

Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2751	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/07/2025
NAME OF PROVIDER OR SUPPLIER HARBOR HILL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE	
P 000	Initial Comments On 10/7/25, an onsite visit was conducted at Harbor Hill Assisted Housing, for the purpose of completing investigations for complaints #44407, #45076, and #45620. It is determined that Harbor Hill Assisted Housing is in substantial compliance with 10/144, Chapter 113-Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000			

Department of Health and Human Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE