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	01/14/2026

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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview, the facility failed to complete annual performance evaluations at least every 12 months for 5 of 5 sampled employees (Certified Nursing Assistant #1 [CNA1] CNA2, CNA3, CNA4, CNA5). Finding:On 01/14/226, at 11:00, the last two performance evaluations were requested for five Certified Nurse Assistance (CNA 1-5). On 1/14/26 at 11:30 a.m., in an interview with the surveyor, the Administrator stated that the 5 C.N.A.'s that were requested have not had a performance evaluation for the past two years.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observations and interviews, the facility failed to ensure the privacy and confidentiality of residents by displaying video camera/monitors at the nurses station that staff, family, visitors and other residents could view and failed to obtain an order for use of a video camera/monitors, or consent from residents and/or resident representatives prior to use of a video camera/monitor for 2 of 2 residents reviewed (Resident #8 [R8] and R2).Findings: Findings: On 1/12/26 at 12:18 p.m., during an initial tour of the Long Term Care unit Fort Point, a surveyor observed 2 video camera/monitors on the nurses station desk in view of staff, family, visitors, and other residents. One video camera/monitor was observed with R8 visible on the video monitor lying in bed on his/her right side with his/her face away from camera exposing his/her bare left shoulder and back. The second video monitor had a white screen visible, and a few minutes later R2 was visible on the video monitor lying in bed on his/her back. In an interview with the Registered Nurse Charge Nurse at time of observation, a surveyor confirmed that R8 and R2's privacy and confidentiality were not maintained. On 1/12/26, during an additional tour of the Long Term Care unit Fort Point, it was observed that on the nurses station desk there were 2 video monitors that showed 2 residents in their beds. Upon further observation it showed R8 lying on their side uncovered which showed they were wearing an incontinent brief, and their body was exposed (bare back and legs). An observation of R8's room was completed and the surveyor observed a video camera on the bedside table pointed towards the resident who was in bed. Review of R8's clinical record lacked evidence of a physician's order for the use of a video camera. R8's clinical record lacked evidence that a consent was obtained from the resident/resident representative prior to use of a video monitor. Review of R2's clinical record lacked evidence that a consent was obtained from the resident/resident representative prior to use of the video monitor. On 1/12/26 at 3:08 p.m., during an interview with the Marketing Clinical Advisor and the Administrator, two surveyors confirmed the use of video monitors located at Fort Point nurses station visible to others, that R8 does not have a physician order for the use of a video monitor, and that R8 and R2 do not have consents from the resident/resident representative prior to use of a video monitor.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment for 3 of 3 days of survey (1/12/26, 1/13/26, and 1/14/26).Findings:On 1/12/26 at 12:24 p.m., a surveyor observed in room [ROOM NUMBER], the wall at the head of bed 1 and the bedside cabinet were heavily soiled with dried fluid residues. Both bedside tables in room [ROOM NUMBER] were observed to be heavily soiled with food debris prior to the lunch service.On 1/13/26 at 10:44 a.m., during an observation of the laundry department, a surveyor observed Laundry Staff folding clean linens. A face cloth was observed laying on the floor below the basket. The Laundry Staff picked up the face cloth, folded it, placed it on the clean linens pile, then continued to fold laundry from the basket. The surveyor asked where the face cloth went. The Laundry Staff patted the pile of folded linens and stated, I folded it. At this time the surveyor confirmed the soiled linen was placed in the clean linen pile with the Laundry Staff.On 1/13/26 at 1:49 p.m., during an interview with a surveyor and the Assistant Director of Nursing (ADON), the following was observed and confirmed:-In room [ROOM NUMBER], the wall at the head of bed 1 and the bedside cabinet were heavily soiled with dried fluid residues.-In room [ROOM NUMBER], the bedside table for bed 2 was observed to be heavily soiled with food debris not associated with the current meal.-In room [ROOM NUMBER], the wedge pillow used in bed 2 has an uncleanable surface as the plastic covering was torn away and the internal foam was exposed.