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	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Hill Center	2 Footbridge Rd Belfast, ME 04915

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews, the facility failed to ensure that a call bell was accessible for 1 of 3 residents reviewed during a complaint investigation (Resident [R]1). Review of policy Call Lights dated 7/15/25 states Patients will have a call light or alternative communication device at each personas bedside, toilet and bathing room to allow patients to call for assistance when attended. Staff will respond to call lights and communication devices promptly. Each patient will be evaluated for unique needs and preferences to determine any special accommodation's that may be needed in order for the patient to use the call system. Special accommodations will be identified on the patients person-centered care plan of care and provided accordingly (examples include touch pads, larger buttons, bright colors etc.). Staff will ensure the call light is within reach of the patient and secured as needed. The call system will be accessible to patients while in their beds or other sleeping accommodations withing the patient's room.During observations of Resident [R1] on 7/22/25 at 8:35 a.m., R1 was observed lying in bed. A red call bell string observed attached to the wall behind the bed and draped over box of popcorn and two photo frames located on top of R1's refrigerator next to the bed and not in reach. At this time R1 was asked how he/she would call for help if needed. R1 then used [his/her] right arm to reach over [his/her] left side of the bed and felt around, was unsuccessful and then used [his/her] left hand to reach over the side of the bed and was observed feeling around.Review of R1's care plan updated 2/5/25 states When [R1] if in bed or bed-side chair place the call light and desired personal items within reach.On 7/22/25 at 8:45 a.m. 8:51 a.m., and 10:09 a.m., Certified Nursing Assistant (CNA1) was observed entering R1's room. After CNA1 left R1's room each time, the call bell was observed attached to the wall behind the bed and draped over box of popcorn and two photo frames located on top of R1's refrigerator next to the bed and not in reach.During an observation of R1 with Registered Nurse (RN)1 on 7/22/25 at 10:17 a.m. RN1 removed the call bell from the top of refrigerator and tied it to R1's bed, within reach. RN1 stated R1's has never been known to use his/her call bell. At this time a surveyor asked if another accommodation was in place for R1 to use when assistance was needed. RN1 stated she did not know.During a follow up observation of R1 on 7/22/25 at 10:30 a.m., a surveyor asked R1 how [he/she] would call for help if [he/she] needed it. R1 used [his/her] right hand to pull the call bell appropriately.During an interview on 7/22/25 at approximately 12:09 p.m., The Director of Nursing stated she had just come out of R1's room and he/she was able to demonstrate using the call bell independently.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to update/implement a care plan in the area of communication for 1 of 1 resident reviewed for falls (Resident [R]1).Review of policy Person-Centered Care plan dated 10/24/22 states .The care plan must be customized to each individual patient's preferences and needs.Care plans will be: communicated to appropriate staff, patient, patient representative, family; Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment's, and as needed to reflect the response to care and changing needs and goals.Resident [R]1was admitted with diagnoses to include anoxic brain damage (brain damage caused by lack of oxygen) and is considered a fall risk.During an observation of Resident [R1] on 7/22/25 at 8:35 a.m. R1 was observed lying in bed. A fall mat was observed on the floor on the left side of the bed.Review of R1's care plan updated 2/5/25 states [R1] is at risk for falls: cognitive loss, lack of safety awareness; Goal: [R1] will have no falls with major injury through the next review, Interventions: When [R1] is in bed or bed-side chair place the call light and desired personal items within reach. Further review of R1'scare plan lacked evidence of fall mat use.On 7/22/25 at 9:54 a.m., the above was disused with the Director of Nursing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure the resident environment remained as free of accident hazards, as is possible, related to side rail use for 1 of 3 complaint investigations (Resident [R]5). The Department of Licensing received a complaint indicating bed 107-B side rail was broken during the previous residents' stay from 7/2/25 through 7/15/25.Review of Tels work order #8718 dated 7/2/25 states Left grab rail needs to be fixed to lick Comments Checked both beds and they are locking.Observation of room [ROOM NUMBER]-B, currently occupied by R5 revealed side rail on left of bed is not attached appropriately to bed causing it to extend outward when grabbed. The resident currently occupying the bed states he/she gets out of the bed on the left side. At this time a surveyor asked R5 how he/she would use the bed rail to assist him/her. R5 stated that staff help him/her get out of bed, but he/she uses the side rail to get support. At this time R5 used his/her left hand to grab the side rail and it extended outward.Observation of R5's side rail on 7/22/25 at 10:17 a.m., Registered Nurse [RN]1 confirmed side rail was not attached to the bed properly and made an attempt to reattach it to the side of the bed but was unsuccessful. RN1 stated she was going to let maintenance know.During observation of bed 107-B with the Clinical Marketing Director (CMD) on 7/22/25 at 3:20 p.m., the above finding was confirmed.

