

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER The Terrace at Denison		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Memorial Dr Denison, TX 75020	
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents have the right to have reasonable access to use the telephone for 7 (Resident #30, Resident #50 and 5 anonymous residents from a group interview) of 12 residents reviewed for resident rights. 1. The facility failed to ensure there was a working phone system to receive and make calls for Resident #30, Resident #50 and 5 anonymous residents on 9/9/25 through 9/11/25. 2. The facility failed to ensure relatives of Resident #30 had a working phone number to reach the resident and facility staff. These failures could place the residents at risk of feelings of isolation and mental decline. 1. Record review of Resident #50's face sheet dated 9/10/25 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (group of thinking and social symptoms that interferes with daily functioning), psychotic disorder, dysphagia (difficulty swallowing) and personality change due to known physiological condition. Record review of Resident #50's most recent admission MDS assessment dated [DATE] revealed the resident was severely cognitively impaired and had a BIMS of 5. Resident #50 displayed behaviors of inattention, disorganized thinking and physical behavioral symptoms directed toward other residents. In an interview with Resident #50's relative on 09/10/2025 at 10:27am revealed she had not gotten through to the facility by phone for several days. She stated Resident #50 could not call her and she could not call him. She stated she had been notified by staff using an anonymous number that Resident #50 had gone to the hospital on 9/4/25. When she tried to contact the facility back because she was concerned, she could not reach them at the facility phone number. The relative stated she was very concerned about the phones, as Resident #50 had returned to the facility on 9/8/25 and she had not been able to reach the facility since then. In an interview with CNA D on 9/10/25 at 1:53pm revealed a relative for Resident #50 had complained to her about not having gotten through on the facility phones to check on the resident. CNA D provided the relative her cell phone number and told Resident #50's relative she could leave messages on her phone for a call back. CNA D stated there was a resident who asked to call a family member daily because the facility phone was not working. CNA D stated they had been in-serviced about the phones not working and were told to use their personal phones to contact family members for notifications or when there was a problem with the residents. 2. Record review of Resident #30's face sheet dated 9/10/25 reflected a [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses that included Pancreatitis (inflammation of the pancreas), Dysphagia (difficulty swallowing), Chronic Obstructive Pulmonary Disease (a condition involving constriction of the airways) and Depression. Record review of Resident #30's Quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired with a BIMS score of 11. Resident #30 needed partial assistance with some ADLs such as dressing, showering and toileting. In an interview with Resident #30 on 09/09/2025 at 10:17am revealed he had a relative who had been trying to call the facility phones several times a day, for several weeks but had not been able to reach the facility and speak to staff about a concern they had. On 09/09/25 at 2:34pm, the surveyor attempted to speak to the relative but was unsuccessful in reaching them. [SP1] 3. In a confidential group interview of 5 residents on 9/10/25 at 11:08am revealed there had been a big issue with the phone lines not working at the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents receive adequate supervision and assistance devices to prevent accidents for two of three residents (Resident #20 and Resident #54) reviewed for accident hazards/supervision/devices 1. The Facility failed to ensure CNA D used a gait belt correctly when transferring Resident #20 from his wheelchair to the bed. 2. The Facility failed to ensure Resident #54's windowsill (a ledge or sill forming the bottom part of a window) was repaired when it had the outer edge broken off exposing approximately 1 inch of raw jagged wood across the entire width of the windowsill and exposing nails. These failures could affect the residents by placing the residents at risk for discomfort, pain, falls, injuries, and skin tears. Findings included: 1. Record review of Resident # 20's Face sheet dated 09/11/25 reflected an [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included an unspecified fracture of right femur (thigh bone) and Alzheimer's disease. Record Review of Resident #20's Significant Change in status MDS assessment, dated 08/15/25, reflected he was severely cognitively impaired with a BIMS score of 4. He was dependent on transfers, toileting, and personal hygiene and required the assistance of 2 people. He was always incontinent of urine and frequently incontinent of bowels. Review of Resident #20's care plan revised on 05/29/25 reflected, ADLs functional status/rehabilitation potential. transfers extensive two-person assistance. Interventions. Assist with transfer as needed. In an observation and interview on 09/09/2025 at 9:27 a.m. Resident #20 was observed being assisted from his bed to his wheelchair by CNA D. Resident #20 was able to stand up with the assistance of CNA D holding on to his arm while the resident grabbed for the arm of the wheelchair. Resident #20 was very unsteady and shaky. No gait belt was used during the transfer. CNA D stated the resident had a fall a few weeks ago and broke his hip. She stated he was doing a little better but stated he would still try and get up without assistance. In an observation on 09/09/2025 at 11:55 a.m. CNA D and CNA E were observed taking Resident #20 to his room to perform incontinence care. CNA E placed a gait belt around Resident #20's waist and tightened the belt. CNA E placed her hands on the front and back of the gait belt while CNA D placed one hand in front and the other under the resident's right arm pit and they lifted him from the wheelchair and transferred him to bed. Both staff provided incontinence care. After completion of care, both staff sat the resident up on the bedside. CNA E placed the gait belt around the resident's waist and again placed one hand in front and the other in back, while CNA D placed on hand in front the other hand under the resident's arm pit. The resident was unsteady and continually reaching for the arm of the wheelchair. In an interview of 09/09/2025 at 12:00 p.m. with CNA D and CNA E, both stated they were not supposed to lift residents under their arms because it could cause injury to their shoulders. CNA D stated she tried not to put her hand directly under his arm pit to prevent injury. She stated she did not know she was supposed to grab the back of the gait belt when doing a 2-person transfer. She stated she had been trained on gait belt transfers but had forgotten that