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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coastal Manor	20 West Main Street Yarmouth, ME 04096

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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 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 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 [NAME], 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 the unwitnessed fall. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37648 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. 1. Review of Resident #1's medical record revealed he/she had 2 unwitnessed falls on 5/31/24. 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 .VS's (vital signs) and neuro check was attempted but declined. 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 . Neuro checks 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 medical record lacked evidence of a new neurological assessment initiated after the second unwitnessed fall. 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. 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 appropriately assess and monitor resident #1 and should have initiated a new neurological assessment after the second fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 .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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.