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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 reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 3 of 4 sampled residents reviewed during a complaint investigation (Resident [R] 1, R3 and R4).1.Review of R1's care plan updated 2/5/25 states It is important for me to be offered a shower Mon Wed Fri but can choose an alternate form of bathing at any time. Review of R1's tub/shower schedule: Monday 7-3 and Wednesday 7-3 and Friday 7-3. Review of R1's GG Bathing task revealed R1 has only received bed baths from 7/1/25 through 7/22/25.During a follow up interview on 7/22/25 at 10:13 a.m., Certified Nursing Assistant (CNA)1 states she was not aware R1 preferred showers because it's not on her task sheet and always gives him/her bed baths because [he's/she's] unable to stand on [his/her] own. CNA1 further states she does not know how to find bathing preferences in the Electronic Medical Record.During an interview on 7/22/25 at 9:53 a.m. Director of Nursing reviewed R1's care plan with this writer and stated R1 should be offered a shower first, if [he/she] refuses then a bed bath can be offered, but there should be documentation in a progress note that it was offered and refused. Review of R1's clinical record lacked evidence this was done. 2. Review of R1's care plan revealed R1 is at nutritional risk: related to Hospice care, varied intake, wound healing.Monitor intake at all meals .Review of task GG Intake lacked evidence of the following meal intakes:-Breakfast meals on 7/9/25, 7/18/25, 7/11/25 and 7/18/25, noon meals on 6/24/25, 6/26/25, 7/2/25, 7/3/25, 7/3/25, 7/3/25, and 7/8/25, and 7/15/25, and evening meals on 6/30/25 and 7/2/25.During an interview on 7/22/25 at 10:13 a.m., CNA1stated all meal intakes are supposed to be documented every shift.3. R3 was admitted with diagnoses to include a recent hip fracture, and dental issues indicating the need for 2 staff for assistance with toileting.Review of R3's care plan updated 7/10/25 states Resident exhibit or is at risk for oral health or dental care problems as evidenced by broken, loose and carious teeth.Encourage resident to brush teeth and gums twice daily and as needed.Provide resident/patient with partial of 1 for personal hygiene (grooming).Review of Task: GG: Hygiene: Oral Hygiene lacked evidence R3 was offered or refused oral hygiene twice daily on 7/2/25, 7/4/25, 7/6/25, 7/11/25, 7/12/25, or 7/13/25.During an interview on 7/22/25 at approximately 3:05 p.m., the above was discussed with Director of Nursing and Regional Clinical Coordinator.4. R4 has diagnoses to include Parkinson's and anxiety disorder and was receiving end of life care.Review of R4'clincial record revealed GG-Eating lacked evidence R4 was offered or refused noon meals on 6/28/25, 6/29/25, 7/2/25, and 7/6/25, and breakfast meal on 6/24/25.During an interview on 7/22/25 at 10:20 a.m., CNA1stated that all meals needed to be document evening if they are receiving hospice care.During an interview on 7/22/25 at 9:55 a.m., the above was discussed with Director of Nursing.5.Review of R3's care plan initiated 7/2/25 states [R3] is at risk for decreased ability to perform ADL(s) .and toileting related to: Right hip fracture and Recent fall .with activity intolerance, and confusion. Provide resident/patient with Dependent assistance of 2 using bed side commode (sit to stand lift for transfer)(specify #) for toileting.Review of R3's GG-Toileting task lacked documented evidence that R3 received appropriate toileting assistance during his/her admission.Interview with the Director of Nursing on 7/22/25 at 2:55 p.m. stated that the staff are trained to document toiling as it happens, but most of them are continuing to do it at the end of the shift Review of provided in-service documentation dated 7/15/25 revealed mandatory in-service regarding timely ADL documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations and interviews and record review the facility failed to follow professional standards of practice to provide a sanitary environment to help prevent the development and transmission of disease and infection related to bed pan storage, and failed to maintain equipment in a sanitary manner related to a ripped floor mat (Resident [R]1).1. During an observation of Resident [R1] on 7/22/25 at 8:35 a.m., a fall mat was observed on the floor of R1's left side with two tears in it, making it an uncleanable surface.2. Observations of R1's bathroom r on 7/22/25 at 8:35 a.m., 10:17 a.m., revealed an unwrapped bed pan leaning on side of wall next to toilet available for use.During an observation of R1 10:17 a.m., with Registered Nurse (RN)1 observed the unbagged bed pan and stated it should be wrapped. At this time RN1 put the bed pan in a bag and stored it.On 7/22/25 at approximately 9:53 a.m., the above was discussed with The Director of Nursing.