| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515066 | A. Building<br>B. Wing | 07/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Dunbar Center | 501 Caldwell Lane<br>Dunbar, WV 25064 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on direct observation and interview with the Facility Maintenance Director (#119), the facility failed to consistently maintain ambient temperatures within the required range in the 100/200 Nurses' Station and the 300/400 Nurses' Station. This was a random opportunity for discovery and had the potential to affect more than a limited amount of residents. Facility census: 118.Findings included:a) On 06/30/2026, at approximately 4:08 PM, the State Surveyor observed and documented the wall-mounted thermostat located at the 100/200 Nurses' Station, which displayed a temperature reading of 83 F.The temperature reading was obtained through direct visual observation of the facility's wall-mounted thermostats in the respective locations at the time of survey observation.On 06/30/2026, at approximately 4:25 PM, the State Surveyor conducted an environmental observation of the facility's ambient temperatures in resident care areas in the presence of the Facility Maintenance Director (#119). During the observation, the surveyor requested that the Facility Maintenance Director obtain ambient temperature readings utilizing the facility's temperature monitoring device to verify the temperatures within the observed areas. The surveyor observed and verified the Maintenance Director performing the temperature checks and confirmed the readings displayed.At that time, the Facility Maintenance Director obtained a temperature reading at the 100/200 Nurses' Station, which measured 82.2 F, and a temperature reading at the 300/400 Nurses' Station, which measured 83.0 F. The surveyor observed and verified both readings as they were obtained.During the same observation, the State Surveyor observed facility residents seated in common areas in close proximity to the 100/200 Nurses' Station and the 300/400 Nurses' Station. Residents were observed remaining in these areas during the period in which ambient temperatures were noted to be above the recommended comfort range. |

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 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and family interviews, and staff interviews, the facility failed to ensure residents received timely assessment, intervention, and treatment for acute changes in condition. Specifically, the facility failed to ensure a resident exhibiting signs and symptoms consistent with sepsis, respiratory distress, hypoxia, hypotension, tachycardia, and acute clinical deterioration received timely emergency medical evaluation and transfer to the hospital; failed to follow physician orders for skin and wound care; and failed to provide pain management as ordered. This failed practice placed residents at risk for serious injury, harm, impairment, or death and had the potential to affect all residents requiring timely assessment, treatment, and intervention for changes in condition. Resident Identifiers: #123, #129, and #4. Facility census: 118.The State Agency determined this deficient practice constituted Immediate Jeopardy beginning on 06/15/2026. The facility implemented its Immediate Jeopardy removal plan, and the Immediate Jeopardy was removed on 07/01/2026, when the facility achieved substantial compliance.<br><br>Findings included:<br><br>a) Resident #123<br><br>Record review of the Nurse Practitioner's acute visit, dated 06/15/26 at 1:00 PM, revealed Resident #123 was more lethargic than normal. The acute visit note stated, . responsive only to verbal stimuli before drifting back to sleep, cool and clammy, tachypneic (abnormal rapid and shallow breathing), with oxygen saturation ranging from 86-89% on room air and heart rate fluctuating to 125 beats per minute. Respiratory therapy initiated oxygen at 3 liters per minute, increasing oxygen saturation to 94%. The resident remained hypotensive with a manual blood pressure of 90/72. The assessment included septicemia, tachypnea, tachycardia, and acute hypotension. Orders were given to obtain laboratory studies including CBC, CMP, lactic acid, blood cultures, urinalysis with culture and sensitivity, KUB, initiate IV fluids, administer ceftriaxone 1 gram IV every 12 hours, and closely monitor vital signs.<br><br>Record review of the After-Hours Telehealth Consult, dated 06/15/26 at approximately 7:00 PM, revealed the following: WBC (white blood count) 22.1, BUN (Blood Urea Nitrogen) 60, creatinine 2.5, GFR 19, hemoglobin 9.4, hematocrit 28.9, and platelet count 105, representing a significant decline from previous laboratory values. During the telehealth evaluation, the resident appeared acutely ill with respiratory distress, increased work of breathing, respiratory rate of 24, oxygen saturation fluctuating between 80% and 92% despite oxygen at 2 liters per minute, fever, acute kidney injury, suspected infection/sepsis, and hypoxia. The assessment included acute respiratory distress with hypoxia, suspected acute infection/sepsis, leukocytosis, acute kidney injury, fever, anemia, thrombocytopenia, and significant decline from baseline laboratory values. The plan from the after hours telehealth consultant directed the resident to be transferred immediately to the emergency department for further evaluation and management.