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	12/04/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to ensure the dignity of all residents by allowing an uncovered urine filled catheter bag to be seen by passersby for 3 of 3 residents with urinary catheters. (Residents #1, #8 and #9) Findigs: 1. On 12/1/25 at 9:15 a.m. during an initial observation, Resident #1 and #8 both had uncovered foley catheter bags containing urine and visible from the hallway. At 9:30 a.m., both the surveyor and the charge nurse observed the above. At this time, the above was confirmed with the Director of Nursing. 2. On 12/1/25 at 10:13 a.m., observation of Resident #9 lying in a low bed with a foley catheter bag resting on the floor. The catheter bag had dark yellow urine and visible from the hallway. Next to the foley catheter bag was a blue privacy bag hanging. Review of the medical record revealed catheter care plan dated 6/6/25 with the interventions of Position catheter bag and tubing below the level of the bladder and away from entrance room door. In addition, there was a provider's order dated 10/2/25 which instructed nursing to Foley Cath Bag to be covered at all times to promote dignity. On 12/1/25 at 1:46 p.m., during an interview, the above was discussed with the Director of Nursing.

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

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	12/04/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment for 2 of 2 floors. (first and second floor) for 3 of 4 days of survey.Findings: 1. On 12/1/25 at 10:01 a.m., and on 12/3/25 at 9:15 a.m., observation of the shared bathroom for room [ROOM NUMBER] and 114 had a bed pan stored on the floor under the sink and the commode had a brown substance around the seam of the seat. On 12/3/25 at 9:21 a.m., both the Director of Nursing and the surveyor observed the bed pan on bathroom floor and the brown substance on the commode seam of the seat. 2. On 12/1/25 at 9:19 a.m. a surveyor observed the second-floor hallway baseboards with scratches and exposed metal. 3. On 12/2/25 at 10:12 a.m. a surveyor observed exposed wood on inside of door frame in resident room [ROOM NUMBER], creating an uncleanable surface. 4. On 12/3/25 at 8:00 a.m. a surveyor observed exposed wood on a windowsill in resident room [ROOM NUMBER], creating an uncleanable surface. On 12/4/25 at 9:18 a.m. a surveyor confirmed with the Director of Nursing the maintenance concerns stated above.

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	12/04/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to ensure medications were administered safely, accurately, and in accordance with provider orders and professional standards of practice for 1 of 3 medication administration observations reviewed. (Resident #14 & #33) On 12/2/25, at approximately 8:15 a.m., during a medication administration observation on the second floor, the surveyor observed the Infection Preventionist (IP) open the top drawer of the medication cart and remove a small plastic bag containing a syringe labeled Omeprazole for Resident #14. When the surveyor asked where the original medication bottle was and when the medication had been prepared, the IP stated he had prepared the Omeprazole syringe prior to starting his medication pass that morning. The IP stated the medication bottle was in the refrigerator in the first floor nurses station. The surveyor inquired whether it was normal practice to prepare medications in advance and the IP stated it was not and confirmed that doing so was against the facilities policy and procedure. Resident #33 was admitted to the facility on [DATE] with a diagnosis of Hypertension. Review of Resident #33's physicians orders dated 10/24/25 instructs staff to administer the (antihypertensive medication) Lisinopril 10 milligrams (mg) by mouth daily hold for systolic blood pressure below 100. On 12/2/25, at approximately 8:30 a.m., during a medication administration observation, the surveyor observed the IP prepare Lisinopril 10 mgs for Resident #33. As the IP proceeded to leave the medication cart to administer the medication to Resident #33, the surveyor intervened and inquired about the resident's blood pressure. The IP confirmed that he had overlooked the order and had not obtained the residents blood pressure that morning as required by the order.Review of the facility's Medication Administration Policy revised 12/2025: Policy Statement: It is the policy of this facility to ensure medications are administered safely, accurately, and in accordance with regulations, provider orders and standards of practice. 6.2 Preparation: Prepare meds for one resident at a time. Do not pre-pour medications. Verify provider orders from the Medication Administration Record. (MAR)In an interview on 12/2/25 at 9:30 a.m., the surveyor discussed the above findings with the Administrator. The Administrator acknowledged that the blood pressure should have been obtained prior to administering Resident #14's (antihypertensive medication) Lisinopril and that medications should not be prepared in advance.

