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 06/03/2024

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 6/3/24 an unannounced on site visit was conducted at Coastal Manor to investigate facility reported incidents #ME00047470, #ME00047637 and complaint #ME00047648. It was determined that Coastal Manor was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000	- see attached	
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580	- see attached	

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

Cheryl Farley, RN, Acting DON | 6/25/24

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 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that a resident's physician and/or representative were notified immediately of a significant change in the resident's medical condition and failed to follow its own policy and procedure for Unwitnessed falls and Head injury protocol for 2 of 4 residents reviewed for falls. (#1, #4) Findings: Coastal Manors Falls Policy and Procedure, revised 6/24 states under, "Types of Falls ... An unwitnessed fall is one in which a resident has sustained a fall in which no clinical staff directly witnessed the incident. Regardless if a resident is alert and oriented and a good historian, if no	F 580		

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F 580	Continued From page 2	F 580		

clinical staff member was there to witness the incident, it shall be classified as an unwitnessed fall", and "Unwitnessed Fall with or without head injury: any type of unwitnessed fall shall be treated under the "Head Injury Protocol".

Coastal Manors Head injury protocol, revised 9/23 states, "If a resident sustains ahead injury while at Coastal Mannor, the charge nurse will assess the situation and contact the resident's physician ...The residents contact person will be notified as well of the incident in the course of action decided upon" and "The nursing staff will do a full set of vital signs as well as neurological testing as follows; every 15 minutes for 1 hr., then every 1 hr. x 4 hrs. then every 4 hrs. x 24 hrs.; once a shift up to 72 hrs. The neurological assessment that should be done includes: check for changes from premorbid status and level of consciousness, pupil responses, vomiting, blood pressure, bradycardia, changes in coordination/gate and speech, hand grasp, and hyperthermia.

1. Review of resident #1's fall incident reports indicated he/she had fallen twice on 5/31/24, one at approx. 5:00 p.m. and one at approx. 10 p.m. The unwitnessed fall incident report dated 5/31/24 at 10:29 stated, "Resident found on [his/her] back on floor, up against door, still hanging on to [his/her] walker". Under the section "People notified" stated, "No notifications found."

A nurses note dated 6/1/24 stated, "Residents [relative]calls nurse to give update. [Relative] inquires why [he/she] did not receive a call after the 2nd fall ..." Further review of the medical record lacked evidence of the resident representative or the physician being notified of

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F 580	Continued From page 3 the unwitnessed fall. 2. Review of Resident #4's medical record indicated he/she had unwitnessed falls on 5/7/24 and 525/24. A nurses note dated 5/7/24 states, "Resident had an unwitnessed fall. Resident states that [he/she] "got up to the bedside commode and legs became weak " and [he/she] slid sideways to the floor. Resident states [he/she] did not hit [his/her] head. VS stable ... Called legal guardian" The medical record lacked evidence of the physician being notified of the 5/7/24 fall. A nurses note dated 5/25/24 states, "Resident had unwitnessed fall at 0500. Nurse was in hallway and heard a "thump" followed by "ouch". Nurse found resident on floor of room on [his/her] lying in prone position. Nurse asked resident what happened, resident stated "I got up to use the bathroom and fell over". Resident denies any pain. VSS (Vitals signs stable), neuro intact. Will continue to monitor." Further review of the medical record lacked evidence of the Legal Guardian being notified of the unwitnessed fall. On 6/7/24 at approx. 2:50 p.m., during an interview, the above concerns of the facilities failure to notify the resident representative and/or physician regarding the falls were discussed with the RN Consultant.	F 580		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684	- See attached	

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F 684	Continued From page 4 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to adequately assess, monitor and/or complete neurological assessments after unwitnessed falls for 4 of 5 resident reviewed for falls (#1, #3, #4 and #5). Findings: Coastal Manors Falls Policy and Procedure, revised 6/24 states under, "Types of Falls ... An unwitnessed fall is one in which a resident has sustained a fall in which no clinical staff directly witnessed the incident. Regardless if a resident is alert and oriented and a good historian, if no clinical staff member was there to witness the incident, it shall be classified as an unwitnessed fall", and "Unwitnessed Fall with or without head injury: any type of unwitnessed fall shall be treated under the "Head Injury Protocol"". Coastal Manors Head injury protocol, revised 9/23 states, "The nursing staff will do a full set of vital signs as well as neurological testing as follows; every 15 minutes for 1 hr., then every 1 hr. x 4 hrs. then every 4 hrs. x 24 hrs.; once a shift up to 72 hrs. The neurological assessment that should be done includes: check for changes from premorbid status and level of consciousness, pupil responses, vomiting, blood pressure, bradycardia, changes in coordination/gate and speech, hand grasp, and hyperthermia.	F 684		