<br><br>Record review revealed Resident #123 was not transferred from the facility until 06/15/26 at approximately 8:38 PM.<br><br>Records dated 06/16/26 at 7:33 AM revealed Resident #123 was admitted to a local acute care facility with diagnoses of sepsis, kidney stone with obstruction, and hypoxic respiratory failure.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 06/24/26 at 1:15 PM, the facility Nurse Practitioner stated there had been been an instance in which, in her professional judgment, residents needed to be sent to the hospital and she had received pushback from the Director of Nursing (DON). The Nurse Practitioner stated during Resident #123's evaluation, she became concerned the resident was septic. The Nurse Practitioner explained that sepsis could be life-threatening and required immediate rehydration, prompt laboratory testing, initiation of broad-spectrum antibiotics, and constant monitoring. The Nurse Practitioner stated she informed the resident's family she was going to send the resident to the hospital. When exiting the resident's room, the DON (in the presence of the Administrator) stated they wanted to treat the resident in-house. The Nurse Practitioner stated the DON entered her orders into the computer. The Nurse Practitioner further stated, It was around 1:00 PM when I wanted to send her (Resident #123) out. It was sometime after I left the building at 5:00 PM when she was sent out. The Nurse Practitioner stated in her professional opinion if the resident had been sent out when she had originally asked, it had the potential to possibly change the outcome.<br><br>Medical Record Review (MRR) revealed Emergency Medical Services (EMS) was contacted on 06/15/26 at 8:15 PM. When EMS arrived the resident's blood pressure was reported to be 70/40. The EMS narrative note stated that upon arrival at the facility, staff reported the patient had recently been battling a UTI (urinary tract infection) for which she was currently receiving Intravenous (IV) fluids. They stated that the patient had been having issues for a few days now, but that she got worse approximately 5 hours ago. EMS narrative note described the resident as pale, clammy, and warm to the touch. The narrative included that the resident was hypotensive (low blood pressure), tachycardic (abnormally fast resting heart rate - typically over 100 beats per minute) and her blood glucose level was 226. Resident's temperature was 101.4. She was on 4 liters of oxygen via nasal canula which the facility had placed her on due to her low oxygen levels. It was noted that the resident was not normally on oxygen.<br><br>During an interview on 06/25/26 at 11:30 AM, Resident #123's sister stated the resident requested her temperature be taken on the morning of 06/15/26 and approximately one hour elapsed before nursing assessed her. The sister stated the resident's temperature initially measured 100.3 degrees F and later increased to 101.9 degrees F. The sister stated she repeatedly requested the resident be sent to the hospital. She stated nursing informed her they planned to keep the resident at the facility, start an IV, and obtain laboratory work. The sister stated the resident's breathing worsened throughout the day and she was not informed the resident would be transferred until approximately 8:00 PM, with EMS transporting the resident around 8:30 PM. The sister stated, I feel if my sister went out that morning, when she wanted to be sent out, she may not have passed away like she did.<br><br>During an interview on 06/29/26 at 12:45 PM, the Administrator stated that when a resident had an order to be sent to the hospital, the nurse was to call the DON or on-call nurse, who would ask about the resident's symptoms, what interventions had been completed, and what the family had been told.<br><br>During an interview on 06/29/26 at 1:16 PM, Resident #123's son stated he spoke with the Administrator and the DON around 9:00 AM on 06/15/26 requesting his mother be sent to the hospital. He stated the DON repeatedly told him the resident could be treated in house. The son stated the resident was not transferred until approximately 8:00 PM. He stated the hospital physician informed the family the resident had an obstructing kidney stone requiring emergency surgery and stated that in 30 years he had never seen an infection that severe. The son stated despite surgery, the resident's condition continued to decline, the family elected comfort measures, and the resident died.<br><br>During an interview with Registered Nurse (RN) #154 the following was reported: Last Monday, I think<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | it was the 15th, I went in to give [Resident's First Name] her morning medications. She could swallow them and was awake and alert. I do not work that side often, so I was not as familiar with her. Her family was with her and said that for the past 2 days she had been sweating so bad that they had to change her clothes several times throughout the day. I finished my morning med pass and was sitting at the nurses station charting, when I saw the CNA, Nurse Practitioner (NP) and Respiratory therapist go into her room, so I followed them. The resident was barely arousable and when the Respiratory Therapist checked her oxygen level, it was sitting in the mid-80's so we put her on 3 liters of oxygen. The NP, Respiratory Therapist, and I assessed