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	12/04/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews the facility failed to ensure that the resident's environment was free of accident hazards relating to chemicals being properly secured for 3 of 3 observations for 3 of 4 days of survey.Findings:On 12/1/25 at 9:31 a.m., observation of Resident #24 to have a bottle of OxiClean and a bottle of Betadine on his/her dresser. In an interview Resident #24 stated he/she uses the OxiClean to spray the stains on his /her clothes and the Betadine is used to clean his/her hands.On 12/3/25 at 7:39 a.m., observation of both the OxiClean and Betadine stored on the resident's dresser. On 12/3/25 at 9:21 a.m., the surveyor and the Director the Nursing observed the above chemicals in room and discussed the chemical's not being properly stored.On 12/4/25 at 7:52 a.m., an additional observation of the OxiClean and Betadine on the residents dresser.On 12/4/25 at 11:13 a.m., during an interview with both the Director of Nursing and the Assistant Administrator, the surveyor discussed the improperly stored chemicals observed again after discussing it with the Director of Nursing the day prior.

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	12/04/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, interviews and facility policy, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 3 residents reviewed for respiratory care. (Resident #38 and #20)Findings:1. On 12/1/25 at 10:02 a.m., Resident #38 was observed receiving oxygen through a nasal cannula, the concentrator filter was coated with a thick layer of dust. Review of Resident #38's medical records contained and order for weekly nasal cannula tubing change but lacked evidence of the filter being cleaned regularly.On 12/1/25 at 1:46 p.m., the above was discussed with the Director of nursing. 2. On 12/1/25 at 12:30 p.m., and on 12/3/25 at 7:39 a.m., observation of Resident #20 receiving oxygen via a nasal cannula. The oxygen concentrator had a layer of dirt and debris built up over the top, by the handle and along area where the oxygen tubing attaches to the machine. In addition, there was an oxygen extension tubing that was wrapped up and stored on the back of the concentrator with Velcro.On 12/3/25 at 9:00 a.m., the above was discussed during an interview with the Director of Nursing.On 12/3/25 at 11:03 a.m., during an additional interview, the Director of Nursing stated the facility didn't have a process for storing nasal cannulas and/or tubing when not in use and they would usually roll it up and put it under the handle but he can request bags to ensure a sanitary environment for storing of tubing while not in use. On 12/4/25 at 7:52 a.m., an additional observation of Resident #20's oxygen concentrator is cleaned however the oxygen extension tubing is still hanging from it with velcro- no bag.Facility policy Oxygen Concentrator and Oxygen tubing policy, date reviewed 12/1/25 states, Under Tubing & Cannula Maintenance, Oxygen tubing: replace every 30 days and PRN. Filters: Clean/replace per manufacturer recommendations. Under Infection Control: Clean concentrator exterior regularly. Under Cleaning & Maintenance: wipe exterior with approved disinfectant.

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	12/04/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview, record review and policy review, the facility failed to ensure temperature documentation was consistently completed for the medication room refrigerator used to store insulin, vaccines, and other refrigerated medications for 1 of 1 medication room refrigerator reviewed. Review of the facilities Refrigerator Temperature Log Summary (June - December 2025) identified days where required AM and PM temperature checks were not recorded. June 2025Temperatures were not documented on 18 shifts total (10 AM shifts and 8 PM shifts). August 2025Temperatures were not documented on 17 shifts total (9 AM shifts and 8 PM shifts). September 2025Temperatures were not documented on 21 shifts total (9 AM shifts and 12 PM shifts). October 2025Temperatures were not documented on 9 shifts total (4 AM shifts and 5 PM shifts). Review of the facilities medication storage policy indicates that refrigerated medications, including insulin, vaccines, and other temperature - sensitive medications, must be stored at 36 F- 46 F. Nursing staff are responsible for monitoring refrigerator temperatures, maintaining organized storage areas, and reporting any temperature excursions immediately and temperatures must be documented daily. On 12/3/25 at 2:00 p.m., during an interview with the Director of Nursing (DON), the DON acknowledged that the required AM and PM temperature checks for the medication room refrigerator had not been consistently completed.