part. She stated the resident had progressed a great deal since he had been in therapy and was starting to try and transfer himself again. She stated you had to be really quick or he would try and get up by himself and sometimes you did not have enough time to put a gait belt around him. In an attempted interview with Resident #20 on 09/09/25 at 12:05 p.m. the resident could not understand the question when asked if he had experienced pain during the transfer, he just smiled and stated he was doing OK. In an interview with the DON on 09/11/25 at 08:23 a.m. she stated staff were to use gait belt when transferring a resident. She stated they had been trying to get each of the staffs training and check offs done. She stated they had just completed skills checks of on gait belt and mechanical lift transfers a few months ago. She stated she had the Director of Rehab assist with that training. She stated the risk of staff not following the correct procedure was injury to a resident's shoulders and arm and or the risk of the resident falling. In an interview with the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DOR on 09/11/25 at 11:20 a.m. she stated she did the gait belt training in the facility. She stated she does one annually or as needed. She stated the last one she had done was June of 2025. She stated she actually had the staff use her as resident and place the gait belt on her to make sure they knew how it should be positioned and where they were supposed to place their hands. She stated it was not acceptable to lift someone under their arm pits due to the potential for injury. She stated it increased the risk of falls, fractures and nerve damage. Record review of CNA D's staff education/ orientation checklist reflected she had been skills checked for gait belt transfers on 06/18/25 and had met the criteria for proper technique. 2. Record review of Resident #54's quarterly MDS assessment reflected a [AGE] year-old male with an admission date of 03/17/25. Staff assessment of resident's mental status reflected he was severely cognitively impaired, required substantial assistance with all activities of daily living and had diagnosis of cerebral vascular accident (stroke) and seizure disorder (brief episode of abnormal electrical activity in the brain). Record review of Resident #54's care plan revised on 07/08/25 reflected, [Resident #54] is at risk for Pressure Injury related to incontinence, immobility, decreased cognition, and history of poor nutrition.Goal.Skin will remain intact.Interventions.CNA to inspect skin, especially over bony prominences, during bathing and personal care and report finding to Licensed Nurse.Licensed Nurse to complete skin assessment weekly. Record review of the facility's maintenance log from 03/25/25 through 09/10/25 did not reflect any repair needs for Resident #54's windowsill. An observation on 09/09/2025 at 2:35 p.m. revealed Resident #54 asleep in his bed. The bed was pushed up against the windowsill which had the outer edge broken off exposing approximately 1 inch of raw jagged wood across the entire width of the windowsill and exposing nails. Resident #54's arm was approximately 12 inches from the exposed wood. An observation on 09/10/2025 at 3:00 p.m. revealed CNA F entered Resident #54's room to provide incontinence care. CNA F asked the resident to roll on his left side toward the window. Resident #54 rolled on his left side and placed his hand in the windowsill where the broken wood and exposed nail was located. No skin tears were observed on the resident's hand or arm. In an interview with CNA F on 09/10/25 at 03:10 p.m. she stated she was not usually assigned to Resident #54, but stated she does assist with his care when needed. She stated she had not noticed the broken wood on the windowsill. She stated they were supposed to put anything in the maintenance log that needed to be repaired. In an observation and interview with LVN H on 09/10/2025 at 3:12 p.m. of Resident #54's windowsill he stated he was not aware of the broken windowsill and stated it was a hazard since the resident's bed was up against the windowsill. He stated he had not noticed during his care of Resident #54. In an observation and interview with the facility's Maintenance Director 09/10/2025 at 3:20 p.m. of Resident #54's windowsill he stated he had not been made aware of the broken windowsill. He stated with the exposed nail and the roughness of the broken wood posed a risk to the resident. He stated he would get it repaired as soon as possible. He stated staff were supposed to place any required maintenance in the maintenance book kept at the nurse's station. In an observation and interview made with the Administrator on 09/10/2025 at 3:26 p.m. of Resident #54's windowsill, he stated it needed to be repaired immediately. He stated it placed the resident at risk of injury. He stated they would move the resident so the repairs could be made. He stated there was no excuse and could not understand how staff would not have noticed it, especially while providing care to the resident. He stated in addition to that they had administrative staff assigned to each resident's room for overall checks. He stated they needed to do much better at noticing needed repairs. He stated staff were required to report any hazard that could potentially cause harm to a resident or staff member. In an interview with CNA G on 09/10/25 at 3:30 p.m. she stated she was assigned to Resident #54 often. She stated the windowsill had been broken since she had been here, which was about 3 months. She stated they were supposed to write things in the maintenance book that needed repaired but stated since it was that way when she started working at the facility she did not think about putting it in the book. She stated she should have said something and stated it could pose a risk to the resident. An observation on 09/11/2025 at 09:15 a.m. revealed Resident #54 had been moved to (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	another room. Repairs had started, and the exposed wood and nail of the windowsill were covered. Record review of the facility's undated policy, Use of Gait Belts , reflected, It is the policy of this facility to use gait belts with resident that cannot independently ambulate or transfer for the purpose of safety.Each nursing department employee will be given a gait belt during orientation.It will be the responsibility of each employee to ensure they have it available for use at all time when at work. Record review of the facility's undated policy, Accidents and Supervision, reflected, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes"" Identifying hazard(s) and risk(s).Implementing interventions to reduce hazard(s) and risk(s).Hazards refers to elements of the resident environment that have the potential to cause injury or illness.Risk refers to any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influence the likelihood of an accident.The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.These sources may include, but are not limited to.Environmental rounds.Individual observation.This information is to be documented and communicated across all disciplines.