the situation and felt that she needed to be sent out. We have instructed before anyone is sent out, we have to run it by the Director of Nursing (DON). I went to tell the DON and she said, 'We can treat that here. It is just Sepsis.' Around 6:00 PM, that evening the daughter came out and said, 'I feel like her temperature has got worse.' I went in and checked her temperature, and it was 101.8. She was taking shallow breaths and not making any sense with her speech. Her oxygen level, on 3 litters at this time, was in the 80's so we bumped it up to 4 liters. I reached out to the DON again, to tell her what was going on. The DON's response was, 'We still are not sending her out it is just Sepsis.' I told the family member that the DON was still not recommending sending her out. The family said we want her sent out immediately, I went to the DON again, and said, 'The family wants her sent out immediately.' The DON said, 'I need you to go back in there and tell the family we can treat her here, and you need to quit freaking out.' I told the DON that I was going to call the on-call physician. She said, 'Go ahead, I still do not think he will send her out.' I called the on-call Physician and went over her lab readings. The on-call physician said, Send her out immediately. I called the DON and told her what the blood work was and that the on-call physician said to send her out immediately. The DON still did not want to send her out. In the meantime, the night shift nurse came in and she has worked here longer than me. I caught her up to speed on what was going on with the resident and the night shift LPN said she did not care what the DON had said. She called EMS. When EMS arrived her blood pressure was 70/40 even after we had bolused all that fluid.<br><br>During an interview with RN #11 the following was reported: There has been a time when I have seen a resident getting worse, and they wouldn't send them out. The management staff (Director of Nursing and Administrator) make it hard. If you have a resident that is in their right mind and has capacity and they say, I don't feel good, send me out, they don't do it. I just don't agree with that at all.<br><br>During an interview with LPN #115 the following was reported, As a nurse, I feel that the facility frowns upon sending people out to the hospital. We (nurses) have been told in monthly nursing meetings not to think about sending anyone out until we talk to [The Director of Nursing's First Name] first. I had a male patient who had capacity. He was coughing up a lot of productive cough and I had to put him on 02. The next morning his O2 kept dropping. The resident wanted to go to hospital. I called Dr. (name). My unit manager said, 'Let's go get (name of DON)'. Dr. (name) said to send him. (DON name) did not want him to go. She said we can treat him here and what exactly did you tell Dr. (name)? I was questioned why I wanted to send him out even when the doctor gave the order to send. It took about 45 minutes. He passed away at the hospital.<br><br>During an interview with LPN #109 the following was reported, The DON has told us that we have to go through her before we send anyone to the hospital.<br><br>During an interview on 06/25/26 at 2:05 PM, the Market President of the facility stated, If a Provider gives an order for someone to go out, they are going to go out. He also reported that the DON would defer to speaking to the Corporate Clinical Lead if she had any clinical questions or needed guidance. (continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 06/25/26 at 2:40 PM, the Corporate Clinical Lead stated the DON had never called her regarding the facility's ability to treat suspected sepsis in-house. She also stated that the DON rarely called her regarding anything.<br><br>During a telephone interview, conducted on 06/29/26 at 4:09 PM, the Director of Nursing (DON) stated the facility attempts to treat residents in-house whenever possible because hospitalization can be a traumatic experience for residents. The DON stated she encouraged the Nurse Practitioner to provide treatment in the facility because the NP was new to the building and unfamiliar with what conditions could be managed in-house. The DON stated orders were obtained for laboratory work, blood cultures, intravenous fluids, and antibiotics. The DON stated antibiotics were not administered because the order directed staff to administer them after obtaining blood cultures; however, blood cultures could not be obtained because the facility did not have the appropriate culture bottles. The DON stated intravenous fluids were administered. After the laboratory results returned and showed abnormal findings, the DON stated staff contacted the telehealth physician, at which time the decision was made to transfer the resident to the hospital.<br><br>Review of hospital medical records was completed on 06/29/26 and revealed the following findings (pasted as written): Emergency Department ED Primary Note History of Present Illness (name of Resident #123) is a 76 y.o. female who had concerns including Weakness. Arrival via EMS. Patient presenting to emergency department for complaint of generalized weakness. Patient presenting here from (name of facility). Patient reporting that she's had 3 days of generalized malaise and weakness not feeling well feels like her heart is been racing. Patient with a previous history of CVA and left-sided deficits. Patient denies any known fever or chills. (Name of facility) reported to EMS that she had a low-grade fever at home.Physical Exam ED Triage Vitals [06/15/26 2103] BP (Non-Invasive) (!) 