STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 1/28/25, an on-site visit was conducted at Harbor Hill Center for the purpose of completing the revisit for their annual Long Term Care Survey Process for Federal Recertification and complaint investigations of 12/4/24. It was determined that Harbor Hill Center is not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}	Harbor Hill Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with State and Federal regulations.	
{F 584} SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	{F 584}	The gap between the toilet base and the floor has been cleaned and resealed in rooms 101, 102, and 103. The caulking around the base of the shower in the Fort Point shower room was removed, cleaned, and resealed. The commode bucket rim was removed from room 105. Missing hooks on the privacy curtains in rooms 109, 110, and 212 have been replaced. The kitchenette cabinets on both Harbor House and Fort Point units noted to be marred with black scuff marks have been repaired and painted. The shower chair observed in the hallway on the Harbor House unit was cleaned and removed from the area.	2/25/25

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

Administrator 2/14/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 584}	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary condition for 1 of 1 environmental tour for 2 of 2 units (Harbor Hill and Fort Point) Findings: On 1/28/25 at approximately 11:30 a.m. an environmental tour was conducted with the Maintenance Director and the Administrator for the purpose of this revisit. Harbor House Unit: Room 101 bathroom, the caulking was removed leaving a gap between the toilet base and the floor with a dark brown unknown substance. Room 102 the flooring seam between the room and the bathroom had dirt built up Room 103 bathroom, the caulking was removed leaving a gap between the toilet base and the floor with a dark brown unknown substance.	{F 584}	The urine smell noted on the Fort Point unit as well as room 212 were attended to by housekeeping to sanitize and mitigate ongoing odors. The handrails on the Fort Point unit with exposed wood have been refinished to create a cleanable surface. Areas noted with black scuff marks and/or being unpainted in rooms 212, 214, 216, the wall near room 211, and the dining room threshold on the Fort Point unit have been repaired and painted. The missing piece of laminate on the edge of the countertop in the Fort Point unit kitchenette has been repaired. The two areas noted to have fecal matter on the Fort Point unit shower room floor were immediately cleaned and sanitized. A facility wide audit was conducted to ensure resident rooms, bathrooms, and commons areas are free of; urine smell, fecal matter, uncleanable surfaces, gauge marks, missing/unpainted areas, unclean areas surrounding the base of toilets, and missing hooks on room divider	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 584}	Continued From page 2 Room 105 a part of a commode bucket (rim) was on the floor and not covered. Room 109 the privacy curtain had missing hooks. Room 110 the privacy curtain had missing hooks. The kitchenette cabinets are marred with black scuff marks A shower chair was observed in the hallway and the seat was observed soiled with a white unknown substance in the seams of the chair cushion. Fort Point Unit Upon entering this unit, a heavy smell of urine was noted on the entire unit. It was noted that the handrails in the hallway were unfinished leaving exposed wood creating uncleanable surfaces. And the walls were noted to have black scuff marks along the bases. A wall near Room 211 had sheetrock compound that was unfinished and unpainted. The Bathroom walls remained black with scuff marks. Room 212, a heavy urine smell and the wall behind bed 2 remained unpainted, the divider curtains were missing hooks. Room 214's bathroom remained with the same scuff marks and unpainted areas as previously cited. Room 216 Bathroom wall remains scuffed and unpainted. The dining room threshold was scuffed and gouged, the wooden kitchenette cabinets are marred and scuffed. The countertop has a missing piece of laminate (the edge of countertop). The whirlpool room was observed to have soiled caulking around the base of the shower and there	{F 584}	curtains. Additionally, this audit included ensuring the proper storage and cleaning of commode buckets and shower chairs. The facility ensures that all areas meet the requirements of being safe, clean, comfortable, and Homelike. The facility also ensures that any areas that do not meet this requirement will receive immediate attention. Housekeeping and maintenance personnel will be re-educated to process. Maintenance Director/designee will audit resident rooms, bathrooms, and common areas for uncleanable surfaces, gauge marks, missing/unpainted areas, missing hooks on room divider curtains, unclean areas surrounding the base of toilets, urine smell, fecal matter on the floors, proper storage and cleaning of commode buckets and shower chairs. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 584}	Continued From page 3 were 2 areas on the floor noted to have fecal matter. (one area near the shower and one area midway from shower to toilet). On 1/28/25 at 12:15 p.m. during an interview with the Administrator it was discussed that the areas cited during the previous survey have not been corrected as indicated on the facilities Plan of Correction with a correction date of 1/14/24. It was stated that the areas had not been completed yet due to the facility not having the matching paint for those areas. The surveyor confirmed the above findings at this time.	{F 584}		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865	The QAA committee will initiate a Performance Improvement Project (PIP) to review and analyze F584. Administrator/designee will review all current PIPs. Any additional plans not being followed will be brought to the QAA committee for further recommendations and implementation. Administrator/designee will provide education to the QAA committee on policy OPS103: Center Quality Assurance and Performance Improvement Process. Maintenance Director/designee will evaluate the effectiveness of the corrective action by assessing resident rooms, bathrooms, and common areas for a safe/clean/homelike	2/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 865	Continued From page 4 promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership	F 865	environment weekly x4 then monthly x3 or until ongoing compliance is noted. Results of these evaluations will be brought to the monthly QAPI meeting. Administrator/designee will audit PIPs weekly x4 then monthly x3 or until ongoing compliance is noted. Results of these audits will be brought to the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 865	Continued From page 5 (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 865	Continued From page 6 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, review of the plan of correction, and interview, the facility's quality assurance committee failed to ensure that the plan of correction for identified deficiencies from the Recertification Survey, dated 12/4/24, were effective. The deficiency F584 (Safe/ clean/ comfortable/ homelike Environment) was again identified during the 1/28/25 Re-visit Survey. Findings: During the Recertification Survey, dated 12/4/24, a deficiency was cited at F584 (Safe/ clean/ comfortable/ homelike Environment for the failure to maintain adequate housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in 2 of 2 units. The facility's Plan of Correction, with a completion date of 1/14/25, for F584 indicated that they would correct the deficiencies in all cited rooms and all rooms through auditing, repairing of flooring, walls, bathrooms, divider curtains unpainted surfaces and caulking around toilets in the cited rooms. Additionally, the facility indicated that they would perform weekly audits x 4 of the environment to ensure that all areas meet the requirements of being safe, clean, comfortable and Homelike. Then the facility indicated that they would have monthly audits done by the Maintenance Director or designee and would bring the audit results to Quality Assurance and Performance Improvement. During the Re-visit survey observations on 1/28/25, F584 was re-cited for failure to follow	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

(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 865	Continued From page 7 their Plan of Correction to have a Safe/ clean/ comfortable/ homelike Environment on 2 of the 2 units cited. In addition, there were new environmental findings on Harbor House, a shower chair was observed in the hallway and the seat was observed soiled with a white unknown substance in the seams of the chair cushion. On Fort Point upon entering this unit, a heavy smell of urine was noted on the entire unit. It was noted that the handrails in the hallway were unfinished leaving exposed wood creating uncleanable surfaces. And the walls were noted to have black scuff marks along the bases. On 1/28/25 at 12:15 p.m. during an interview with the Administrator it was discussed that the areas cited during the previous survey have not been corrected as indicated on the facilities Plan of Correction with a correction date of 1/14/24. It was stated that the areas had not been completed yet due to the facility not having the matching paint for those areas. The surveyor confirmed the above findings at this time.	F 865		