from 38 opportunities, resulting in a 7.89 percent (%) medication error rate. The deficient practice placed residents at risk for inaccurate dosing and adverse clinical outcomes.Findings include:1. On 04/18/2026 at 8:50 AM, Licensed Practical Nurse (LPN) FF was observed giving R216 his morning medications. The medications included citalopram 20 mg (milligrams) tablet and hydralazine 50 mg tablet.Review of the Physician Orders dated 04/14/2026 revealed an order for citalopram 10 mg, give one tablet by mouth one time a day for depression; and hydralazine HCl (hydrochloride) 50 mg, give one tablet by mouth every 8 hours related to essential hypertension.Review of the Medication Administration Record (MAR) dated 04/18/2026 revealed a different nurse had already given the hydralazine 50 mg at 6:00 AM.Observation and interview on 04/19/2026 at 9:00 AM, Registered Nurse (RN) Supervisor GG revealed the citalopram 20 mg blister pack was still located in the medication cart on top of the citalopram 10 mg blister pack. She removed the citalopram 20 mg blister pack and stated the nurse that took the order change should have removed the package for 20 mg once the 10 mg came in. She also confirmed the hydralazine 50 mg was given at 6:00 AM and should not have been given again at 9:00 AM. Interview on 04/19/2026 at 10:53 AM, RN Supervisor GG stated that she contacted the physician regarding the medication error and monitored the resident's blood pressure with no adverse findings. 2. On 04/19/2026 at 8:15 AM, LPN EE was observed giving R102 his morning medications. The medications included Mucinex 400 mg tablet.Review of the Physician Order dated 04/08/2026 revealed Mucinex Oral Tablet, Extended Release 12 Hour 600 mg, give one tablet by mouth every 12 hours for cough/congestion for 14 days.During a follow up observation and interview on 04/19/2026 at 10:00 AM, RN Supervisor GG and LPN EE confirmed the resident received the wrong dose of Mucinex. At 10:56 AM, RN GG stated she notified the physician to report the error.Review of the Medication Administration Policy, dated 04/2025 documented Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.10. Ensure that the six rights of medication administration are followed. c. right dosage.e. right time.12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.

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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, staff interviews, and a review of the facility policy titled Medication Storage, the facility failed to properly lock, secure and discard medications on two of seven medication carts (500 Hall and 200 Hall.) The deficient practice increased the risk of unauthorized access and potential medication diversion.Findings include:Review of the facility policy titled Medication Storage, with a revised date of 10/01/2025 documented under the section Policy Explanation and Compliance Guidelines (1) General Guidelines (a). all drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerator, medication rooms) under proper temperature controls.During an observation and interview on 04/18/2026 at 3:09 AM with Licensed Practical Nurse (LPN) KK revealed the medication cart on the 500 Hall was unlocked and unattended while LPN KK was sitting behind the nurse's station on the computer. In addition, an unsecured round pink pill was observed sitting on top of the medication cart. LPN KK confirmed the medication cart was unlocked while she was putting in her notes and the cart is supposed to be locked when not in use. She stated the unsecured round pink medication pill was found on the floor and she forgot to discard it.During an observation and interview on 04/18/2026 at 11:40 AM with LPN LL revealed the medication cart on 200 Hall was unlocked and unattended while LPN was observed in a resident's room. LPN LL confirmed she was in a resident room retrieving a glucose check while the cart was unlocked and unattended. She stated she is not sure what the protocol was related to unlocked medication carts.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of facility policy titled Resident Nutrition Services, the facility failed to ensure that meal preferences were followed for one resident (R) (R165) of 35 sampled residents. The deficient practice had the potential to affect the quality of life for R165. Findings includeReview of the electronic medical record (EMR) for R165 revealed diagnoses that included but not limited to cerebral infarction, chronic kidney disease stage 5, and type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema left eye.Review of the EMR revealed a Minimum Data Set (MDS) quarterly assessment dated [DATE], Section C: Brief Interview of Mental Status score of 15, which indicated little to no cognitive impairment.During an interview and observation on 04/17/2026 at 8:11 AM, R165 reported that she was sent grits all the time and she did not like hot cereal. Review of the breakfast tray revealed a bowl of grits. Further review of the breakfast tray revealed a meal ticket indicating a list of dislikes that included hot cereal.During an interview on 04/18/2026 at 8:47 AM, R165 reported that she received grits again this morning for breakfast.During an observation on 04/19/2026 at 8:28 AM, R165's breakfast tray was at the bedside and paramedics were preparing R165 for transfer to the hospital. R165 was observed with food in her mouth and a bowl of grits on her breakfast meal tray. Review of the meal ticket located on the tray documented hot cereal as a dislike.During an interview on 04/19/2026 at 10:57 AM, Food Service Director (FSD) reported that the checker (Dietary role) was responsible for ensuring that the food on the tray was correct.Interview with Registered Dietician (RD) JJ and FSD on 04/19/2026 at 11:57 AM, reported that dietary staff were educated to ensure the meal tickets were being followed correctly. RD JJ reported that the meal ticket was updated to reflect grits and oatmeal specifically named and added as dislikes for R165.Interview on 12/19/2026 at 12:34 PM Certified Nursing Assistant (CNA) II, who reported that when passing the meal tray for R165 she had to set her up and let her know what she was eating. When questioned about the meal ticket CNA II reported that she did not read the meal ticket. CNA II stated that the resident can say what she liked and if the resident didn't like something she would take the tray back to the kitchen to get something else. Review of the facility policy titled Resident Nutrition Services, dated April 2024, documented Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service and appropriate feeding assistance. Documented for Guidelines: .2. Nursing personnel will ensure that residents are served the correct food tray. 3. Prior to serving the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure the correct food tray is being served to the resident. If there is doubt, the Nurse Supervisor will check the written Physician's order. 4. If an incorrect meal has been delivered, Nursing staff will report it ot the Nutrition Services Manager so that a new food tray can be issued.