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F 684	Continued From page 5 Review of the facilities Neurological Assessment Flow Sheet instructs nursing to document "Observations (i.e. seizures, headaches, vomiting, paralysis)" 1. On 6/3/24 a review of Resident #1's medical record revealed the resident was admitted to the facility on 5/16/23 with diagnoses of repeated falls, congestive heart failure and chronic atrial fibrillation requiring the use of Rivaroxaban, a blood thinner, daily. A nurses note dated 5/31/24 at 5:29 p.m., stated, "Resident found lying on [his/her] side, in [his/her] room, still hanging onto [his/her] walker. Resident was assessed for injury, none noted. Denied hitting [his/her] head and denies pain at this time. ROM WNL (range of motion within normal limits) for all extremities. [He/she] was assisted to [his/her] recliner where VS's (vital signs) and neuro check was attempted but declined. POA (Power of Attorney), was notified of fall. Copy of fall report left for provider." A nurses note dated 6/1/24 at 2:20 a.m., stated, "Unwitnessed fall on 5/31 at 17:06 [5:06 p.m.] reported at shift change 23:00 [11:00 p.m.]. Resident requested Tylenol for 5/10 head pain at 23:20 [11:20 p.m.]. At 00:00 [12:00 a.m.] resident requested to lay down, and was assisted x 2 to bed. At 01:00 [1:00 a.m.] resident told nurse "I feel bad" resident denied feeling nauseated, nursed assessed resident and noted pin-point pupils, grip strength equal bilaterally, skin clammy and diaphoretic. Resident was able to answer questions appropriately and nurse observed mentation at baseline for resident. VS T 98.1, BP (blood pressure) 144/76, HR (heart rate) 84, 20 R	F 684		

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F 684	Continued From page 6 (respirations), SPO2 (oxygen saturation) 95% on RA (room air). Nurse reviewed medication list and found prescribed blood thinner. Nurse notified on-call provider at 01:15, verbal order to send resident out to r/o brain bleed. 01:20 [1:20 a.m.] nurse called 911. 01:50 [1:50 a.m.] resident transported via ambulance to ED. 02:15 [2:15 a.m.] POA notified." A nurses note dated 6/1/2024 at 5:13 a.m. stated, "Resident's [relative]calls nurse to give update. [Relative] inquires why she did not receive a call after the 2nd fall ... [Relative] updates nurse that resident will stay at [hosptial] where [he/she] is being kept comfortable until [he/she] passes." A nurses note dated 6/1/2024 at 11:28 a.m., stated, "Late note: Last evening at approximately 10 pm a loud bang was heard from resident's room. Was found on [his/her] back still holding on to [his/her] walker with [his/her] head against the door ... This writer was called and went to the room immediately. Assessed for injuries: Full ROM all extremities, alert, denied pain/discomfort. Was noted to have taken off [his/her] slipper socks, was bare foot at time of fall. Was assisted up into Broda chair by this writer and 3 CNA's, and brought to nurses station to monitor. Neuro checks in place from previous fall ... Durning report at change of shift [resident] stated that [he/she] had a HA (headache). Was offered Tylenol which was given within a few minutes by 11-7 charge nurse." The unwitnessed fall incident report for 5/31/24 at 10:29 p.m. stated, "Resident found on [his/her] back on floor, up against door, still hanging on to [his/her] walker". "Resident did not describe just asking "help me up" ... resident was assessed,	F 684		