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 two (Dietary [NAME] L and Dietary Aide M) of two dietary staff reviewed for food service safety. The facility failed to ensure Dietary [NAME] L and Dietary Aide M wore effective hair restraints during lunch meal preparation on 09/10/2025. This failure placed residents at risk for food-borne illness and food contamination. Findings included: During an observation on 09/09/2025 at 12:12 PM and 12:26 PM during lunch meal service revealed Dietary [NAME] L's hair restraint was not covering about 2 inches of the back of her hair below the restraint and 1.5 inches on both sides of her hair in front while she was plating food for resident lunch. During an observation on 09/09/2025 at 12:15 pm and 12:27 PM revealed Dietary Aide M's hair restraint was not covering about 1 inch hair on both sides in front of her ear and about 0.5 inch of hair in the back below the hair restraint while she was putting condiments on plate and silverware and back about 0.5 inches for dining room hall trays. Interview on 09/09/25 at 12:50 PM with Dietary Aide M revealed she was not aware of her hair restraint not covering her hair. She stated she had taken the food handler's course. She stated she should have had her hair restraint covering her hair during lunch meal service. Interview on 09/10/25 at 12:52 PM with Dietary [NAME] L revealed she was not aware hair hair restraint was not fully covering her hair on the sides and back of her hair. She stated the hair restraint must have slipped up. She stated she was aware the hair restraints should be covering her hair completely. Interview on 09/10/25 at 1:02 PM with Dietary Manager revealed he expected hair restraints to fully cover all hair for dietary staff. He stated he would monitor and in-service his dietary staff on hair restraints policy. He stated he had not recently in-serviced the dietary staff on hair restraints. Interview on 09/10/25 at 1:30 PM with Dietary Manager revealed the importance of hair restraints was to keep the hair out of resident food and placed food at risk for cross contamination. Review of facility's policy Safe Food Handling, dated 08/01/20, reflected, Proper food handling is essential in preventing foodborne illness.8.Anyone working in the kitchen during normal food production hours is expected to wear appropriate hair restraints (such as hats, hair covers or nets, beard restraints).		

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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 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 4 of 13 residents (Resident #36, Resident #14, Resident #54, and Resident #48) observed for infection control and 1 of 5 staff (CNA I) observed during meal tray delivery. 1. The facility failed to ensure LVN B sanitized the blood pressure cuff, pulse oximeter and electronic thermometer after using equipment on Resident #36 during medication pass on 09/10/25. 2. The facility failed to ensure LVN A did not cross contaminate Resident #14's medication and piston syringe used for medication administration via the residents' g-tube during a medication pass on 09/10/25 and failed to sanitize the blood pressure cuff after use. 3. The facility failed to ensure CNA F used the required PPE for Resident #54, who was on enhanced barrier precautions due to his urinary catheter and failed to perform hand hygiene while providing incontinent care on 09/10/25. 4. The facility failed to ensure the Treatment Nurse performed hand hygiene during wound care for Resident #48 on 09/10/25. 5. The facility failed to ensure CNA I performed hand hygiene between 4 residents after delivering food trays during lunch service in the memory care unit on 9/9/25. These failures placed residents at risk of cross-contamination and the development of infection. Findings included: 1. Record review of Resident #36's face sheet, dated 09/11/25, reflected a [AGE] year-old male with an admission date of 01/17/25. Diagnosis included dementia and diabetes. During a medication pass observation on 09/10/25 at 07:52 a.m., LVN B was observed at the medication cart. LVN B sanitized her hands and picked up the wrist blood pressure cuff, a pulse oximeter (device used to test the amount of oxygen in the blood) and an electronic thermometer. LVN B entered the dining area of the memory care unit and took Resident #36's blood pressure and then applied the pulse oximeter to the resident's finger to obtain the oxygen saturation level and held the electronic thermometer to the resident's forehead to obtain his temperature. LVN B then returned to the medication cart and laid the contaminated equipment on the top to the medication cart. LVN B sanitized her hands and pulled Resident #36's scheduled medications and then administered the medications to the resident. LVN B then checked the computer for the next resident who required medication administration. In an interview with LVN B on 09/10/2025 at 8:04 a.m. she stated she was supposed to sanitize the equipment she used on any resident immediately after use. She stated she failed to do that and by placing the equipment on her medication cart she had also cross contaminated her cart. She stated they had recently switched to electronic records, and she was so focused on that, she forgot to sanitize the equipment. She stated the risk to the residents when they did not sanitize the equipment was the spread of germs. 2. Record review of Resident #14's Quarterly MDS assessment, dated 08/29/25, reflected a [AGE] year-old female with an admission date of 06/15/18. Staff assessed her mental status as severely cognitively impaired. Diagnoses included coronary artery disease (damage or disease in the heart's major blood vessels), hypertension (high blood pressure) and quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). Resident received over 51 % of her total calorie intake through the feeding tube. During a medication pass observation on 09/10/25 at 07:52 a.m., LVN A was observed at the medication cart. LVN A sanitized her hands and picked up the wrist blood pressure cuff and entered Resident #14's room to obtain her blood pressure. LVN A then returned to the medication cart and laid the contaminated blood pressure cuff on the top to the medication cart. LVN A sanitized her hands and pulled Resident #14's scheduled medications, placing each pill in a separate cup. LVN A then went to pour one pill into a plastic sleeve to crush the medication when she dropped the pill on the cart. LVN A picked up the pill and placed it back in the cup and then placed it in the sleeve and crushed the pill for administration. After pulling all of Resident #14's medications, LVN A sanitized her hands, put on a gown and gloves and entered the resident's room. LVN A turned off the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was unaware she had to change her gloves during care and did not know she could not place the catheter bag on the bed. She stated she had only worked at the facility for about a month. 