

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2025
NAME OF PROVIDER OR SUPPLIER  Harbor Hill Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to ensure safe transfer practices implement clear, consistent transfer instructions for 1 of 2 residents reviewed for falls. The failure resulted in Resident #5 being transferred with an inappropriate device, inconsistent with therapy recommendations, which contributed to a fall-related injury requiring hospitalization and surgical intervention. Findings: Review of an incident report dated 11/15/25 indicated that at approximately 6:30 a.m. staff attempted to transfer Resident #5 with a sit-to-stand lift. During the transfer, the resident's foot slipped from the lift platform, and staff were unable to safely reposition the foot. The resident was lowered to the floor. A full mechanical lift (Hoyer) was then used to complete the transfer. While being repositioned, the resident cried out and stated his/her knee had popped. A nursing assessment completed on 11/15/25 identified swelling and continued complaints of pain to the residents' left leg. The physician was notified and ordered an X-ray for further evaluation. The X-ray revealed a left femur fracture, and the resident was transferred to the hospital for surgical intervention. Resident #5's physical therapy documentation, dated 11/11/25, indicated the therapist assessed the resident as requiring a full mechanical lift (Hoyer) for all transfers due to instability and inability to safely bear weight. The therapist documented that nursing staff were notified of the change in transfer status and the care plan was updated. Additionally, the clinical record lacks evidence that nursing staff were notified of the change in transfer status prior to the incident. Review of Resident #5's comprehensive care plan under Activities of Daily Living (ADL) revealed that two transfer interventions were listed simultaneously. One intervention, initiated on 10/22/24, instructed staff to use a sit-to-stand lift for all transfers. A separate intervention dated 11/11/25, instructs staff to utilize a total lift for all transfers, and bed pan for toileting, until further notice while therapy continues to assess L ankle ROM and transfer options. Resulting in conflicting transfer instructions. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] Section GG: Functional Abilities, revealed the resident required substantial to total assistance with mobility and transfers. Chair/Bed-to-Chair Transfer (GG0170E) was assessed as 01-Dependent indicating staff provided all assistance and the resident did not perform any portion of the transfer independently. Sit-to-stand (GG0170D) and Toilet Transfer (GG0170F) were assessed as 02- Substantial/Maximal Assistance indicating the resident was unable to safely come to standing position. without extensive physical assistance. During an interview on 12/30/25 at 2:55 p.m., the Administrator confirmed that Resident #5 required use of a full mechanical lift (Hoyer) for all transfers. The residents' care plan further confirmed that the residents care plan continued to list both sit-to-stand and full mechanical lift (Hoyer) for all transfers and had not been appropriately edited or updated to reflect the change in transfer status.</p>		

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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