STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205157	A. BUILDING _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL MANOR	20 WEST MAIN STREET YARMOUTH, ME 04096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 8/12/2024 to 8/14/2024, on-site visits were conducted at Coastal Manor to complete the annual Long Term Care Survey Process for Federal Recertification and investigating complaint #ME00048414, and facility reported incident (FRI) #ME00048439. It was determined that Coastal Manor was not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
K	Administrator	08/28/2024

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.

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a safe, clean, comfortable and homelike environment on 2 of 2 units. Findings: On 8/14/24 at 9:30 a.m., during tour of the facility with Director of Nursing and the Maintenance Director, the following were observed and confirmed: First floor: Upper Dining Room - Stained ceiling around speaker in the middle of the room. Hallway connecting Upper Dining Room and Lower Dining Room has stained ceiling tiles. First floor living room has stained and damaged ceiling. First floor resident hallway at North end has stained ceiling tile near external door. There are also stained ceiling tiles across from rooms 102, 104, the Nurses Station, 108, 109, and at the Main entrance.	F 584	See Attached	

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F 584	Continued From page 2 Resident Rooms on the first floor: Room 102 - The curtains in room are dirty and have brown stains. Bathroom shared by rooms 108/110, Resident sink does not work and has a sign on it that says it is out of order. Room 110 - There are stained ceiling tiles over bed near window, and in the corner near second bed. The wallpaper above bed near window is torn with a piece approximately 3" x 5" missing, exposing the bare wallboard. Room 113 - The floor mat beside bed and in front of the recliner has dirt/debris. The heater behind the edge of the bed is exposed, there are 3 metal safety straps along the register; however, the heating element is exposed. Equipment on the first floor: Room 102- The sit to stand has no non-slip grip on feet, it appears that they have been ripped off. Second Floor: Resident Hallway - There are 3 ceiling tiles with very deep gouges near the old nurses' station. The handrail in main stairway has areas of bare and rough wood creating an uncleanable surface.	F 584	See Attached	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately in the area of "Active Diagnosis" for 1 of 3 sampled residents	F 641	See Attached	

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F 641	Continued From page 3 with the diagnosis of Post Traumatic Stress Disorder (PTSD) (Resident #9). Finding: On 8/13/24, R9's clinical record was reviewed and indicated the resident was admitted to the facility on 4/15/24. The provider's admission progress note dated 4/19/24 states under "Problem List/Past Medical History, ongoing: Nightmares, from PTSD. HX of abusive relationship" ... "PTSD, Pt states from horrible divorce, husband abusive mentally and physically suffers nightmares" ... "Pt fears leaving home. States only drives to get groceries. Suffers from PTSD." The Admission minimum data set (MDS) 3.0 dated 4/22/24 and the most recent Quarterly MDS dated 7/23/24 indicates, under "Active Diagnosis" Section I6100, states that the resident did not have PTSD. The surveyor was unable to find information in the clinical record that indicated what R9's PTSD trigger(s) might cause re-traumatization. On 8/13/24 at 11:15 a.m., the above was discussed with the Administrative Assistant.	F 641	See Attached
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656	See Attached

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F 656	Continued From page 4 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 656	See Attached	

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F 656	Continued From page 5 Based on record review and interview, the facility failed to develop a care plan for a resident with a current diagnosis of Post-Traumatic Stress Disorder (PTSD) for 1 of 3 sampled residents reviewed (Resident #9). Finding: Resident #9 was admitted to the facility on 4/15/24. The provider's admission progress note dated 4/19/24 states under "Problem List/Past Medical History, ongoing: Nightmares, from PTSD. HX of abusive relationship" ... "PTSD, Pt states from horrible divorce, husband abusive mentally and physically suffers nightmares" ... "Pt fears leaving home. States only drives to get groceries. Suffers from PTSD." A review of Resident #9's care plan did not include a care area with interventions for the diagnosis of PTSD. On 8/13/24 at10:19 a.m., the above was discussed with the Director of Nursing. The surveyor confirmed that there was no evidence addressing what might trigger the PTSD symptoms and there was no evidence of interventions that indicated what staff should or should not do that may cause re-traumatization from the resident's PTSD.	F 656	See Attached	
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may	F 699	See Attached	