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	12/04/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 1 resident reviewed for activities of daily living care. (Resident #32)Findings:Review of Resident #32's Certified Nurses Aide (CNA) documentation revealed the following lack of documentation/omissions for ADL's.October 2025: Bed mobility, toilet use, transferring, oral hygiene, Personal hygiene, Shower/Bathe Self each had 25 out of 93 shifts where there was no completed documentation. Bladder and bladder elimination had 21 out of 93 shifts missing documentation.November 2025: Bed mobility, Transferring, Eating, Oral hygiene and Shower/bathe each had 28 out of 90 shifts where there was no completed documentation. Toilet use and Personal hygiene had 29 out of 90 shifts and bladder elimination had 27 out of 90 shifts missing documentation.On 12/3/25 at 12:29 p.m., the Director of Nursing and the MDS Coordinator reviewed the documentation with the surveyor and confirmed the above, stating the CNA's should be documenting every shift on ADL care being provided.

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	12/04/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observations, interviews and record review, the facility failed to ensure that a resident's choice in meal preferences was followed for 2 of 3 sampled residents (resident #1 and #29). Finding: 1. On 12/1/25 at 12:00 p.m. during an interview, Resident #29 stated he/she has on their food slip that he/she do not want eggs or hot cereal, but the facility keeps giving him/her these items on the food tray. On 12/3/25 at 8:06 a.m. a surveyor observed Resident #29 being served hot oatmeal for breakfast. The food slip on his/her tray stated his/her dislikes are eggs and hot cereal. On 12/3/25 at 12:20 p.m. a surveyor confirmed with the Food Service Director that Resident #29's choices were not being met. 2. On 12/1/25 at 9:10 a.m., during an interview, Resident #1 stated that he/she had never been visited by the Kitchen staff and has not been asked about likes and dislikes. Review of the medical record stated Resident #1 was admitted in early October 2025. On 12/2/25 at 9:00 a.m. during an interview with the Food Service Manager, she stated that Resident #1 had not been in the facility very long and the staff had not met with him/her. At this time, the surveyor discussed the he/she had been at the facility for over a month. The food Service Manager stated, yes that is too long and she will go and see him/her. On 12/4/25 at 9:30 a.m., in an additional interview, Resident #1 confirmed he/she had not been visited by kitchen staff and stated that he/she would like more fresh fruit, vegetables and rice, they never have rice. On 12/4/25 at 9:15a.m. the Food Service Manager was asked if the Dietician was the only person that can interview a resident and obtain their likes and dislikes and she stated that anyone from the Kitchen can do that. She was informed that even after a conversation with her on Wednesday, no one has been to see the resident. She confirmed that she would see him/her today.

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	12/04/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 4 sampled residents reviewed for new admissions (Resident #38).Findings:Resident #38 was admitted on [DATE] with diagnosis of Atherosclerosis with gangrene to bilateral feet. Review of a nurse's skin check on 11/21/25 stated necrotic toes to both feet-rash to back and chest, gangrene to bilateral feet. The providers history and physical dated 11/21/25 stated under EXTREMITIES- bilateral lower extremities anterior and posterior tibia with multiple wounds in various stages of healing.As of 12/1/25 Resident #38's medical record lacked evidence of a baseline care plan that included the instructions necessary to properly care for Resident #38's, in the area above.On 12/1/25 at 1:46 p.m., the above was discussed with the Director of Nursing.