-The ceiling tile just inside the door to Fort Point had an unidentified red stain on it.At 2:00 p.m., during an interview with ADON, the surveyor confirmed the observations from 1/12/26 were consistent with this day's observation.On 1/14/26 at 8:43 a.m., during an interview, a surveyor and Lighthouse Keeper 3 observed and confirmed that the wall at the head of bed 1 and the bedside cabinet were heavily soiled with dried fluid residues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy reviews, and interviews, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection for 2 of 3 days of survey by failing to ensure staff utilize proper personal protective equipment (PPE) in an Enhanced Barrier Precaution (EBP) room and failing to ensure staff washed their hands after handling soiled linens and touching multiple surfaces (1/13/26 and 1/14/26). Findings: On 1/12/26 a review of R8's clinical record was completed. In the Physician order section, it indicated R8 had treatments to open wounds on his/her coccyx and on the right and left heel (pressure ulcers) A review of the Facilities Enhanced Barrier Precautions with a revised date of 5/1/25. Indicates Enhanced Barrier is used for all patients with any of the following: Infection or colonization with a targeted MDRO when contact precautions do not apply, chronic wounds and /or indwelling medical devices (central line, urinary catheter, enteral feeding tube, tracheostomy. Enhanced barrier precautions are precautions that in addition to Standard Precautions, will be implemented during high contact resident care activities . On 1/13/26 at 1:20 p.m., a surveyor observed the Charge Nurse assisting a resident in room [ROOM NUMBER]. The Charge Nurse exited room [ROOM NUMBER] holding a clear plastic bag containing a soiled incontinence pad, brought the bag to the soiled utility room, stopped at the door, returned with the bag to the nurse's station, obtained a key, returned and opened the soiled utility room door, threw the bag into a bin from the door then let the door close. The Charge Nurse then returned the key to the nurse station and invited the surveyor to come to the nurse station for an interview. At this time the surveyor confirmed with the Charge Nurse that she did not wash her hands after returning from the soiled utility room. On 1/13/26 at 2:10 p.m, during an observation of R8 in their room, a staff member was coming in to assist with repositioning, R8 has several open areas to his/her right ear, buttocks and bilateral heels. The CNA came into the room without donning PPE, the surveyor asked if they were supposed to use PPE due to open areas and she was not aware. The sign outside of R8's room was brought to CNA3's attention, and she and a second staff donned PPE to assist R8. On 1/14/26 at 10:38 a.m. during an observation as CNA2 was entering the room to assist R8 with repositioning. She entered the room and was about to assist R8 when surveyor asked her to review a sign on the outside of the door (EBP sign). CNA2 stated she was not aware that they had to wear full PPE when providing care to R8. The precaution cart was outside the room but she was not aware they needed to use PPE. This surveyor confirmed this finding with CNA2 at the time of this observation On 1/14/26 during a joint interview with the Administrator and the Unit Manager the surveyor confirmed the above findings.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews, the facility failed to promote care for residents in a manner that maintains each resident's dignity and respect when staff were perceived by several residents as being rude, mean and who denied toileting needs for 4 of 4 residents interviewed.Finding:During the recertification survey from 1/12/26 to 1/14/26 several residents were interviewed and requested to remain anonymous as they are afraid of retaliation from this nurse.During resident interviews it was stated by the residents that a nurse LPN has made them cry and is very rude and mean when they ask for assistance. The residents also reported that LPN will cover for her favorite staff when the staff don't provide the care needed, whirlpools, washing up daily, toileting the staff won't do the work and when the next shift comes on LPN will tell the oncoming staff the residents refused care the residents stated they do not refuse showers because they don't get them all the time. In addition, they stated on a few occasions that when they ask to use the bathroom LPN will tell them No that she does not have time to help them.On 1/14/26 at 12:04 p.m., during an interview with the Administrator, it was noted that this LPN has not worked this week and residents did not have to interact with her. LPN is scheduled to work on 1/15/26 and is now on administrative leave until the facility conducts an investigation. The surveyor confirmed with the Administrator that residents are concerned about LPN's treatment of them.