84/44 Heart Rate (!) 135 Respiratory Rate (!) 24 Temperature 37.1 degrees C (98.8 degrees F) SpO2 95 % CT CHEST ABDOMEN PELVIS WO IV CONTRAST Final Result by Edi, Radresults In (06/15 2354) 1. Moderate right hydroureteronephrosis with obstructive calculus in the distal right ureter measuring 6 mm. Additional nonobstructive right renal calculi. 2. Small right and trace left pleural effusions. 3. Large hiatal hernia with partially intrathoracic stomach. 4. Avascular necrosis of the right femoral head and moderate degenerative joint disease of the right Medical Decision Making [AGE] year-old female patient presenting to emergency department complaint of weakness. Patient presenting here from local nursing facility (name of facility) patient reporting 3 days of generalized weakness malaise not feeling well fast heart rate. Patient reporting that she has had some abdominal pain reports she has colitis but it has not been confirmed. Patient also reporting that she thinks she's still has a urinary tract infection that she had been treated for. EMS reporting that the patient had low-grade fever at the facility. Patient's physical exam reveals a ill-appearing pale appearing elderly female patient that has generalized weakness appearance with irregular rate and rhythm, abdomen exam is benign, left-sided deficits present Please see ED course below for details the patient's laboratory and image findings. Patient taken to exam room [ROOM NUMBER] rather quickly after triage secondary to tachycardia and hypotension. Patient ordered 30 per kg IV fluid resuscitation that is adjusted full were concerns for potential heart failure. As can be seen below patient's laboratory workup reveals multiple abnormalities most significant in his leukocytosis 17.2 patient's creatinine at 1.99 patient's urinalysis shows abnormalities as below. Patient's initial lactate is 4.0. Patient has never been to this facility before unable to compare labs to what baseline is for this patient. I did scan the patient chest abdomen pelvis given the patient was now requiring oxygen does not typically require oxygen but her renal function does not support IV contrast for CT angiogram therefore without contrast as chest abdomen pelvis was performed reveals abnormalities as seen below. Patient covered with sepsis protocol treatments if foods and antibiotics. Sepsis protocol was satisfied. Patient's case was discussed with Urology which has recommended NPO status may<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | require stent placement tomorrow. Patient's case then discussed with the hospitalist which did agree with admission of the patient. Critical Care Attestation: As the ED physician, I have provided critical care for this patient. This patient has high probability of imminent life or limb threatening deterioration due to acute renal failure, acute respiratory failure, and sepsis<br><br>d) Center for Disease Control<br><br>According to the Center for Disease Control, If an individual is suspected of having sepsis, the healthcare provider overseeing care of the resident/patient should immediately be alerted. Antibiotics should be started as soon as possible. Resident/patient progress should be checked frequently. Treatment requires urgent medical care, usually in an intensive care unit in a hospital, and includes careful monitoring of vital signs and often antibiotics (https://www.cdc.gov/sepsis/hcp/clinicalcare/index.html#cdc_clinical_care_treatment_care_specific-treatment-A resident with sepsis might have one or more of the following signs or symptoms: -Clammy or sweating skin, -Extreme pain or discomfort, -Fever, -High heart rate, -Low blood pressure, -New onset or increased confusion or disorientation, -Shortness of breath. Immediately alert the doctor, physician assistant, or nurse practitioner overseeing the resident's care. In most cases, a resident who is suspected of having sepsis, or who may be developing sepsis, will need to be transferred quickly to a hospital to receive intensive evaluation and treatment. (https://www.cdc.gov/sepsis/media/pdfs/Factsheet-Longterm-care-sepsis-nurses 508.pdf)<br><br>The facility administration was informed of the immediate jeopardy on 06/30/26 at 5:09 PM. A plan of correction was accepted on 06/30/26 at 5:09 PM. The immediate jeopardy began on 06/15/26 when the Nurse Practitioner's request to send the resident out for acute care treatment was not followed up on by the Director of Nursing (DON). The immediate jeopardy was abated on 07/01/26 at 8:40 AM. The abatement plan of correction is listed below:<br><br>All residents of the facility have the potential to be affected. NHA and IDON were Re-educated by the market team on the escalation process on 6/30/26 with a post test. Nurse Practitioner Re-educated on 6/30/26 concerning orders to send residents to the hospital with a post test. The Director of Nursing/designee completed an audit on 6/30/26- to ensure residents are not showing signs and symptoms of sepsis with immediate correction upon discovery. Reeducation will be provided by the Director of Nurses (DON)/designee to all licensed nurses beginning on 6/30/26 to ensure residents are provided timely follow up of care and escalation process. Post test completed to validate understanding. Any facility staff not available during this time frame will be provided reeducation, including posttest by the DON/designee upon the beginning of next shift to work. New facility staff will be provided education, including posttest during orientation by the DON/designee. The Director of Nursing (DON)/designee will monitor starting on 7/1/26 to ensure all residents are not showing signs and symptoms of sepsis by reviewing progress notes, vital signs, ACS reports, missed antibiotics and IVF and lab results daily for 2 weeks including weekends and holidays, then 3 times a week for 2 weeks then randomly thereafter. Results of monitors will be reported by the DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the QIC committee.