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	12/04/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that a residents' care plan was developed within seven days after each comprehensive assessment for 1 of 4 residents reviewed for activities (resident #33). Finding:Resident #33's medical record, had an Minimum Data Set (MDS) dated [DATE], with the interdisciplinary team/care plan meeting held on 10/20/25, 7 days before the completion of this comprehensive assessment. the MDS dated [DATE], had the interdisciplinary team/care plan meeting held on 7/27/25, 1 day before the completion of the comprehensive assessment.On 12/3/25 at 2:05 p.m. during an interview, the Licensed Social Worker confirmed that the two care plan meetings were held before the comprehensive assessments were completed.

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	12/04/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews and record review the facility failed to provide residents a whirlpool/shower/shampoo as directed by the resident's shower schedule for 1 of 1 resident reviewed for Activities of Daily Living (ADL's)(Resident #32).Finding:On 12/1/25 at 9:12 a.m., during an interview and observation of Resident #32, the surveyor observed resident with oily/greasy hair. When asked if he/she has a shower weekly he/she stated, not always, and once in a while he/she will refuse a shower but hasn't recently.On 12/1/25 during a record review for resident #32 the most recent MDS 3.0, showed the resident is dependent on one staff for showers and needs partial moderate assist of one staff for personal hygiene.Review of the shower/whirlpool list updated on 11/30/25 indicates Resident #32 is to receive a shower on Wednesday evenings.Review of Resident #32's Certified Nurses Aid (CNA) documentation for whirlpools/showers indicated that he/she received no showers for the month of November, when resident should have had 4 showers in that time frame. On 12/3/25 at 12:29 p.m., Director of Nursing and the MDS Coordinator reviewed the documentation with the surveyor and confirmed the documentation lacks evidence of a shower given to resident #32 for the month of November.

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	12/04/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on care plan reviews, observations and interviews, the facility failed to provide residents with a continuous resident centered activities program for 1 of 4 residents reviewed for activity participation. (Resident #1). Finding: On 12/1/25 at 9:44 a.m. during a interview, Resident #1 stated It would be nice to have something to keep my mind busy, would be nice. I have nothing. It would be nice to have a fucking paper once in a while. Review of the Resident's Care Plan for Activities initiated on 10/13/25, states the following: resident has little or no activity involvement r/t Disinterest, Physical Limitations. Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary. Modify daily schedule, treatment plan PRN (as necessary) to accommodate activity participation as requested by the resident and resident needs assistance/escort to activity functions. The care plans lacks interventions to include mental stimulation/activities and/or mental exercises. On 12/2/25 at 8:30 a.m., during an interview, the Activities Director stated that she attempts to have at least 2 group activities a day. When asked about residents that do not participate in the group activities (Resident #1) she stated, she has given him/her 2 magazines but could have gotten more and will try and get some word search material and other such items to him/her.

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	12/04/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review the facility failed to follow a physician order relating to diabetes management for 1 of 1 resident reviewed for insulin. (Resident #38)Findings:Resident #38's medical record reveals he/she was admitted in late November 2025 with a diagnosis of Diabetes Mellitus with Providers orders dated 11/20/25 instructing nursing to administer Lispro insulin 100 units/milliliter, Inject as per sliding scale: if 71 - 199 = 0 no intervention; 200 - 249 = 2 units; 250 - 299 = 4 units; 300 - 349 = 5 units; 350 - 399 = 8 units; 400 - 449 = 10 units, subcutaneously after meals for diabetes. Review Resident #38's medication administration record lacked evidence of a blood glucose monitoring for the evening (after dinner) of 11/24/25 and lacks evidence of Lispro insulin 2 units being administered on the evening of 11/26/25 when the residents blood glucose was 208.On 12/3/25 at 9:21 a.m., the above was discussed with the Director of Nursing.

