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 _____	C 12/10/2024

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 On 12/10/24, an unannounced on-site visit was conducted at Coastal Manor for the purpose of an investigation of complaint #ME00049751. It was determined that Coastal Manor was not in substantial compliance with 42 CFR 483, Sub-part B-Requirements for Long Term Care Facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility staff failed to provide access to resident call bell device for 3 of 35 residents (#2, #3, and #4). Findings: On 12/10/24 at 8:15a.m. Resident #2 was asked if he/she had a device to call the staff if he needed them, he/she said, "Sometimes." No device was observed at that time. The call device was observed hanging on the wall, approximately 5 feet from the resident's bed. This was pointed out to the Certified Nursing Assistant (CNA) #1 and she moved it to the resident's bed covers. On 12/10/24 at 8:55a.m. Resident #3 was asked if he/she had a device to call the nurses if he/she needed anything, he/she looked around and said, "No." No call bell observed. With a search the	F 558		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 558	Continued From page 1 device was found with the cord behind him/her and the button on the floor between his/her chair and his/her bed. On 12/10/24 at 9:00a.m. Resident #4 was observed in bed with no call bell near him/her. He/She was unable to respond to questions about his/her call bell. Observed that there was no call for this resident. A Registered Nurse was asked if she knew about the call bell. A search of the area found that the call device was pulled out of the wall, on the floor wrapped around the bed. On 12/10/24 at 9:10a.m. Infection Preventionist and surveyor toured the remaining residents. No other residents had a call device that was not in reach and knew where it was. She confirmed that 3 of 35 residents did not have access to a call bell.	F 558		