

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205157		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/10/2024	
NAME OF PROVIDER OR SUPPLIER COASTAL MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 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			F 000			
F 558 SS=D	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. 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

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 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			