STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING 01 B. WING	12/03/2024

RECEIVED DEC 12 2024 BY

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
E 000	Initial Comments Federal Recertification Survey Survey Date: 12/3/24 Harbor Hill Center, a long term care facility, is in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities Emergency Preparedness.	E 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.	
K 000	INITIAL COMMENTS Federal Recertification Survey: Survey Date: 12/03/2024 Harbor Hill Center, a Long Term Care Facility, was surveyed to the National Fire Protection Association 101 Life Safety Code 2012 Edition as reference on 42 CFR 483.90 (a-d) physical environment and is not in substantial compliance.	K 000		
K 371 SS=F	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the Nursing Facility failed to ensure the 1 hour rated fire barrier is free from penetrations Per NFPA	K 371	Penetrations observed on 1 hour rated fire barrier in 2 separate locations have been repaired with fire stopping material in accordance with NFPA 101, 2012 edition 8.3.5.1. An audit of any 1 hour fire barriers with penetrations was conducted to validate the presence of required fire stopping material. The facility ensures that all penetrations on 1 hour rated fire barriers are repaired with fire stopping material for the safety of the residents, staff, and visitors.	1/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/12/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING 01 RECEIVED DEC 12 2024 B. WING BY	12/03/2024

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
K 371	Continued From page 1 101, 2012 edition 8.3.5.1 in 1 of 3 smoke compartments. Findings include: Based on observation, on 12/03/2024 between 9:00 AM and 12:30 PM, surveyors, in the presence of the Regional Maintenance Director, Regional Clinical Nurse, and Maintenance Director, the following was not met: 1. The 1 hr wall located in the corridor entering Harbor House in front of the Physical Therapy office above the ceiling tiles and corridor door, had a bundle of CAT 5 cables that penetrates the wall with no fire stopping material present. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. 2. The 1 hr wall located in the corridor above the ceiling tiles that separates the Lobby and Physical Therapy lobby, had 3 CAT 5 cables that penetrate the wall with no fire stopping material present. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device.	K 371	**Maintenance Director will complete weekly audits x4, then biweekly audits x1 month, then monthly audits x3 months of 1 hour rated fire barriers to ensure compliance with NFPA 101, 2012 edition 8.3.5.1. Results of these audits will be brought to the monthly QAPI meeting for review and recommendations.**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING 01 RECEIVED B. WING DEC 12 2024	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BY: 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
K 371	Continued From page 2 This finding was verified by the Regional Maintenance Director, Regional Clinical Nurse, and Maintenance Director at the time of the observation.	K 371		