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F 684	Continued From page 7 alert, full ROM of all extremities and denied pain. Resident was assisted by this writer and 3 CNA's into a broda chair and brought to the nurses station for monitoring as neuro checks were in place from previous fall." Review of the neurological assessment flow sheet indicated it had been started after the first fall on 5/31/24 at 4:30 p.m. The last neurological assessment prior to the second fall was completed at 9:15 p.m., with normal neurological results. The next neurological assessment was scheduled for 4 hours later, at 1:15 a.m. This assessment indicated abnormal pupil response, inappropriate pain response, increased blood pressure and observation of headache worsening. The medical record lacked evidence of a new neurological assessment initiated after the second unwitnessed fall, which would have had Resident #1 being monitored every 15 mins for 1 hour then every 1 hr. x 4 hrs then every 4 hours. On 6/3/24 at 11:14 a.m., during an interview, the Registered Nurse (RN#1), who was in charge during both unwitnessed falls confirmed she should have stopped the current neurological assessment and initiated a new one after the second fall which would have monitored the resident more frequently. In addition, RN#1 confirmed that during the changes of shift, while she was giving report to the oncoming RN#2, she confirmed resident #1 requested Tylenol for a headache. On 6/3/24 at approx. 2:50 p.m., during an interview with the RN consultant, the surveyor discussed the above concerns. The RN consultant confirmed that RN#1 failed to	F 684		

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F 684	Continued From page 8 appropriately assess and monitor resident #1 and should have initiated a new neurological assessment after the second fall but could not speak to if that would have made a difference or if there would have been a noticed change. On 6/13/24 at 11:20 a.m., during an interview, the RN#2 stated upon shift change approx. 11:00 p.m., Resident #1 complained of a headache and received Tylenol at that time. RN #2 stated she was aware that Resident #1 had 2 falls prior to her shift however, she was unaware that there was a possible head injury. It wasn't until approx. 1;00 a.m., when resident #1 reported to staff, "I feel bad" and was noted to have a worsening headache, pinpoint pupils, skin clammy and diaphoretic. It was at that time when RN #2 learned that he/she had a possible head injury. The RN completed a neurological assessment, reviewed medications and noted he/she was prescribed a blood thinner. The physician was notified and resident #1 was then sent to the hospital for further evaluation. 2. Review of Resident #3's medical record revealed he/she had unwitnessed falls on 3/20/24, 4/4/24, 4/14/24, 4/18/24 and 5/28/24. A nurses note date 3/20/24 states, "Resident fell out of wheelchair onto floor ... Fall protocol initiated ..." A review of the neurological assessment flow sheet initiated on 3/20/24 lacks evidence of the neurological assessment being completed on 3/21/24 at 12pm and 4pm, on 3/22/24 and 3/23/24 the 11pm-7am shift and on 3/24/24 all 3 shifts. A nurses note dated 4/4/24 states, "Resident was found by RN on the floor in the back dining room	F 684		

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F 684	Continued From page 9 ...Resident denied hitting his head ... Fall protocol initiated..." A review of the neurological assessment flow sheet initiated on 4/4/24 lacks evidence of the neurological assessment being completed on 4/7/24 and 4/8/24 for all 3 shifts. A nurses note dated 4/14/24 states, "Resident had a fall from wheelchair in the hall while trying to get himself up after hearing a thump staff found resident lying on [his/her] right side ... neuro's initiated." A review of the neurological assessment flow sheet initiated on 4/14/24 lacks evidence of the neurological assessment being completed on 4/14/24 the 11pm-7am shift and on 4/16/24 for all 3 shifts. A nurses note dated 4/18/24 states, "Resident attempted to self transfer back to wheelchair and was found on the ground. Resident denied hitting head ...Fall protocol initiated." A review of the neurological assessment flow sheet initiated on 4/18/24 lacks evidence of the neurological assessment being completed on 4/18/24 for 3:45pm, 4pm and 11pm, on 4/19/24 the 11am, and on 4/20/24 the 11pm-7am shift. A nurses note dated 5/28/24 at 7:51 p.m., states, "CNA alerted this RN at 1900 that resident had an unwitnessed fall in the front dining room... Will monitor resident per the facilities unwitnessed fall protocol..." A review of the neurological assessment flow sheet initiated on 5/28/24 lacks evidence of the neurological assessment being completed on 5/30/24 on the 11pm-7am shift. 3. Review of resident #4's medical record revealed he/she had unwitnessed falls on 5/7/24 and 5/25/24.	F 684		