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F 699	Continued From page 6 cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify a resident's past history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 2 of 3 sampled residents reviewed with a current diagnosis of PTSD (Resident #9, and #31). Findings: 1. On 8/13/24, R9's clinical record was reviewed and indicated the resident was admitted to the facility on 4/15/24. The provider's admission progress note dated 4/19/24 states under "Problem List/Past Medical History, ongoing: Nightmares, from PTSD. HX of abusive relationship" ... "PTSD, Pt states from horrible divorce, husband abusive mentally and physically suffers nightmares" ...Pt fears leaving home. States only drives to get groceries. Suffers from PTSD." On 8/13/24 at 10:16 a.m., during an interview, the Licensed Social Worker confirmed she does not complete a trauma assessment on residents other than Veterans. On 8/13/24 at 10:19 a.m., the above was discussed with the Director of Nursing. 2. On 08/12/24 at 9:50 a.m., a surveyor observed Resident #31 yelling and in distress. Resident #31 was admitted to the facility on 6/25/24 with dementia from his/her home. A record review of Resident #31's progress notes showed Resident #31 had a significantly difficulty	F 699	See Attached	

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F 699	Continued From page 7 adjustment to the recent changes in his/her life. In addition, a note from the hospice medical social worker (MSW) dated 6/2/24 located in Resident #31's medical record indicated the behaviors were most likely stemming from a trauma background from their childhood as opposed to his/her dementia deficits. A review of Resident #31's Minimum Data Set (MDS) admission assessment dated 7/2/24 indicated behavioral symptoms that interfered significantly with resident care and participation in activities or social interactions. On 08/12/24 at 1:41 p.m. a surveyor met with the facility MSW and learned that Resident #31 was not screened for trauma upon admission to the facility despite the behavioral indications that trauma may be a factor, and unless the resident is a veteran, they don't screen for any other resident's for trauma history or attempt to determine triggers to avoid re-traumatization. On 8/12/24 at 2:03 p.m. a surveyor requested the trauma informed care policy for the facility. A policy was not presented by the end of survey.	F 699	See Attached	
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance;	F 803	See Attached	

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F 803	Continued From page 8 §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, review of 4-week menu cycle, and interviews, the facility failed to follow the printed menu for 3 of 3 days of the survey, and not complying with regulation §483.60(c)(2) that menus be prepared in advance; and §483.60(c)(3) that menus must be followed. This has the potential to effect all 33 of the residents in the facility. Findings: On 8/12/24 at 8:56 a.m. a surveyor met with a resident who states "it feels like we have the same meal every week, the variety is not a lot" 0n 8/12/24 at 10:34 a.m. a surveyor met with a resident in his/her room. He/She also said the same things are served all the time and they never know what it's going to be because they don't get a menu.	F 803	See Attached	

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F 803	Continued From page 9 On 08/13/24 at 12:16 p.m. a surveyor met with a resident who stated "The variety is lacking. It feels like we get the same thing every week. I get tired of the same food." A surveyor reviewed the notes from the food committee meeting held on Monday August 5, 2024 with the permission of Resident Council president. The activities Director and 5 residents were in attendance. The following was recorded: "The residents would like to see more variety and choices with varying alternative choices Which are always egg salad or peanut butter and jelly" On 8/13/24 at 11:14 a.m. a surveyor met with the facility cook regarding the variety of food. A 4-week rotated menu was provided but the cook said that it's not followed, and they write the menu on the dry erase board outside the kitchen every day. The menus were not followed for lunch or dinner for 3 out of 3 survey days. If the resident doesn't like the meal served, they have a choice of chicken noodle soup, tomato soup, and/or sandwich of the day. On 08/13/24 at 12:43 p.m. a surveyor met with the Director of Nursing regarding the menu not being followed. He was unaware the menu was not being followed but was aware of complaints about the variety of food served. On 8/13/24 at 9:45a.m. - the cook, was asked what week they were on in the printed 4-week cycle? She stated that they never follow that. When asked why the meal that is served is different from the printed menu, she stated that she cooks what the manager tells her to. She is	F 803	See Attached	

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F 803	Continued From page 10 on vacation this week and before she left she gave me a hand written menu for the week. She stated that the chicken the facility ordered did not come in so she, the manager told her to cook something different, But that is not unusual because we hardly ever follow the printed menu. 8/14/24 at 9:50a.m. - Called placed to the dietitian, she stated that she had no idea that the facility was not following the published menu. She stated that when she is in the facility she spends about 2 hours there and that is divided between the kitchen and the residents. She stated that she makes her nutritional assessments based on the published menus and she has no knowledge that they were not being followed.	F 803	See Attached	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to serve food that was at an appetizing temperature to residents on 2 of 2 floors. Findings: On 8/12/24 at 8:56 a.m. a surveyor interviewed a resident in the dining room and was told the food	F 804	See Attached	