4. Record review of Resident #48's face sheet dated 09/11/25, reflected a [AGE] year-old female with an admission date of 07/17/24 and a re-admission date of 09/08/25. Diagnoses included diabetes and viral pneumonia (lung infection caused by a virus that inflames one or both lungs). An observation on 09/10/2025 at 09:00 a.m. of wound care for Resident #48 revealed the Treatment Nurse washed her hands and put on gown and gloves. The Treatment nurse cleaned the pressure ulcer with peri wipe. The area was approximately the size of a pencil eraser with no apparent drainage and no signs of infection. After cleansing the wound, the Treatment nurse applied the treatment of zinc and collagen powder without changing her gloves or performing hand hygiene. The Treatment Nurse then removed her gown and gloves and left the room to obtain hand sanitizer. The Treatment Nurse then re-entered the room, sanitized her hands and put on gown and gloves to continue the wound care on Resident #48's toes and knee. The Treatment nurse removed her gloves and sanitized her hands after cleaning wounds and before applying the treatment to the areas on her left knee and the resident's toes. In an interview on 09/10/25 at 09:20 a.m. with the Treatment Nurse, she stated she had forgotten her hand sanitizer and realized it when she had finished cleaning the first wound. She stated she was thrown completely off and stated she was supposed to remove her gloves and perform hand hygiene after she cleaned the wound. She stated she could have gone to the sink and washed her hands, but stated all she could think about was she needed hand sanitizer. She stated she should have washed her hands before she left the room. She stated the risk to the resident was the spread of germs and infection. In an interview with the DON on 09/10/25 at 4:00 p.m., she stated any resident who had any type of indwelling medical device was placed on Enhanced Barrier precautions to help reduce the spread of MDRO's. She stated signage was posted outside to the door, which explains what PPE was to be worn and for what task the PPE was to be worn for. She stated any contact with a resident with a wound or a catheter required the use of gown and gloves. She stated the staff had received trainings on the use of Enhanced Barrier Precautions. She stated regardless of if the staff were assigned to a resident they were expected to follow the necessary precautions. She stated staff were to perform hand hygiene before care, when going from dirty to clean, and after care and prior to leaving the resident's room. She stated the ADON was the infection preventionist for the facility and conducted several in-services to make sure the staff were following the infection control protocol. She stated they still had some work to do. In an interview with the ADON on 09/11/25 at 03:25 p.m., she stated she was the infection preventionist for the facility. She stated she had in serviced the staff on Enhanced barrier precautions and the use of Personal Protective Equipment. She stated she was monitoring for compliance by doing spot checks and skills checks on the employees for competency in infection control. She stated she should have already done a skills check on CNA F since she was a new hire recently. She stated staff were instructed to perform hand hygiene before and after care and any time a glove change was required. She stated all the residents who required Enhanced Barrier Precautions had signs posted outside of their room and the necessary supplies outside of their room. She stated they would continue to monitor and do skills checks as needed. 5. Observation of CNA I on 9/9/25 at 12:12 p.m. passing out food trays in the memory care unit dining room. CNA I delivered a tray to a resident in the dining room, removed the food from the tray and placed the meal on the table in front of a resident, returned to the cart, got a sweetener and gave the sweetener to the resident. CNA I then returned to the cart, got another food tray for a resident without sanitizing or wash her hands. She delivered the tray to a resident and returned to the cart and got another tray. CNA I walked the tray down the hall and delivered it to a resident in their room. She returned and did not sanitize or wash her hands. When she returned to the cart, she got an iced tea from the cart and walked it down the hall to a resident. CNA I went back to the cart and another staff member handed her a food tray and she did not sanitize her hands before she got the tray and delivered it. A bottle of hand sanitizer was observed on the top of the cart with the food trays. In an interview with CNA I on 09/09/2025 at (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safety Requirements revised in 2025 reflected .Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include but are not limited to.Washing hands properly before distributing trays. Washing hands between contact with residents and after collecting soiled plates and food waste.		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to participate in the development and implementation of his or her person-centered plan of care and facilitate the inclusion of the resident and/or resident representative for 1 of 8 residents (Resident #10) reviewed for resident rights. The facility failed to ensure Resident #10's representative was offered the opportunity to participate in Resident #10's care plan meeting via telephone. This failure could place residents at risk of not being informed of resident's plan of care and a decline in quality of life. Findings included: Review of Resident #10's Quarterly MDS assessment dated reflected Resident #10 was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Alzheimers disease (progressive brain disorder that causes gradual decline in memory, thinking and language), coronary artery disease (condition in which the arteries that supply blood to the heart become narrowed or blocked) and epilepsy (neurological disorder characterized by recurrent, unprovoked seizures). Resident #10 had a BIMS of 1 indicating she was severely cognitively impaired. Resident #10 required substantial/maximal to total dependent with ADLs. Review of Resident #10's face sheet undated reflected Resident #10 was not her own responsible party and had a responsible party listed. Review of Resident #10's comprehensive care plan last updated 07/15/25 reflected Resident #10 had a diagnosis of Alzheimer's.at risk for an increase in confusion and decline in ADL's as the disease progresses. Review of Resident #10's care plan conference letter for the last year addressed to Resident #10's representative completed by social worker to responsible party reflected the following:- Dated 01/06/25 reflected If you can not attend this meeting, but have issues you need to discuss, please call at any time so we can address these issues in a timely manner. The care plan meeting was scheduled for 01/21/25 at 2:30 PM. It did not reflect option for responsible party to be called for the care plan meeting.