

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Terrace of Jacksonville, The		STREET ADDRESS, CITY, STATE, ZIP CODE 10680 Old St Augustine Rd Jacksonville, FL 32257	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on food service observations, staff interviews, and facility policy and procedure review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness, with the potential to affect all residents who consumed foods from the facility, by failing to ensure food items were properly labeled and dated in both the main kitchen and nourishment rooms. This deficient practice prevents staff from determining appropriate use and increases the risk of pathogen exposure. The findings include: On 05/04/2026 at 10:47 AM, an observation of the kitchen's dry storage room revealed one basket of onions, two loaves of bread, one bag of hamburger buns, one bag of pasta noodles, and one bag of sugar frosted flakes cereal with no labels or dates. On the same day at 10:59 AM, an observation of the kitchen service area revealed one box of bananas on a shelf with no label or date. On the same day at 11:00 AM, an observation of the kitchen's freezer revealed one pie and one container of bags of chicken with no labels or dates. (Photographic evidence obtained) On 05/06/2026 at 11:42 AM, an observation of the kitchen service area revealed the same box of bananas beside one serving tray which also contained bananas with no date or label. On the same day at 11:45 AM, a follow-up observation of the kitchen's dry storage room revealed two loaves of bread, one bag of [NAME] buns, one bag of hamburger buns, and one bag of sugar frosted flakes cereal with no dates or labels. On the same day at 11:55 AM, an observation of the kitchen freezer revealed one box of frozen pancakes and one container of plastic bags of chicken with no dates or labels. (Photographic evidence obtained) On 05/07/2026 at 10:36 AM, observations of the front nourishment room refrigerator revealed two bottles of chocolate syrup, two bottles of strawberry syrup, two bottles of maple syrup, one bottle of caramel sauce, one jar of honey, two bottles of flavored coffee creamer, two bottles of pina colada drink mix, one bottle of [NAME] mix, one bottle of Hawaiian punch, two cases of non-alcoholic beer, one container of to-go food, two limes, and one cup of chicken wings with no date markings. The same observation revealed one expired Chobani yogurt and one gallon of chocolate milk with no date marking. An observation of the freezer revealed one unmarked bag of popsicles, one to-go container, a plastic container with small, round, green-colored food items, four gallons of ice cream, and one box of ice cream bars with no date markings. On the same day at 11:00 AM, observations of the Memory Care unit's nourishment room refrigerator revealed one bottle of diet coke, a four-pack of Jell-o, a can of whipped cream, one bottle of coffee creamer, and one jar of jelly with no labels or dates. (Photographic evidence obtained) On 05/07/2026 at 1:03 PM, during an interview with Dietary Aide C, she stated, Everything needs to be labeled and dated. If a food item was prepped, it needs to have that date and the date it is going to be used. She stated kitchen staff was responsible for checking for expired items in the nourishment rooms. On 05/07/2026 at 1:17 PM, an interview with [NAME] D revealed that the facility's policy regarding date marking was first-in, first-out. She stated any food item that was opened and went back in the refrigerator, freezer or dry storage must be labeled with the date it was opened. On 05/07/2026 at 1:23 PM, an interview with Kitchen Manager/Registered Dietician E revealed that food items were supposed to be labeled and dated with the date they were opened and utilized prior to their expiration (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	date. She stated it was the responsibility of the nursing and dietary staff to label, date, and check for expired items in the nourishment rooms.Reference: FDA Food Code 2022. https://www.fda.gov/media/184685/download?attachment; (Accessed on 4/21/2026) Annex 5 - C. Intervention Strategies for Achieving Long-term Compliance. 4. Establish First-In-First-Out (FIFO) Procedures. Page 555. Product rotation is important for both quality and safety reasons. First-In-First Out (FIFO) means that the first batch of products prepared and placed in storage should be the first one sold or used. Date marking foods as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirements.A review of the facility's policy and procedure titled Food Receiving and Storage (dated 2026), revealed:Policy: Foods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation: 6.Dry foods that are stored in bins will be removed from original packaging, labeled, and dated (use by date). 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 (use by date). 13. Food items and snacks kept on the nursing units must be maintained as indicated below.B. All foods belonging to residents must be labeled with the resident's name, the item, and the use by date.D. Beverages must be dated when opened and discarded after twenty-four (24) hours.E. Other opened containers must be dated and sealed or covered during storage.F. Partially eaten food may not be kept in the refrigerator.