

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/10/2025
NAME OF PROVIDER OR SUPPLIER  Pinnacle Health & Rehab Canton		STREET ADDRESS, CITY, STATE, ZIP CODE  26 Pleasant St Canton, ME 04221	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on record review and interview, the facility failed to ensure a residents call bell was within reach for 1 of 1 resident (Resident #1).</p> <p>Findings:</p> <p>Review of Resident #1 progress note dated 5/27/25 at 10:55 a.m. indicated that he/she sustained an unwitnessed fall, he/she was found in front of his/her wheelchair next to his/her bed.</p> <p>Review of the post fall assessment completed 5/27/25 showed the resident did not have his/her call bell within reach at the time of the fall.</p> <p>Review of Resident #1 care plan under the focus states he/she is at risk for falls. Further review shows that under Interventions/Tasks section of the care plan staff should Be sure (his/her) call light is within reach and encourage the resident to use it for assistance as needed</p> <p>On 6/10/25 at 11:00 a.m., the above information was discussed with the Director of Nursing.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.  Deficiency Text Not Available