Cummings, Joanne

From: Cummings, Joanne
Sent: Wednesday, October 18, 2023 9:22 AM
To: Hanson, Nancy
Cc: Day, Gregory J; Peaslee, Ronald J
Subject: 205122 Harbor Hill SOFD
Attachments: 205122 Harbor Hill Statement of Deficiency.pdf

Good Morning Executive Director Hanson,

On October 16, 2023, your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code only.

Please do not send your plan of correction to the office via US Mail or fax

Please email back the plan of correction to: FMOHealthcare@Maine.gov.

Joanne Cummings
Office Associate II
Maine State Fire Marshal's Office
45 Commerce Drive, Suite 1
Augusta, ME 04330
O (207) 626-3882
F (207) 287-6251

State of Maine
Department of Public Safety
Office of Fire Marshal
45 Commerce Drive, Suite 1
Augusta, ME 04330

JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISIONER

RICHARD MCCARTHY
STATE FIRE MARSHAL

October 18, 2023

Harbor Hill Center
Attn: Nancy Hanson, Executive Director
2 Footbridge Rd
Belfast, ME 04915

Provider ID#: 205122
Facility ID#: 2703
Event ID#: HS7S21

Executive Director Hanson,

On **October 16, 2023**, the Office of the Fire Marshal conducted a Life Safety Code and Emergency Preparedness survey to determine if your facility complies with Federal participation requirements for nursing facilities in the Medicare and/or Medicaid program (In which you will be receiving a Form CMS-2567 for Life Safety Code and Emergency Preparedness). Your facility was found not to be in substantial compliance with the participation requirements for Life Safety Code only.

The Federal regulatory requirements referenced in this letter are found in Title 42, Code of Federal Regulations (CFR) and in the National Fire Protection Association (NFPA)101 Life Safety Code Standard, 2012 Edition.

PLAN OF CORRECTION

Attached is Form CMS-2567 "Statement of Deficiencies" which enumerates the deficiencies found as a result of the survey. A Plan of Correction (POC) must be submitted by the **tenth (10th) calendar day** from your receipt of this letter. **Please note that a POC is not needed for isolated deficiencies which cause no harm (S/S of A).** Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- **Include dates when corrective action will be completed**. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility;

- Include documentation to support a waiver request (if appropriate).

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided on page one.** Return the forms(s) with the POC to **State of Maine, Department of Public Safety, Office of State Fire Marshal, 45 Commerce Drive, 52 State House Station, Augusta, ME 04330-0052**.

Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by **December 4, 2023** (Opportunity to Correct). Informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

RECOMMENDED REMEDIES
Based on the deficiencies cited during the Life Safety Code and Emergency Preparedness Survey of **October 16, 2023**, we are recommending to CMS the imposition of the following remedy(ies):

A Civil Monetary Penalty per day to be determined by CMS.

Directed Plan of Correction (DPOC) effective immediately. The State Agency directs the plan of correction noted on the attached CMS-2567 for deficiencies K222(SS=D), K232(SS=D), K712(SS=F), K754(SS=D) & K920(SS=D) (Tags). [42 CFR 488.424]

If you do not achieve substantial compliance by **January 18, 2024,** the CMS Regional Office or State Medicaid Agency must deny payments for new (Medicare/Medicaid) admissions. In addition, we may recommend that **termination of your provider agreement be effective on April 18, 2024,** if substantial compliance is not achieved by that time. [42 CFR 488.456]. **Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

ALLEGATION OF COMPLIANCE

The Plan of Correction will serve as your allegation of compliance until substantiated by a revisit or other means. If upon revisit your facility has not achieved substantial compliance, recommended remedies may be imposed as determined by the CMS Regional Office and continue until substantial compliance is achieved. Additionally, CMS Regional Office may impose revised/additional remedies, if appropriate.

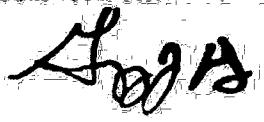
INFORMAL DISPUTE RESOLUTION

In accordance with 42 Code of Federal Regulations §488.331, you have one opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies, which may have resulted in a finding of substandard quality of care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC
or immediate jeopardy) to **Asstistant State Fire Marshal Gregory J. Day** at the address below. This request must be sent during the same **10 calendar days** you have for submitting a POC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action. IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present.

Please email back the plan of correction to: FMOHealthcare@maine.gov.

If you have any questions, please contact me at (207) 626-3880.

Yours for Better Fire Prevention,



Gregory J. Day
Assistant State Fire Marshal

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 _____	10/16/2023

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 10/16/23 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		
K 000	INITIAL COMMENTS Federal Recertification Survey: Survey Date: 10/16/23 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 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K 222		

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

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.

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K 222	Continued From page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised	K 222		

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K 222	Continued From page 2 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the Nursing Facility failed to ensure the means of egress was accessible to egress at all times. 19.2.2.2.5.2* Door-locking arrangements shall be permitted where patient special needs require specialized protective measures for their safety, provided that all of the following are met: (1) Staff can readily unlock doors at all times in accordance with 19.2.2.2.6. (2) A total (complete) smoke detection system is provided throughout the locked space in accordance with 9.6.2.9, or locked doors can be remotely unlocked at an approved, constantly attended location within the locked space. (3)*The building is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.1. (4) The locks are electrical locks that fail safely so as to release upon loss of power to the device. (5) The locks release by independent activation of each of the following: (a) Activation of the smoke detection system required by 19.2.2.2.5.2(2) (b) Water flow in the automatic sprinkler system required by 19.2.2.2.5.2(3) Finding: Based on observation of the surveyor 39983 on 10/16/23 between 10:30 AM and 1:30 PM, in the presence of the Maintenance Director and Supervisor of Maintenance, the following was not met: 1. The door to the folding room next to the laundry room, has a locking hasp installed to lock	K 222		

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K 222	Continued From page 3 the door from the outside, not allowing the door to be opened from the inside for egress. The locking device was removed during the inspection. This finding was verified by the Maintenance Director and Supervisor of Maintenance at the time of the observation.	K 222		
K 232 SS=D	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the Nursing Facility failed to ensure the means of egress was free from all obstructions in 1 of 4 patient areas, per NFPA 101, Life Safety Code, 2012 Edition, Section 19.2.3.4. Findings: On 10/16/2023, between 10:30 AM and 1:30 PM, surveyor 39983, with the Supervisor of Maintenance present, observed the following: 1. Med carts are stored in the corridor across from the nurses station located in the skilled nursing wing. Staff members stated the med carts are normally stored there unless the fire alarm goes off.	K 232		

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K 232	Continued From page 4 2. Cardboard boxes with curtains and patient slings stored in corridor across from oxygen storage room. The surveyor confirmed this finding with the Supervisor of Maintenance at the time of the observation.	K 232		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and document review and confirmed with the Maintenance Director, the long-term care facility failed to ensure that fire drills were held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Section 19.7.1.4 through 19.7.1.7 Findings: On 10/17/2023, between 10:30 AM and 2:30 PM, surveyor 47175, with the Maintenance Director present, observed the following:	K 712		

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K 712	Continued From page 5 1. The facility failed to conduct the proper number of fire drills during the previous 12 months. The following fire drills for the facility were not completed or missing: A. Third quarter of 2023, second shift B. Second quarter of 2023, Second and third shift C. First quarter of 2023, Second shift D. Fourth quarter of 2022, Second and third shift The surveyor 47175 confirmed this finding with the Maintenance Director at the time of the observation.	K 712		
K 754 SS=D	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observations and within the presence	K 754		

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K 754	Continued From page 6 of the Maintenance Director, the Nursing Facility failed to ensure that trash cans were stored properly. NFPA 101 Life Safety Code, 2012 edition. 19.7.5.7 Soiled Linen and Trash Receptacles, (1) The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4 L/m2). (2) A capacity of 32 gal (121 L) shall not be exceeded within any 64 ft2 (6 m2) area. Finding: Based on observation of the surveyor 39983 on 10/16/23 between 10:30 AM and 1:30 PM, in the presence of the Supervisor of Maintenance, the following was not met: 1. Trash cans located outside of resident rooms 104 and 105 in corridor. This finding was verified by the Supervisor of Maintenance at the time of the observation.	K 754		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		

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K 920	Continued From page 7 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the Nursing Facility failed to ensure appliances were plugged in directly to a wall outlet by using an extension cord per NFPA 99, 2012 edition, 10.2.3.6, 10.2.4, NFPA 70, 400-8, 590.3(D) Findings: Based on observation of the surveyor 39983 between 10:30 AM and 1:45 PM on 10/16/23, in the presence of the Supervisor of Maintenance, the following was not met: 1. A portable air conditioner located in the nurses station is plugged into an extension cord that runs under the med room door plugged into an outlet in the med room. This finding was verified by the Supervisor of Maintenance at the time of the observation.	K 920		