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the resident's right to a dignified existence by leaving a urinary catheter collection bag uncovered for one (Resident #81) of seven residents observed with urinary catheters, from a total survey sample of 52 residents. The findings include: On 05/04/2026 at 1:15 PM, Resident #81 was observed lying in bed with her urinary catheter bag uncovered and exposed on the side of the bed, visible from the open doorway. (Photographic evidence obtained)On 05/06/2026 at 9:48 AM, Resident #81 was observed lying in bed with her urinary catheter bag uncovered and exposed on the side of the bed, visible from the open doorway. (Photographic evidence obtained)A review of Resident #13's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included Infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter; neuromuscular dysfunction of bladder, unspecified; urinary tract infection, site not specified; and disorder of kidney and ureter, unspecified.A review of the quarterly minimum data set (MDS) assessment, dated 04/23/2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. Resident #81 was documented as dependent for toilet transfers with an indwelling catheter.A review of Resident #13's care plan revealed a focus area related to indwelling suprapubic catheter related to chronic urinary retention, bilateral ureteral stents. (05/01/2026) Approaches included positioning the drainage bag below the level of the bladder and covering the drainage bag for dignity.A review of Resident #81's active physician's orders revealed an order for a 16 FR (French) suprapubic catheter in place for neurogenic bladder (01/16/2026); Dignity bag in place for privacy every shift, morning 7:00 AM - 7:00 PM, night 7:00 PM - 7:00 AM (1/14/2026).On 05/07/2026 at 11:35 AM, Licensed Practical Nurse (LPN) B was asked what the facility policy was related to urinary catheter bags. She replied, Bags should always be below the bladder and covered in a blue bag. When asked if it was okay for Resident #81's catheter collection bag to be uncovered and facing the door, LPN B replied, When the resident is mobile in a wheelchair, the catheter bag is to be hung on the wheelchair frame. She added that she would review the facility policy regarding specific in-room placement.During an interview with the Director of Nursing (DON) on 05/07/2026 at 12:21 PM, the DON stated, urinary catheter bags should be covered at all times.A review of the facility's policy and procedure titled Quality of Life - Dignity (revised: 1/2021 and reviewed 1/2026), revealed:Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.Policy Interpretation and Implementation 1. Residents shall be treated with dignity and respect at all times.11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by a. helping the resident to keep urinary catheter bags covered.		

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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 reviews and staff interviews, the facility failed to ensure a medication error rate of less than 5% based on three errors out of 27 opportunities for error, resulting in an error rate of 14% and impacting two (Residents #171 and #86) of seven residents observed during medication administration, from a total survey sample of 50 residents. Failure to administer medications as ordered and to follow recognized standards of practice could result in medication side effects and/or potential harm to residents. The findings include: 1. During a medication administration observation on 5/6/26 at 8:20 a.m., Licensed Practical Nurse (LPN) A was preparing medication for Resident #171. He reviewed the Medication Administration Record (MAR) and pulled Ativan 0.5 mg (milligrams), which was ordered twice daily, and diluted it with a small amount of water (5 cc - cubic centimeters) in a medication cup. He then walked away from the medication cart to administer Acetaminophen 650 mg (ordered twice a day), and he left the Ativan sitting on top of the cart. The cart was out of LPN A's line of sight, and he was administering medication in the Memory Care unit. An interview was conducted with LPN A at 8:21 a.m. on 5/6/26. He was called back to the medication cart and was reminded that he left the Ativan on the top of cart. Multiple residents were sitting nearby and could have accessed the medication while the nurse was away from the cart. LPN A stated, I do that all the time. He was asked about diluting the Ativan with water and reported it was easier for the resident to take it that way. LPN A was advised that medications should not be left on the top of the cart and multiple residents had access to the medication. The physician's orders noted Resident #171's medications could be crushed but not diluted with water. 2. During a medication administration observation for Resident #86 at 8:35 a.m. on 5/6/26, LPN B took the resident's vital signs before administering his medications due to parameters for his Losartan. The MAR was reviewed and medications were pulled. The resident had two different eye drops ordered (Tobradex and Olopatdine). LPN B walked away from the cart to go into the resident's room, and the medication cart was left unlocked. LPN B was called back to the cart to lock it. The Tobradex was administered first after LPN B washed her hands and applied gloves, with two drops administered in both eyes. LPN B waited three minutes and proceeded to administer the olopatadine, one drop in both eyes. She did not wash her hands or change gloves after administering the Tobradex eye drops in both eyes or after administering the Olopatdine eye drops. An interview was conducted with LPN B after returning to the medication cart at 8:56 a.m. on 5/6/26. She was asked if she knew what the policy was for washing hands and applying gloves when administering eye drops, especially when there were two different types of eye drops ordered. LPN B stated she did not know. She was asked about the unlocked medication cart. She stated, I forgot. The facility's policy and procedure titled Instillation of Eye Drops was requested from the Chief Nursing Officer at 10:15 a.m. on 5/6/26. The policy was received at 11:00 a.m. on 5/6/26 and reviewed. It noted under General Guidelines: 2. Should both eyes require instillation, wash and dry your hands thoroughly before treating each eye. (Photographic evidence obtained) A review of the facility's policy titled Administering Medications (revised 12/2012), revealed: 3. Medications must be administered in accordance with the orders, including any required timeframe. 16. During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse. No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. (Photographic evidence obtained)		