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interviews and observation, the facility failed to provide residents with access to personal funds after business hours during the evenings and on weekends for 1 of 1 resident reviewed for personal funds (Resident #16 [R16])Finding:On 1/12/26 at 12:20 p.m. during an interview with R16 he/she stated they do have money in the office and if he/she wants any they need to get it when the office is open. If they want money they have to get it before the office is closed or they have to wait until Monday.On 1/14/26 at 11:30 p.m. during an interview with the Social Worker the surveyor was told that money after hours or on weekends is not available. The receptionist keeps it locked up in the office; she manages the residents accounts. They do not have a petty fund, if residents want money they have to ask when the office is open. The Surveyor confirmed that the facility does not have a petty fund available for residents during evening and weekend hours.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a resident's right to formulate an advanced directive regarding code status (cardiopulmonary resuscitation [CPR]) was accurate in the clinical record for 1 of 5 residents reviewed for Advanced Directives (Resident #6 [R6]).Finding:On [DATE] at 3:58 p.m. during a clinical record review, it was noted that R6's code status was not accurate he/she was listed as a Full Code on his/her physician orders but review of his/her care plan reflects that R6 is listed as Do Not Resuscitate, Do Not Intubate (DNR, DNI). R6's social services assessment dated [DATE] that was completed at admission indicates that he/she does not want to to address advanced directives and per his/her discharge summary from the Hospital R6 wishes to remain a Full code.On [DATE] at 11:36 a.m. during an interview with Social Services, the surveyor was able to confirm that R6's code status was not accurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record reviews and interviews, the facility failed to resubmit a Preadmission screening and resident review (PASRR) Level 1 screen when the nursing home stay of residents who were admitted under convalescent care exceeded the allotted 30 days for 2 of 2 residents whose PASRR's were reviewed (Resident #6 [R6] and R16).Findings:On 1/13/26 at 8:34 a.m., during a clinical record for R6 the clinical record showed that a PASRR Level I Screen was done on 11/21/25 prior to R6's admission. The PASRR Level I Screen indicated that R6 meet criteria for convalescent care categorical. The PASRR instructs that if R6 needed to stay longer than the approved number of days, the nursing facility must submit a new PASRR screen request to Maximus 7 -10 days before the time approval expires. There is no evidence in R6's clinical record or in the Social Service office that a screen request was resubmitted in a timely manner as instructed.On 1/13/26 at 4:28 p.m., during an interview with the Administrator, the surveyor was able to confirm that a new PASRR screen was not resubmitted or requested from Maximus before time approval expiration. On 1/14/26, during a clinical record for R16, the clinical record showed that a PASRR Level I Screen was done on 11/5/25 prior to R16's admission. The PASRR Level I Screen indicated that R16 meet criteria for convalescent care categorical. The PASRR instructs that if R16 needed to stay longer than the approved number of days, the nursing facility must submit a new PASRR screen request to Maximus 7 -10 days before the time approval expires. There is no evidence in R16's clinical record or in the Social Service office that a screen request was resubmitted in a timely manner as instructed. On 1/14/26 at 1:35 p.m., during an interview with the Administrator and the Social Worker, the surveyor was able to confirm that a new PASRR screen was not resubmitted or requested from Maximus before time approval expiration.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, the facility failed to ensure a Baseline Care Plan was developed and implemented within 48 hours, that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 2 residents (Resident #46 [R46]) reviewed for Activities of Daily Living (ADL).Findings:On 1/13/26, R46's record was reviewed. R46's Baseline Care Plan did not address R46's Provider's orders regarding R46's need to have the Head of Bed elevated to avoid shortness of breath while lying flat every day and night shift, Physical Therapy, Occupational Therapy, dietary orders, and/or R46's needs regarding ADL care.On 1/13/26 at 2:00 p.m., during an interview with a surveyor and the Assistant Director of Nursing (ADON), R46's clinical record was reviewed. At this time the surveyor confirmed with the ADON that the Baseline Care Plan did not contain information regarding ADL care for R46.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, record reviews and interviews, the facility failed to update/revise care plans for the use of Enhanced Barrier Precautions (EBP) for 1 of 2 resident reviewed (Resident #8 [R8]). In addition, the facility failed to ensure a care plan was updated and implemented for 1 of 1 resident reviewed with a new diagnosis (R39).Findings: 1.On 1/13/25., a surveyor observed an EBP sign on the outside of the door of R8's room. Record review showed that R8 has open wounds on his/her coccyx and on the right and left heels (pressure ulcers). The review of R8's care plan was reviewed and lacked evidence of addressing the need for the EBP while providing care to R8. On 1/13/26 at 9:25 a.m., during an interview and record review with the Unit Manager the surveyor confirmed that R8's care plan did not include the use of EBP. 2. On 1/14/26 at 9:30 a.m., during an interview, a surveyor and the Assistant Director of Nursing (ADON) reviewed R39's clinical record and confirmed the following: -On 6/6/25, the Provider's Progress Note did not include a diagnosis of Type 2 Diabetes. - On 8/5/25, R39 had a normal Hemoglobin A1c result (test showing the average blood sugar over the past 2-3 months; used for diagnosing prediabetes and diabetes). -On 9/30/25, the clinical record indicated R39 had a new diagnosis of Type 2 Diabetes. There were no notes associated with this new diagnosis. -R39's Care Plan was not revised to address the new diagnosis of Type 2 Diabetes. On 1/14/26 at 11:08 a.m., during an interview with a surveyor, the ADON stated R39 is diagnosed with Type 2 Diabetes, the Hemoglobin A1c confirmed R39's Type 2 Diabetes is diet controlled, and that R39 is monitored annually for Type 2 Diabetes. At this time the surveyor confirmed R39's Care plan was not updated/revised to include problems, goals, and interventions, for the monitoring and treatment of R39's new Type 2 Diabetes diagnosis.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interviews, the facility failed to provide the necessary services for a resident to maintain personal hygiene for 1 of 2 residents reviewed for activities of daily living and who were dependent on staff for their care [Resident #46 (R46)].Findings:On 1/12/26 at 1:45 p.m., a surveyor observed R46's hair appeared greasy and the hair around his/her temple area was standing on end. During an interview with the surveyor, R46 stated they have not had a shower/bath or had their hair washed since admission. On 1/13/26 at 1:02 p.m., a surveyor observed R46 sitting on his/her bedside. A physical therapy staff member came to bring R46 to the gym. R46 stated, I'm not dressed yet. The physical therapist stated she would return after R46 finished eating lunch. At 1:05 p.m., the physical therapist returned and stated the therapy session was moved to 2 p.m., so R46 will have time to get dressed after eating.On 1/13/26 at 1:06 p.m., during an interview with a surveyor, R46 stated his/her hair was brushed not washed. R46 stated he/she was able to wash up this morning after set-up, but staff did not assist R46 with bathing, washing their hair, or getting dressed. R46 stated he/she was still wearing the same pajamas from the night before.On 1/13/26 at 1:15 p.m., during an interview with a surveyor, a Certified Nurse Assistant (CNA8) stated all resident bathing schedules are in the binder on the desk. During the interview the CNA and a surveyor observed and confirmed the binder contained a paper with residents listed on it, dated October of 2025, with several names crossed out, and R46 was not on the list for the bathing schedule. The CNA stated they are not allowed to update or change the schedule.On 1/13/26 at 1:23 p.m., during an interview with a surveyor, the Charge Nursed stated the schedule for each resident is in the binder. The Charge Nurse stated R46 is not on the list but based on their room assignment it should be on Wednesdays. The Charge Nurse stated she was unsure who updates the binder and/or bathing schedule.On 1/13/26 at 2:00 p.m., during an interview with a surveyor and the Assistant Director of Nursing (ADON), R46's clinical record was reviewed. The ADON stated R46 was scheduled for the whirlpool on Thursdays. At this time the surveyor confirmed that the clinical record lacked evidence that R46 received their whirlpool bath on his/her scheduled day and that his/her hair has not been washed since admission.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical record review and interviews, the facility failed to initiate a resident's bowel regime protocol timely for 1 of 5 residents reviewed for unnecessary medications (Resident #2 [R2]). Findings:Review of R2's clinical record, effective date: 12/31/25 9:42 a.m., Type: Care Plan Meeting. Summary of meeting. Occupational Therapy (OT) - Initiated beginning OT with an evaluation on 12/30/25). R2 was in significant pain resulting to inability to do ADLs(activities of daily living)/functional mobility assessment, but agreeable to evaluation write up to be complete. 9/10 pain due to constipation during evaluation.Review of Order Summary Report, active orders as of 1/14/26 pertaining to bowel protocol are as follows:Polyethylene Glycol 3350, MiraLax Powder, Give 17 gram by mouth as needed for Constipation in 4 to 8 ounces of fluid-if resident has not had a bowel movement in past 72 hours., ACTIVE, 9/24/2025.Magnesium Hydroxide, Milk of Magnesia (MOM) Suspension 400 MG(milligram)/5ML(milliliter), Give 30 ml by mouth as needed for Constipation give at bedtime if no BM (bowel movement) in 3 days, 400MG/5ML, ACTIVE, 7/23/2025Dulcolax Suppository 10 MG (Bisacodyl) Insert 1 suppository rectally as needed for Constipation if no result from MOM and/or Miralax by next shift.Mineral Oil, Enema Mineral Oil Rectal Enema, Insert 1 application rectally as needed for CONSTIPATION 1x a day as needed, ACTIVE, 7/28/2025.Review of R2's clinical record, Task: GG-Toileting report for bowel movements (BM):R2 had a large BM on 12/26/25 5:00 a.m., and 2:34 p.m., no BM on 12/27/25, 12/28/25, and 12/29/25. Bowel protocol started on 12/30/25 at 12:07 p.m., R2 was given MiraLax at this time, but the bowel protocol should have begun on 12/29/25 at 2:34 p.m. with Milk of Magnesia 72 hours after R2's last bowel movement.R2 had a medium BM on 1/2/26 at 11:24 p.m., no BM on 1/3/26, 1/4/26, and 1/5/26, bowel protocol should have started on 1/5/26 at 11:24 p.m. 72 hours after R2's last bowel movement. No bowel protocol was initiated.On 1/13/26 at 2:58 p.m. in an interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), a surveyor confirmed that the bowel protocol was not followed as ordered. The order was for the resident to receive MiraLAX, then MOM, then suppository. The facility was starting the bowel protocol on the 4th day with no bowel movement instead of the third day after 72 hours with no bowel movement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, pharmacy consultant monthly review, and interview, the facility failed to adequately monitor a resident who was on an antipsychotic medication for tardive dyskinesia and/or other movement disorders for 1 of 5 residents reviewed for unnecessary medications (Resident #3 [R3]) and failed to ensure that a resident's drug regimen was free from unnecessary medications by administering an excessive dose of an antibiotic in less than 12 hours for 1 of 5 residents reviewed for unnecessary medications (R2).Findings:1.On 1/14/26, a review of R3's clinical record was completed. On 1/2/26, a pharmacist consultant recommended that an Abnormal Involuntary Movement Scale (AIMS) be done within 30 days of admission or start of the antipsychotic, and once every 6 months. (AIMS is a clinical tool used to detect and measure involuntary movements such as tardive dyskinesia-it helps assess severity and monitor treatment effectiveness). Documentation in the clinical record indicated that when R3 was admitted to the facility he/she had a physician order for Quetiapine (Seroquel) give 0.5 mg by mouth daily at 9 a.m. and 25 mg by mouth daily at 6 p.m. A review of the facility's 'Behaviors: Management of Symptoms' policy, under #7.3: 'Complete the Abnormal Involuntary Movement Scale (AIMS) per nursing schedule for patients receiving antipsychotic medications.' There was no evidence in R3's clinical record of a completed AIMS. On 1/14/26 at 11:45 a.m., in an interview with the surveyor, the facility consulting Administrator confirmed that the standard for the nurse's to follow is to do an AIMS upon admission if the resident is on an antipsychotic or when an antipsychotic is started and then it is to be completed every 6 months. The consulting Administrator confirmed that the AIMS was not completed for R3. 