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F 804	Continued From page 11 is not hot enough and it feels like the same foods are served every week. On 08/12/24 at 09:40 a.m. a surveyor asked a resident in her bed about breakfast and was told "Breakfast was not good. It's cold" On 8/12/24 at 10:34 a.m. a surveyor met with a resident in [his/her] room who had a piece of French Toast on a plate. [HeShe] held up the French Toast and said it was cold this morning. The food is always cold. [He/She] also said the same things are served all the time and they never know what it's going to be. On 8/13/2024 at 11:00 a.m. a surveyor interviewed the cook in the kitchen and learned that the food is temperature checked as it's plated, a cover is placed over the plate and the tray is moved to the carts for transporting by the designated time for each meal. She often sees the carts sit there 30-40 minutes before the CNAs take them to be passed. On 08/13/24 at 11:18 a.m. a surveyor met with a resident who requested to speak with a surveyor. This resident stated that the food is not delivered to the residents on time to keep the hot foods hot and the cold foods cold. [He/She] can see the trays delivered to the second-floor unit by elevator and it sits in the hallway for sometimes 30 minutes or more before the CNAs start passing the trays. [He/She] never sees anyone, but the CNAs pass the trays. Also, this resident stated its unappetizing to see the same foods all the time. There is no variety. The residents recently started a food committee led by this resident about the food complaints.	F 804	See Attached	

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F 804	Continued From page 12 A surveyor reviewed the notes from the food committee meeting held on Monday August 5, 2024 with the permission of Resident Council President. The Activities Director and 5 residents were in attendance. The following was recorded: 1. "Food is often served cold or less than lukewarm" 2. "Ice cream is often melted by the time residents eat dessert." 3. "The residents would like to see more variety and choices with varyng alternative choices 4. Which are always egg salad or peanut butter and jelly" 5. "..snacks be available in the evening. In the past, a snack cart was brought to the rooms one or two times a day" 6. "Presentation is important. Often the food may taste ok, but the presentation makes it unappealing" On 8/13/2024 a surveyor observed the lunch meal tray pass on the first floor. Two CNAs were passing the trays to residents in their rooms. Residents were also seen in the dining room at tables waiting for food. A licensed nurse was at the desk, when this surveyor asked if licensed nurses ever helped pass the trays she responded affirmatively. I did not see any licensed staff passing trays at any point during the survey. On 8/13/2024 at 1:00 p.m. a surveyor interviewed a CNA and was told that CNAs pass the meal trays. I was told that by the time all the trays are delivered, and he/she is able to assist those that need help eating, the food isn't very warm for those residents. On 8/13/2024 at 1:30 p.m. a surveyor met with the Director of Nursing about the above issues	F 804	See Attached	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL MANOR	20 WEST MAIN STREET YARMOUTH, ME 04096

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 13 and was told that food was an issue they were addressing. On 08/13/24 at 1:43 p.m., a surveyor spoke with a family member for a resident who has lived at the facility since 2015. This family member visits 5 days a week for several hours at a time and helps to feed her family member lunch. When asked about the temperature and quality of the food. He/She stated that the food temperature was not very warm and the variety was poor.	F 804	See Attached	

F 584: Safe/Clean/Comfortable/Homelike Environment

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

All stained ceiling tiles and ceilings will be replaced/cleaned by 09/20/2024

The curtain in room 102 has been replaced

The bathroom shared by 108/110 sink is now in working order

The wallpaper in room 110 has been repaired.

The mat in room 113 has been cleaned

The metal safety straps along the heating register have been realigned, no longer exposing the heating element

New grip non-slip grips have been applied to the sit to stand lift in room 102

The handrail in the main stairway has been sanded and repainted no longer creating an uncleanable surface.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

A full walk through of the facility was conducted by the Director of Maintenance on 8/20/24. Any additional stained ceiling tiles/ceilings, soiled curtains, sinks out of order, wallpaper disrepair, soiled floor mats, sharp/exposed heating elements, equipment without safety grips and chipped paint on the main handrails were addressed.

What measures will be in put into place, or systemic changes made, to ensure that the deficient practice will not reoccur;

Beginning the week of 8/26/24; the Maintenance Director will conduct weekly audits for 4-weeks followed by monthly audits for 3 months, to identify any of the following: stained ceiling tiles/ceilings, soiled curtains, sinks out of order, wallpaper disrepair, soiled floor mats, sharp/exposed heating elements, equipment without safety grips and chipped paint on the main handrails. Results will be reported at the QAPI Meeting 10/02/24.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Weekly audits will be reviewed at the monthly QAPI meeting; 9/4/24 and at the quarterly QAPI meeting; 10/02/24.