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	12/04/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on interviews, observation, record review and facility policy review, the facility failed to provide appropriate treatment and services to prevent the risk of complications related to enteral feeding for 1 of 1 resident reviewed for enteral feeding. (Resident #14)Record review of Resident #14's physicians orders dated 10/13/25 required staff to check for Gastric tube (G-Tube) placement and residual prior to administering medication and flush the G tube with 60 cc's of water following medication administration. The physicians' orders also indicated that crushed medications may be administered together via the G-tube. Care plan review for Resident #14 indicated the resident will have no complications related to the feeding tube. The care plan documented that the resident requires total assistance from nursing staff for G-tube feedings and water flushes, including verifying G-tube placement and assessing gastric contents/residuals per facility policy/protocol and record. A review of the facility's policy, Administering Medications Through an Enteral Tube, Steps in the Procedure, page 2, step 19, indicates Check gastric residual volume (GRV) to assess for tolerance of enteral feeding. On 12/2/25 at approximately 8:30 a.m., during a medication administration observation, the surveyor observed the Infection Preventionist (IP) prepare and administer medications through Resident #14's G-tube without verifying G-tube placement or assessing gastric residuals prior to administration. When interviewed immediately following the observation. The IP acknowledged that he should have assessed G-tube placement or gastric residuals prior to administering the medications. This finding was confirmed with the Administrator on 12/2/25 at 9:30 a.m.

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	12/04/2025

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to assure that adaptive cups were available for 1 of 1 resident as directed by their care plan and physician orders (Resident #29).Findings:On 12/3/25 at 8:06 a.m. a surveyor observed a tray delivered to Resident #29's room with no sippy cup on their tray, and the resident stated his/her son had [NAME] in some sippy cups, but they have gone missing. On 12/3/25 at 11:03 a.m. the surveyor reviewed a doctor's order dated 11/21/25 for Resident #29 that states, Level 4 Puree texture, Honey consistency, for aspiration precautions, eat with strict supervision/assist a sippy cup, watch for left side pocketing.On 12/3/25 at 12:03 p.m. a surveyor reviewed Resident #29's care plan with a focus of nutritional concerns dated 11/14/25 with an intervention of use sippy cup.On 12/3/25 at approximately 12:20 p.m. a surveyor interviewed the Food Service Director regarding Resident #29's missing sippy cup. The Food Service Director stated, there is no order, but was aware of the missing sippy cups.On 12/3/25 at approximately 12:30 p.m. a surveyor confirmed with the Food Service Director the findings above and that there were physician orders in place for the use of a sippy cup .

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	12/04/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interview, the facility failed to serve and store food in a sanitary manner on 2 of 4 survey days. (12/1/25 and 12/2/25) Findings:On 12/1/25 at 8:15 p.m., during the initial visit to the Kitchen, with the Manager, the following was observed: the refrigerator contained a container of applesauce, a sandwich and a plate of eggs were unlabeled and undated. At this time, the above was confirmed with the Kitchen Manager.On 12/1/25 at approximately 12:30 p.m., two surveyors observed dietary staff with hair nets on but did not encompass the entirety of their hair. This was confirmed with the Dietary Director at that time. On 12/2/25 at 10:00 a.m. during an additional observation of the Kitchen, a moderate amount of dust was on a wall mounted fan. The Dietary manager stated that she had just dusted it yesterday. There was a line above the stove and the vents had a light to moderate amount of dirt and grease build up. The emergency food supply in the basement, contained the following: 6 #10 cans of Beef stew3 Large Cans of Tomato Soup1 Small can of Tomato Soup2 Large cans of Cream of Mushroom Soup1 #10 can of beans1 #10 can of Kidney Beans1 #10 can of Beets1 12oz box of pasta1 #10 can of stewed tomatoes At this time the surveyor questioned if the amount of emergency food is sufficient to feed 39 residents for 3 days. The [NAME] confirmed stating I think I need to bring more things down.

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	12/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an Infection Control Program designed to help prevent the development and spread of infection relating to hand hygiene during 1 of 3 medication passes observed, linen handling and Enhanced Barrier Precautions (EBP) for 1 of 1 resident reviewed for wound management (Resident #38) and 1 of 4 residents reviewed for indwelling foley catheter (Resident #9).Findings: 1. On 12/2/25 at 8:15 a.m., during medication administration observations, the Infection Preventionist (IP) prepared medications for Resident #14 and left the medication cart without sanitizing his hands. The IP proceeded to enter Resident #14's room and stopped to don a gown and gloves. The surveyor inquired whether the facility utilizes EBP signs for residents who require them? The IP stated that they do. However, no EBP sign was posted on Resident #14's door at the time of observation. The IP administered Resident #14's medications via the gastrostomy tube. Upon leaving the residents' room the IP doffed the gown and gloves and proceeded to exit the room. Immediately following the observation, the surveyor inquired about the hand hygiene practices observed. The IP acknowledged that he did not perform hand hygiene before entering or after exiting Resident #14's room and confirmed that he should have sanitized or washed his hands. He further acknowledged that an EBP sign should have been posted on the resident's door. Review of the facilities Infection Control Policy under General Guidelines #3 states: Employees must wash their hands for 10 - 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after direct contact with residents. After removing gloves. On 12/2/25 at 9:00 a.m., the surveyor discussed the above findings with the Administrator. 2. On 12/3/25 at 8:34 a.m. a surveyor observed Laundry Staff #1 transporting clean linens that were not covered. At this time, the Laundry Staff confirmed the clean linens should be covered during transportation. 3. On 12/1/25 at 10:02 a.m., during an interview, Resident #38 stated he/she has dry gangrene to both feet due to diabetes. At this time, the surveyor noted there was no EBP posted and/or personal protective equipment available at the resident's room. Review of Resident #38's medical record revealed he/she was admitted on [DATE] with diagnosis of Atherosclerosis with gangrene to bilateral feet. A nurse's skin check on 11/21/25 stated necrotic toes to both feet-rash to back and chest, gangrene to bilateral feet. Review of the providers note date 11/21/25 stated, Resident #38 has multiple wounds in various stages of healing to his/her bilateral feet with strong, pungent odor to the feet, multiple necrotic lesions. thick brown, exudative, wet and dry material with pet hair embedded in the material, exquisitely tender. On 12/1/25 at 1:46 p.m., during an interview, the Director of Nursing confirmed Resident #38 should have EBP posted with appropriate PPE available at the door entrance. 4. On 12/1/25 at 10:13 a.m., observation of Resident #9 lying in a low bed with a foley catheter bag resting on the floor. Next to the foley catheter bag was a blue privacy bag hanging. At this time, the surveyor noted there was no EBP posted and/or personal protective equipment available at the resident's room. Review of the medical record revealed catheter care plan dated 9/24/25 with the (continued on next page)

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	12/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions of Enhanced Barrier Precautions. On 12/1/25 at 1:46 p.m., during an interview, the above, infection control concern relating to the foley catheter bag on the floor and the lack of EBP were discussed with the Director of Nursing. He confirmed the catheter bag should be in the privacy bag not on the floor. The facilities Enhanced Barrier Policy last reviewed on 8/30/25 states under Initiation of Enhanced Barrier Precautions.Nursing staff initiates EBP for residents with any of the following: Wounds or indwelling medical devices, even id the resident is not known to be infected or colonized with a MDRO's (Multidrug Resistant Organism).

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	12/04/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, review of the facility's Pneumococcal policy, and interviews the facility failed to implement their Pneumococcal policy for 1 of 5 sampled residents (resident #31).Finding:On 12/3/25 at 11:06 a.m. a surveyor reviewed Resident #31's medical records which contained a signed consent to receive the Pneumococcal vaccine dated 7/18/25. The medical records lacked evidence of Resident#31 receiving the Pneumococcal Vaccine.The facilities Pneumococcal Vaccine policy, sub title Policy Interpretation and Implementation section 1 states, Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. On 12/4/25 at 9:50 a.m. a surveyor confirmed these findings with the Infection Preventionist and Director of Nursing.