2.R2's clinical record was reviewed for unnecessary medications. Review of R2's Medication Administration Record (MAR) under Schedule for [DATE] has an order, Doxycycline (antibiotic) Hyclate (how the medicine dissolves in stomach) Tablet 100 MG milligrams [mg] Give 1 tablet by mouth two times a day. -Start Date- 12/18/25 2100 (9:00 p.m.) – D/C (discontinue) Date-12/19/25 1440 (2:40 p.m.). Dose was given at approximately 9:00 a.m. on 12/19/25. Review of R2's MAR under Schedule for [DATE] has an order, DOXYCYCLINE MONO (how the medicine dissolves in stomach) 100 MG CAP (capsule) Give 1 tablet by mouth two times a day. -Start Date- 12/19/2025 1000 (10:00 a.m.) Dose was given at approximately 10:00 a.m. on 12/19/25. Doxycycline was given to R2 three times on 12/19/25 instead of the ordered two times daily. The first dose given was ordered as Doxycycline Hyclate (fully dissolves in water) 100 mg by mouth and was given at approximately 9:00 a.m., and the second dose was ordered as Doxycycline Mono (monohydrate) (dissolves slower in the stomach potentially reducing gastrointestinal effect, and lower risk of irritating the esophagus) 100 mg by mouth and was given at approximately 10:00 a.m. The provider ordered Doxycycline Mono 100 mg by mouth twice daily on 12/19/25 at 10:00 a.m. and did not discontinue Doxycycline Hyclate 100 mg by mouth twice daily until 12/19/25 at 2:40 p.m. the medication is the same; however, the way it dissolves in the stomach is different. R2 received 2 doses of Doxycycline in the morning of 12/19/25. Both orders were to give Doxycycline two times daily, R2 received 2 doses in the morning and a 3rd dose on 12/19/25 in the evening. On 1/14/26 at 1:46 p.m. in an interview with the Clinical Reimbursement Manager, and Clinical (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reimbursement Manager – Genesis, a surveyor confirmed that R2 received 3 doses of Doxycycline on 12/19/25 instead of 2 doses as ordered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not ensuring emergency food supplies were labeled with expiration dates and not ensuring that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 1 of 3 days of survey (1/13/26). This has the potential to effect all residents.Findings: On 1/13/26 at 10:44 a.m., during an interview with a surveyor and the Dietary Account Manager, the emergency food supply was observed and confirmed to be unlabeled with dates of expiration. The Dietary Account Manager stated the food parcels are labeled with the month and day they are received but not the year, and the expiration dates are on the boxes the food parcels come in, but the boxes are discarded to save space. On 1/13/26 at 11:04 a.m., a surveyor observed and confirmed with the Dietary Account Manager that the ice machine outside the kitchen did not have a 1 air gap. The floor was observed to be wet around the drain, 3 drain type tubes were observed behind the ice machine, a black tube and a clear tube were observed resting on the floor, the clear tube was actively draining water, and an orange tube was observed descending into the drain beyond sight.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interview, the facility failed to post, in a place readily accessible to residents, family members, and legal representatives, the results of the most recent survey of the facility in the survey folder (located in the entrance foyer) for 2 of 3 days of survey (1/12/26 and 1/13/26). On 1/12/26 at 10:45 a.m., a surveyor observed a bin labeled Survey Results, located in the entrance foyer, was empty. On 1/13/26 at 1:45 p.m., during an interview with a surveyor and the Administrator, the bin labeled Survey Results, located in the entrance foyer, was observed and confirmed to be empty. At 1:47 p.m., the Administrator stated the survey results binder was in the Director of Nursing's office.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to issue a written bed-hold notice to the resident and/or legal representative for 1 of 1 sampled resident's reviewed for re-hospitalization/transfer to an acute care facility (Residents #37 [R37]). In addition, the State Ombudsman Program was not notified of residents that were transferred to an acute care facility. Findings: On 1/13/26, a review of R37's clinical record was completed. Documentation indicated that on 12/22/26, R37 was transferred to the hospital due to an infection and returned four days later. There was no evidence that R37 or their representative was provided a written copy of the bed-hold notice. On 1/14/26 at 9:40 a.m., in an interview with the surveyor, the Administrator confirmed that R37's representative/POA/brother did not receive a written copy of the bed-hold notice. In addition, the Administrator stated the facility notifies the State Ombudsman Program monthly of residents discharged from the facility, but does not notify the State Ombudsman Program of the transfer/discharges of residents sent to the hospital.