F 641: Accuracy of Assessments

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Resident 9's clinical record, which included the trauma assessment dated 08/28/24 was reviewed by the Social Worker and a progress note was entered into her chart.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

By 9/28/24, the DNS or designee, will review all resident charts with positive results from the trauma assessment to assure "Active Diagnosis" included trauma related diagnosis as appropriate.

What measures will be in put into place, or systemic changes made, to ensure that the deficient practice will not reoccur;

Beginning 9/2/24; the DNS or designee, will conduct audits on all new residents to assure the "active diagnosis" includes any diagnosis identified in the trauma assessment as appropriate. Weekly audits with be conducted for 4-weeks and then monthly for 3 months.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Weekly audits will be reviewed at the monthly QAPI meeting; 9/4/24 and at the quarterly QAPI meeting; 10/02/24.

Compliance Date:

9/28/24

F 656: Develop/Implement Comprehensive Care Plan

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Resident 9's care plan was reviewed on 08/28/24. The resident met with the Social Worker on 08/28/24 and completed the trauma assessment. At this time, the resident reports no PTSD triggers.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

By 9/20/24; all residents positively screened and identified by the trauma assessment will meet with the social worker, or designee to identify and add trauma triggers and interventions to the care plan as appropriate.

What measures will be in put into place, or systemic changes made, to ensure that the deficient practice will not reoccur;

By 9/28/24; the DNS, or designee will review all current resident care plans for those residents who have been identified by the trauma assessment to need interventions and trauma triggers added to their care plan. On-going audits of new admssions will be completed weekly for 4-weeks, followed by monthly for 3 months.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Weekly audits will be reviewed at the monthly QAPI meeting; 9/4/24 and at the quarterly QAPI meeting; 10/02/24.

Compliance Date: *9/28/24*

F 699: Trauma Informed Care

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

On 08/28/24 the trauma assessment was conducted by the social worker on Resident 9. On 08/28/24 the trauma assessment was conducted by the social worker on resident 31.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

By 9/20/24, the social worker (or other identified clinical staff) will complete the trauma assessment on all current residents.

What measures will be in put into place, or systemic changes made, to ensure that the deficient practice will not reoccur;

Effective 8/19/24,all new admission will be screened with the trauma assessment upon admission. Audits of new admissions will be completed by the DNS (or designee) for 4 weeks, followed by monthly audits for 3 months.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Weekly audits will be reviewed at the monthly QAPI meeting; 9/4/24 and at the quarterly QAPI meeting; 10/02/24.

Compliance Date:

9/20/24

F 803: Menus Meet Resident Nds/Prep in Adv/Followed

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Effective; 9/1/24; residents will receive a copy of the monthly menu by the end of the previous month, distributed by the Director of Activities or designee.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

By 9/4/24, the Dietician will provide education to all cooks about the use of the Dietician approved menus. A food committee will be re-established and assemble by 9/18/24. The committee will be led by the FSD and in attendance will be the DNS, 2 residents (one from each floor) a C.N.A., cook, dietary aide and other staff as invited/appropriate. The committee will meet bi-weekly and the minutes will be reviewed at resident council and presented to the Administrator or designee for review.

What measures will be in put into place, or systemic changes made, to ensure that the deficient practice will not reoccur;

The dietician will be in the building for 2 hours each week. Bi-weekly audits will be conducted by the Dietician, DNS or designee, during various meal services to assure meals are accurate to the dietician approved menu.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Weekly audits will be reviewed at the monthly QAPI meeting; 9/4/24 and at the quarterly QAPI meeting; 10/02/24.

Compliance Date:

9/18/24

F 804: Nutritive Value/Appear, Palatable/Prefer Temp

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Effective; 9/2/24, meal carts will be delivered to the units at a consistent time and location for each meal. The diet aide delivering the carts will inform a staff that the cart has "arrived" on the unit. There will be an "all hands-on deck" approach to distributing resident trays; i.e. nurses and leadership staff will assist as appropriate.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

A food committee will be established and assemble by 9/18/24. The committee will be led by the FSD and in attendance will be the DNS, 2 residents (one from each floor) a C.N.A., cook, dietary aide and other staff as invited/appropriate. The committee will meet bi-weekly and the minutes will be reviewed at resident council.

What measures will be in put into place, or systemic changes made, to ensure that the deficient practice will not reoccur;

Bi-weekly audits will be conducted by the DNS or designee, during various meal services to assure meals are being passed timely and are served at a satisfactory temperature.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Weekly audits will be reviewed at the monthly QAPI meeting; 9/4/24 and at the quarterly QAPI meeting; 10/02/24.

Compliance Date:

9/18/24