- Dated 03/27/25 reflected If you can not attend this meeting, but have issues you need to discuss, please call at any time so we can address these issues in a timely manner. The care plan meeting was scheduled for 04/17/25 at 2:45 PM. It did not reflect option for responsible party to be called for the care plan meeting. Interview on 09/10/25 at 12:24 PM with Resident #10's representative revealed she was provided notice of Resident #10's care plan meeting by letter and was unable to come in person to meetings. She stated when she called the facility the phone was difficult for them to get hold of anyone and it would just keep ringing at times. She stated when someone answered the phone she would ask about Resident #10 and seemed like he or she did not know much about resident. When they were able to get hold of someone, she was given excuses of Resident #10's charge nurse was not available at this time. Resident #10's representative stated she had not been provided the opportunity to be available by phone for care plan meetings. She stated she would like to be involved in care plan meetings but by phone. Interview on 09/11/25 at 2:15 PM with the Social Worker revealed Resident #10 was not her own responsible party and had a representative. The Social Worker stated Resident #10's representative should be provided the option of phone for care plan meetings. She had not discussed with Resident #10's representative the option of phone call for care plan meetings. She stated moving forward will update the care plan letter going out to the facility to ensure resident's representative were offered the option of phone for care plan meetings. Interview on 09/11/2025 at 2:51 PM the DON stated she was not aware of phone option being provided or not provided to resident family for care plan meeting. She stated it was important for resident's representative to give their insight and if they were any concerns that need to be improved. The DON stated the care plan meetings can give the resident's representative an opportunity to be updated about their resident care. She stated the social worker was responsible for contacting resident's representative to ensure they were notified for care plan meetings. She stated resident's representative should be offered the option of phone for care (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan meetings. Review of the facility's policy Care Planning-Resident Participation dated 2024 reflected This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care).The facility will honor the resident's right to participate in . the plan of care. 10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences.The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative.		

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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 interview and record review the facility failed to develop and implement a comprehensive care plan to meet the highest practicable physical, mental, and psychosocial wellbeing for 1 (Resident #3) of 8 residents reviewed for comprehensive care plans. The facility failed to develop and implement a comprehensive care plan for Resident #3 to address the resident's left pelvic fracture and to address Resident #3's falls. This failure could place residents at risk for not receiving care required to meet their individualized needs and place them at risk for falls and injury. Findings included: Review of Resident #3's face sheet undated reflected Resident #3 was an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnose of dementia (group of conditions that cause a decline in cognitive abilities, memory and thinking skills that interfere with daily life), generalized muscle weakness, unsteadiness on feet, repeated falls and lack of coordination. Review of Resident #3's admission MDS assessment dated [DATE] reflected Resident #3 had a BIMS of 2 indicating he was severely cognitively impaired. Resident #3 had 1 fall with no injury since last assessment or since admission. Review of Resident #3's comprehensive care plan last revised 07/18/25 reflected Resident #3 was at risk for falling [related to] muscle weakness, decreased cognition and vision problems. The care plan did not reflect Resident #3's actual falls. It did not reflect Resident #3's left pelvic fracture. Review of Resident #3's Incident/Accident Reports for July and August 2025 reflected the following:- Dated 07/09/25 Resident #3 had a witnessed fall at 8:50 AM Resident stood up out of [wheelchair] and was trying to move dining room table chair feet slipped out from under him resulting in a fall Resident #3 had injury of a red area on mid back. - Dated 08/12/25 Resident #3 had an unwitnessed fall at 5:01 PM observed resident on the floor in a fetal position laying on his right side. Head to toe assessment completed: laceration to [right] side of forehead. First aid administered. resident was yelling upon movement to [left] leg. Prn medication Tylenol #3. Resident #3 was sent to local hospital emergency room for further evaluation and treatment. - Dated 08/18/25 Resident #3 had an unwitnessed fall Nurse passing medications opened resident's door, observed resident sitting on the floor beside bed. No injuries noted. Review of Resident #3's reportable incident 1029158 provider investigation report dated 08/15/25 reflected on 08/06/25 at 12:35 AM Resident #3 was found lying on the floor in his room with his dinner tray on the floor also. CNA just rounded and visited with resident and he was coming out of his room with his tray. Upon noticing he didn't come out she went back to check on him and found him on the floor. Assessment at time of incident reflected full body assessment by nurse with no concerns of pain. On 08/08/25 Resident #3 complained of pain to the middle/left side of his buttocks while transferring to a [wheelchair]. Resident was sent out 911 to [local hospital]. Upon report from the hospital x-rays indicated resident had a fracture to his left superior/inferior pubic bone.' Interview on 09/11/2025 at 2:46 PM with the DON revealed she was responsible to ensure Resident #3 care plans addressed his falls and fracture. She stated she may not have completed Resident #3's care plan to address the pelvic fracture and when reviewing the care plan she could not find the fracture on the care plan. She stated she thought Resident #3's care plan addressed Resident #3's actual falls prior to incident. She stated he had a fall on 08/18/25. The DON stated she usually updated the care plan for falls. She stated she was responsible to ensure Resident #3's fracture was care-planned. She stated it was important to care plan to include interventions in place to address the falls and fractures. Review of the facility's policy Care Planning-Resident Participation dated 2024 reflected .6. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences. Review of the facility's policy Comprehensive Care Plans dated 2025 reflected to develop and implement a person-centered care plan for each resident. that includes measurable objectives and timeframes to meet a resident's medical, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing.and all services that are identified in the resident's comprehensive assessment and meets professional standards of quality.		