<br><br>Physician Orders: Must be carried out timely, including oxygen, IVF, labs, hospital transfers, medications and documented in the medical record<br><br>Family/POA Requests: Resident and/or POA request for resident to be sent to the hospital. staff must carry out the order timely with physician notification<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Escalation and Notification Protocol: If the nurse providing care does not agree with the physician/DON/Administrator, the escalation process will be activated. The employee should notify the Market Clinical/Regulatory team.<br><br>e) Resident #129<br><br>Record review completed on 07/01/26 of the Treatment Administration Record (TAR) revealed the following dates were not signed of as being completed or refused:<br><br>Skin tear treatment: 03/07/26, 03/15/26, 03/29/26, 04/11/26<br><br>Stage two (2) pressure ulcer treatment: 03/07/26, 03/15/26, 03/29/26, 04/11/26<br><br>Wound care to Left Lower Limb: 04/11/26<br><br>During an interview on 07/01/26 with the Interim Director of Nursing (IDON), the IDON confirmed the TAR was not signed off as being completed or being refused by Resident #129 for the above-mentioned days.<br><br>f) Resident #4 An electronic medical record review, completed on 07/02/2026 at 9:33 AM, revealed the following physician order: 06/12/26 Physician Order: HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Controlled Drug. Give 2 tablets by mouth every 4 hours as needed for pain level 4-6. The physician order was dated 06/12/26.<br><br>Review of June 2026 and July 2026 Medication Administration Records revealed the medication had been administered without a documented pain level of 4-6 on the following dates:-06/12/26-06/13/26-06/14/26-06/15/26-06/16/26-06/17/26-06/18/26-06/19/26-06/20/26-06/21/26-06/22/2<br><br>During an interview, on 07/02/26 at 10:44 AM, the Corporate Clinical Lead/RN reported the facility had failed to capture Resident #4's pain levels prior to administering the medication (as per physician orders) and that it would be addressed immediately. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on record review, resident interviews and staff interviews, the facility failed to ensure all food was temped before leaving the kitchen, to ensure safe and appetizing temperatures of the food and to prevent foodborne illness. The facility failed to ensure all foods were palatable, hot foods were served hot, and cold foods were served cold. This failed practice was also true for one (1) of one (1) meal tray's tested throughout the survey process. This failed practice had the potential to affect more than a limited number of residents. Facility census: 118. Findings Included: a) Healthcare Services Group (HCSG) Policy #6 titled, Food Quality and Palatability states: -Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served in a manner, form, and texture to meet resident's needs.-Proper safe and appetizing temperature: Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction and minimize the risk for scalding and burns. b) HCSG Policy #16 titled, Food Preparation states: -All foods are prepared in accordance with the FDA Food Code. c) Food Temperature Logs On 06/29/26 at 11:01 AM this surveyor asked the Healthcare Services Group (HCSG) Dietary Account Manager (DAM) for a copy of the food temperature logs for the month of June 2026. She stated I cannot find it. The State Agency Surveyor then asked for any food temperature logs for this year (2026). The DAM stated I have checked the trash and everywhere, and I cannot find the temperature logs. On 06/29/26 at 12:12 PM, before starting the tray line, the dietary staff only took and wrote down four (4) regular consistency food item temperatures. Temperatures were taken for the BBQ Chicken, Coleslaw, [NAME] Beans, and the Ham & Cheese Sandwich. d) Test Tray. On 06/29/26 at 12:50 PM, a regular consistency test tray was made and sent to Dogwood Hall at 12:51 PM. The HCSG Director of Operations (DO) took the temperature of the following foods at 1:02 PM. The temperatures were: -Ham & Cheese Sandwich - 67.5 degrees Fahrenheit (F)-Coleslaw - 68 degrees F-Lettuce and Tomato - 79.3 degrees F-Mixed Fruit - 55.2 degrees F At the time of receipt by the resident, foods should be at a temperature of no less than 120 F for hot foods and no more than 50 F for cold foods, per the food code. e) Resident Council Resident Council was held on 07/01/26 at 10:30 AM. The residents in attendance stated, If we eat in our rooms, the cold food is hot and the hot food is cold. If we want it to be the correct temperature, we have to eat in the dining room. |