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F 684	Continued From page 10 A nurses note dated 5/7/24 states "Resident had an unwitnessed fall ... Resident states [he/she] did not hit [his/her] head ...Will continue to monitor." Review of the medical record and the facility incidents lack evidence of an incident report and neurological assessment being completed after the 5/7/24 fall. A nurses note dated 5/25/24 states, "Resident had unwitnessed fall at 0500. Nurse was in hallway and heard a "thump" followed by "ouch". Nurse found resident on floor of room ...Will continue to monitor." Review of the neurological assessment flow sheet initiated on 5/25/24 at 5:00 a.m., lacks evidence of the neurological assessments being completed on 5/26/24 for all 3 shifts (11pm-7am, 7am-3pm and 3pm-11pm) and on 5/27/24 for the 3pm-11pm and 11pm-7am shift. 4. Review of Resident #5's medical record revealed he/she had an unwitnessed fall on 5/22/24. A nurses note dated 5/22/24 states, "Resident was observed sitting on the floor. Resident denied hitting head/denied pain ... Fall protocol initiated." Review of the medical record lack evidence of a neurological assessment being completed after the 5/22/24 fall. On 6/3/24 at 2:03 p.m., during an interview, the RN consultant confirmed residents #3, #4 and #5 should have had completed neurological assesments in their entiryity after each unwitnessed fall.	F 684		

COASTAL MANOR, CORP.

20 West Main Street • Yarmouth, Maine 04096 • (207) 846-5013 • FAX (207) 846-2252

Coastal Manor
Plan of Corrections
Complaints; #ME00047470, #ME00047648 & #ME00047637
Revised: June 25, 2024

F580

On June 3, 2024 DLC conducted a survey for above listed complaints; Coastal Manor was found to not be in compliance with F580 Notify of Changes. More specifically, in some instances, Coastal Manor failed to notify family and/or physicians of falls. It is Coastal Manor's policy that when a resident has a change of status, fall, decline, etc; that the family/POA/Guardian and physician would be notified immediately. Coastal Manor held a Charge Nurse Staff Meeting on 6/11/24 that reviewed the Fall Policy and Procedures and Change in Resident's Condition or Status Policy. All nurses that were in attendance, signed in and DON will follow-up and educated those whom could not attend. Record of this will be kept with DON. New order sets have been entered into PCC for nurses to initiate when a resident has a fall; the order set includes the fall protocol for that type of fall and a reminder to nurses to notify POA/Guardian and Physician. A review of the Risk Management Incident reporting system has also been reviewed with the nurses. All nurses will sign off that they understand the risk management system and new order sets.

This deficiency in practice has the potential to affect all residents whom have a fall. To monitor and ensure this deficiency does not continue to happen; DON will monitor risk management incidents that are entered and sign off in a timely manner. A weekly audit of falls will be done. Audit to include but not limited to ensuring Risk management incident was created, nurses note was written, POA /Guardian and physician were notified, V/S and neuros were initiated and completed per policy, and that PCC orders were entered. When a deficiency is found in this process, the nurse on duty during the fall will be educated. A copy of these audits will be kept with DON and reviewed at next QAPI meeting, July 11, 2024.

This deficiency to be corrected no later than July 15, 2024

F684

On June 3, 2024 DLC conducted a survey for above listed complaints; Coastal Manor was found to not be in compliance with F684; Quality of Care. More specifically, for falls reviewed for resident #3, #4 and #5 did not have neurological assessments completed in their entirety. Coastal Manor held a Charge Nurse Staff Meeting on 6/11/24 that reviewed the Fall Policy and Procedures and Change in Resident's Condition or Status Policy. All nurses that were in attendance, signed in and DON will follow-up and educated those

whom could not attend. Record of this will be kept with DON. New order sets have been entered into PCC for nurses to initiate when a resident has a fall; the order set includes the fall protocol for that type of fall (timing of neurological assessments). A review of the Risk Management Incident reporting system has also been reviewed with the nurses. All nurses will sign off that they understand the risk management system and new order sets. The neurological assessment flow sheet has been updated to also include a copy of the Head Injury Protocol on the back.

This deficiency in practice has the potential to affect all residents whom have a fall. To monitor and ensure this deficiency does not continue to happen; DON will monitor risk management incidents that are entered and sign off in a timely manner. A weekly audit of falls will be done. Audit to include but not limited to ensuring Risk management incident was created, nurses note was written, POA /Guardian and physician were notified, V/S and neuros were initiated and completed per policy, and that PCC orders were entered. When a deficiency is found in this process, the nurse on duty during the fall will be educated. A copy of these audits will be kept with DON and reviewed at next QAPI meeting, July 11, 2024. Nurses will also demonstrate a complete neurological assessment with the DON or RN consultant; record of successful demonstration will be signed off by DON or RN Consultant.

This deficiency to be corrected no later than July 15, 2024

Cheryl Farley, RN - Acting DON