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NAME OF PROVIDER OR SUPPLIER The Terrace at Denison		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Memorial Dr Denison, TX 75020	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 (Resident #39) residents reviewed for respiratory care. 1. The facility failed to ensure Resident #39's oxygen was administered at the correct setting of 2 liters per minute on 9/9/25 and 9/10/25 as ordered by the physician. This failure could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. Record review of Resident #39's admission record dated 10/10/25 reflected an [AGE] year-old female with an admission date of 9/11/24. Resident #39 was diagnosed with chronic obstructive pulmonary disease (constriction of the airways with difficulty breathing). Record review of Resident #39's Annual MDS assessment dated [DATE] reflected Resident #39's BIMS score was 14 which implied she had little to no cognitive impairment. Resident #39 was marked as receiving oxygen therapy while at the facility. Record review of Resident #39's Physician Order Report dated 8/1/25-8/31/25, reflected an order on 9/11/24 O2 at 2 liters per minute via nasal cannula every shift; shift 1, shift 3, shift 1. Record review of Resident #39's person-centered care plan revised 6/27/25 reflected .Problem Start Date: 9/23/24 Resident #36 is at risk for respiratory distress/SOB due to DX of COPD. Edited 6/27/25. Approach Start Date: 9/23/24 Apply O2 as ordered. Observation of Resident #39 on 09/09/2025 at 10:12am revealed resident was asleep; oxygen concentrator was on at 3 liters per minute, but the resident did not have the oxygen on her face. Observation and interview of Resident #39 on 9/9/25 at 2:07pm revealed resident was awake with oxygen via nasal cannula and the concentrator was set at 3 liters per minute. Resident #39 stated she needed to have the oxygen on but sometimes the nose piece bothers her. Observation of Resident #39 on 09/10/2025 at 8:31am revealed she was asleep with oxygen on via nasal cannula. The concentrator was set at 3 liters per minute. Interview and observation with LVN A on 9/10/25 at 2:10pm revealed it was her first day at the facility, since a long leave of absence. LVN A was assigned to Resident #39 but did not know if she had an oxygen concentrator and whether Resident #39 was ordered to have oxygen. LVN A checked Resident #39's electronic medical record and could not locate an order for oxygen. She then called LVN H, who had just started his shift, to help verify whether Resident #39 had an order for oxygen. Interview and observation with LVN H on 9/10/25 2:13pm revealed he was starting his shift and Resident #39 was assigned to him. He provided a copy of Resident #39's order from her paper file. He stated Resident #39 received oxygen and should have gotten 2 liters per minute continuously. Surveyor requested LVN H read Resident #39's concentrator and he stated it was set a 3 liters per minute. He stated that was incorrect as Resident #39 should have had her concentrator set at 2 liters per minute to match the physician orders. He was unaware of the reason the concentrator was set at a higher rate. He stated at times the family would visit resident and would put water in the concentrator and adjust it. He stated the concentrator should have been checked during every shift, but he had just started his shift and hadn't checked Resident #39's concentrator yet. He was observed adjusting the oxygen concentrator to 2 liters per minute. He was unable to state when he last checked Resident #39's concentrator. He stated for sure they checked the level on the concentrator on Sunday when the tubing was changed. LVN H stated he was not the person who changed the tubing on Sunday. LVN H stated the risk to the resident of having had received more oxygen then was orders could have been more breathing complications or respiratory distress. Interview with LVN K on 9/11/25 at 10:59am revealed the expectation at the facility was the oxygen concentrator be checked weekly, however some residents required as needed checks. LVN K determined the amount of oxygen given by the physician order. The risk to the resident of not following the order would be not administering enough oxygen or over oxygenating the resident. Too (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	much oxygen could have lead to respiratory distress. Interview with the ADON on 9/11/25 at 11:24am revealed the expectation for a resident with continuous oxygen was the concentrator be checked weekly when the tubing was changed. Staff should have been following the orders when determining the amount of oxygen given to residents. For residents who received continuous oxygen, the nurses needed to check oxygen stats every shift to ensure the residents were receiving enough oxygen. If the staff determined the resident had not gotten enough oxygen, then they needed to call the physician for a new order. The ADON's expectation from the nurses would be for them to check the concentrator every shift to ensure it matched the order. The risk of administering too much oxygen would be it could affect the resident's COPD and if it was too low the resident may not have gotten enough oxygen. Interview with the DON on 9/11/25 at 11:53am revealed nurses determined levels for oxygen concentration based on orders. The concentrator should have been checked every shift to make sure it matched the orders. The risk to the resident of not having received the oxygen as ordered would be they may have gotten to little or too much oxygen thus affecting the accuracy of the O2 stats. Review of facility's policy Oxygen Administration revised 2025 reflected. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not 5% or greater. The facility had a medication error rate of 6.25 %, based on 2 errors of 32 opportunities, which involved one of six residents (Residents #14) and one of three staff (LVN A) reviewed for medication errors, in that: LVN A failed to administer Resident #19's Digoxin 250 mcg with Digoxin 125 mcg for a total dosage of 375 mcg daily and failed to administer Ergocalciferol 1.25 mg on 09/10/25 as ordered by the physician. This failure could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings include: Record review of Resident #14's Quarterly MDS assessment, dated 08/29/25, reflected a [AGE] year-old female with an admission date of 06/15/18. Staff had assessed her mental status as severely cognitively impaired. Diagnoses included coronary artery disease (damage or disease in the heart's major blood vessels), hypertension (high blood pressure), and quadriplegia (paralysis that affects the ability to voluntarily move the upper and lower body). A record review of Resident #14's Physician's order summary report, dated 09/11/2025, reflected Resident #14 was to receive the following medications: Digoxin Oral Tablet 250 mcg (used to improve the strength and efficiency of the heart) Give 1 tablet via G-Tube one time a day related to tachycardia (rapid heart rate) Hold for pulse <60. Give with Digoxin 125 mcg to equal 375 mcg with a start date 08/28/25. Ergocalciferol (Vitamin D2 supplement) 1.25 mg (5000 UT) Give 1 capsule via G-Tube one time a day every Wednesday for supplement with a start date of 08/28/25 During a G-Tube medication pass observation on 09/10/25 at 08:08 a.m., revealed LVN A administered the following medications to Resident #14: Digoxin 125 mcg 1 tablet Coreg 6.25 mg 1 tablet Docusate 100 mg 1 tablet Cyclobenzaprine 10 gm 1 tablet Hydrochlorothiazide 25 mg 1 tablet Lactulose oral solution 100 mg/ml -10 ml Metoclopramide oral solution 5 mg/ml -5 ml MiraLAX oral powder 17 gm/ scoop -1 scoop Levetiracetam oral solution 100 mg/ml -10 ml LVN A did not administer Digoxin 250 mcg 1 tablet, or Ergocalciferol 1.25 mg 1 capsule as ordered for daily administration. Record review of Resident #14's September 2025 medication administration record on 09/10/25 at 12:00 p.m. reflected Digoxin 250 mcg tablet at AM (7) and Ergocalciferol 1.25 mg AM (7) on Wednesday were signed out as given by LVN A on 09/10/25. In an interview with LVN A on 09/10/25 at 12:48 p.m. she stated she had not administered any additional medications to Resident #14 since her morning medication administration. Upon reviewing the medication administration record she acknowledged she had not administered the Digoxin 250 mcg or the ergocalciferol 1.25 mg but had signed them out as administered. She stated she remembered the resident had that combination of Digoxin back in December, which was the last time she had worked at the facility. She stated today was her first day back. She stated the facility had asked her if she needed some additional training before doing the medication pass this morning and she told them no, she felt like she had been a nurse for many years and was familiar with Resident #14. She stated by her signing the medication off as given, it would not have triggered to indicate it still needed to be administered and no one would be aware the medication was missed. She stated the risk of not administering the resident's medication as ordered would be the resident would not receive the full therapeutic value of the medication that was ordered for her. In an interview with the DON on 09/11/25 at 08:22 a.m., she stated she expected the staff to follow the 5 rights of medication administration which were right drug, right dose, right route, right patient, and right time. She stated failing to follow these rights put residents at risk of not receiving all their medications or could lead to drug interactions if the correct medication or dosage was not given. She stated they do skills checks annually and the pharmacy consultant observed medication administration. She stated they had now flagged the digoxin order for Resident #14 since it is listed as 2 separate drug administrations and was easy to overlook. She stated they had also clarified the order for the Ergocalciferol 1.25 mg 1 capsule since it was a gel capsule and stated she was not sure (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	how the staff were administering via the G-tube. She stated they had since ordered the liquid solution to be used going forward. Record review of the facility undated policy titled Medications Administration, reflected, .Ensure that the six rights of medication administration are followed.Right residentRight drugRight dosageRight routeRight timeRight documentationReview MAR to identify medication to be administered.Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, mediation name, form, dose, route, and time.Sign MAR after administered.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 8 residents (Resident #7) reviewed for the storage of drugs and biologicals. The facility failed to ensure Resident # 7's Clobetasol Propionate external cream 0.05% was stored properly. This failure could place residents at risk of medication misuse, administration of incorrect dosage of medications which could result in non-therapeutic treatments or injuries. Findings included: Record review of Resident #7's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female with an admission date of 10/22/13. The resident had a BIMS score of 12 which indicated she was moderately cognitively impaired and had refused care 4-6 days out of the week. Resident #7 required supervision assistance with bathing and partial to moderate assistance with personal hygiene and dressing. Diagnoses included post-traumatic stress disorder (mental health condition that's caused by an extremely stressful event), cerebral vascular accident (stroke), peripheral vascular disease (blood vessels supplying the limbs and other body parts become narrowed or blocked) and hypertension (high blood pressure). There was no indication of skin disorders. Record review of Resident #7's care plan, dated 05/29/25, reflected, .Skin concerns.Psoriasis vulgaris (autoimmune skin condition characterized by raised, red, scaly patches of skin) with risk of flare up with risk of infection and further skin breakdown.Interventions.Monitor areas for flare up.discomfort, administer treatment as needed monitor for relief. Record review of Resident #7's Physicians Order Summary Report dated 09/11/25 reflected, Clobetasol Propionate (high potency topical corticosteroid used to treat sever inflammatory skin and scalp conditions like psoriasis) External Cream 0.05%. Apply to affected area topically every 12 hours as need start date 06/10/25. There were no orders for resident to have medication at bedside. An observation and interview on 09/09/2025 at 10:15 a.m. revealed Resident #7 in her room lying in bed watching television. A box containing a tube of Clobetasol Propionate 1% cream was observed on her overbed table. Resident #7 stated she kept the medication at bedside for her psoriasis. She stated she was not sure who brought it to her. She stated she does not recall the last time she used it. An observation 09/10/2025 at 1:30 p.m. revealed the tube of Clobetasol Propionate 1% cream was still in Resident #7 room on her bedside table. In an observation and interview with the DON on 09/10/2025 at 1:55 p.m. in Resident #7's room, the DON picked up the tube of Clobetasol Propionate 1% cream and asked the resident if she could read the instructions on the box for medication. The resident looked at the box and stated no she could not read it. The DON asked her if she knew how often she was using the medication and she stated she just put it on when she needed it. Resident #7 stated LVN C had given it to her. Resident #7 stated she did not care if the staff kept the medication and brought it to her when she needed it. The DON removed the medication and stated it should not have been left in the room. In an interview with the DON on 09/10/25 at 02:00 p.m., she stated for them to be able to leave medication at the bedside they have to complete a resident assessment to determine if the resident understands the directions for the use of the medication and the resident still must let the nurse know when they had administered the medication so it could be documented in the record. She stated Resident #7 did not have the capacity to manage her own medications. She stated the risk of leaving medications at the bedside was the resident could use the medication improperly, or some other resident could have access to a medication not prescribed for them. She stated it was the staff's responsibility to ensure the medications were kept secure and stored properly. She stated LVN C had been on medical leave for several weeks. In an interview with LVN C on 09/11/25 at 03:00 p.m. she stated she was returning to work this week after being off for several weeks. She stated she never left a tube of Clobetasol Propionate 1% cream in (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's room. She stated when she had flares of her psoriasis she would place a small amount of cream in a medication cup and take it into her room to be applied to the affected areas. She stated medications were not to be stored at bedside. Record review of the facility undated policy Medication Storage, reflected, It is the policy of this facility to ensure all medications house on our premises will be stored in the pharmacy and/medication rooms according to the manufacturers recommendations.All drugs and biologicals will be stored in locked compartments(i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperatures controls.Only authorized personnel will have access to the keys to locked compartments.During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review the facility failed to provide food that was served at an appetizing temperature, and prepared by methods which conserved the nutritive value, flavor, and appearance for one (Lunch 09/10/25) of one meals observed for food palatability. The facility failed to ensure egg salad was served at an appetizing temperature for lunch on 09/10/25. This failure could place residents at risk of food borne illness and a decline in their quality of life. Findings included: In a confidential group interview with five residents on 09/10/25 at 11:00 AM revealed residents' concerns with their food not being served at the right temperatures. Observation on 09/10/25 at 11:57 AM, revealed Dietary [NAME] L took the food temperature using a thermometer and food temperature of the pureed egg salad at 51.5 degrees Fahrenheit and 12:03 PM egg salad 42.3 degrees Fahrenheit. There was no ice under the egg salad containers. Dietary [NAME] L left the egg salad sandwiches and pureed egg salad on the serving line. Dietary [NAME] L did not take the food temperature of the egg salad. She documented the food temperatures on the log. At 12:08 PM, Dietary [NAME] L started plating food including egg salad to the residents' lunch plates in the dining room. Observation of a lunch test tray on 09/10/25 at 12:39 PM revealed the last hall resident meal tray was served on Hall 3 to a resident. Observation on 09/10/25 at 12:40 PM of a lunch test tray revealed egg salad was slightly warm to touch and tasted warm. Interview on 09/10/2025 at 1:10 PM Dietary [NAME] M revealed she was not trained on what the food temperatures should be and what to do if temperatures were not cold or hot enough. She stated this time she put the egg salad on the slider buns and then put them in refrigerator about an hour ago prior to serving. She stated she had not completed the food temperature of the egg salad until it was ready to be served. She stated she had to put boiled eggs in the egg salad for the pureed she stated this could have affected the food temperature. Interview on 09/10/25 at 1:30 PM with Dietary Manager revealed the egg salad should be served at 41 degrees Fahrenheit or below. He stated the cold food temperatures need to be followed to not place residents at risk of bacteria. Review of food temperature log dated 09/08/25 to 09/10/25 reflected on 09/10/25 at lunch regular entree was 42.3 F and pureed entree was 51.3 F. Review of Egg Salad on Croissant Recipe reflected under procedures 4. Chill egg salad until service.5. Chill to 41 F or below and keep refrigerated until serving. Review of facility's policy Safe Food Temperatures, dated 06/20/23, reflected, food temperatures will be maintained at acceptable levels during food storage, preparation, holding, serving, delivery.PROCEDURES: 6.Hold cold foods at 40 F or lower during meal service (on the trayline).		