MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES LICENSING AND CERTIFICATION
ASSISTED HOUSING PROGRAM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Biennial Survey	DATE COMPLETED 11/19/2025
NAME OF FACILITY: HILLHOUSE, INC. ADMINISTRATOR: PETER R. MANSFIELD LICENSE NUMBER: RCD485 CENSUS: 33 TOTAL CAPACITY: 56	ADDRESS: 166 WHISKEAG RD BATH, ME 04530-4135

HILLHOUSE, INC., RESIDENTIAL CARE FACILITY, is not in compliance with part of 10-144 C.M.R. Chapter 113, Assisted Housing Program Licensing Rule.

The following requirements were not met:

RULE	SUMMARY STATEMENT OF DEFICIENCIES

5(E)(3)(a)

Section 5. Medications And Treatments

E. Medication storage

3. Medications administered by the facility that do not require controlled temperature storage, such as refrigeration, must be kept in their original containers in a locked storage cabinet. [Class III]

a. The cabinet must be equipped with separate cubicles, plainly labeled, or with other physical separation for the storage of each resident's medications; [Class III]

This has not been met as evidenced by:

Based on observation and interview, the facility did not maintain separate, clearly labeled cubicles or other physical means of separation for each resident's medications.

Finding:

On 11/13/2025, observation of the facility's medication carts revealed:

- Schedule II/controlled medications belonging to multiple residents were stored together in Cart #1 and Cart #2 without physical separation or individual labeling identifying each resident's medications.

This observation was confirmed with the Certified Residential Medication Aide (CRMA) on duty at the time of observation, and with the Administrator at the exit interview on 11/13/2025.

AGENCY PLAN OF CORRECTION:

Procure physical separators from the consultant pharmacy, which furnished medication carts #1 and #2. Install plainly labeled physical separation system when received. This item shall be added to the med cart audit process, confirming medication storage is in compliance.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/2/2026	Administrator

8(A)(1)(b)(c)(d)(e)(f)(m)

Section 8. Administrative and Resident Records

A. Individual records required. The facility must maintain information pertaining to a resident centralized in an individual record that is chronologically organized and legible. The record must contain the following, where applicable: [Class IV]

Signature of Administrator: _____ Date:

(Signature binding on all 8 page(s))

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Rev-1, 1/6/2026
Rev-2, 1/7/2026

1. A summary, completed at admission and updated with changes as needed, that includes the following information, as applicable: [Class IV]

b. Birth date, gender, and marital status
c. Date of admission and source
d. Religious affiliation
e. Duly authorized licensed practitioner's name, address, and telephone number, and any known resident allergies
f. Dentist's name, address, and telephone number, and denture use, if applicable; with the name, address, and telephone number of the denture manufacturer
m. Language spoken/communication method

This has not been met as evidenced by:

Based on record review and staff interview, the facility failed to ensure that required resident information was complete and maintained in the individual resident record for 2 out of 3 resident records reviewed (Resident #1 and Resident #2).

Findings:

Review of resident records revealed missing required Summary Sheet information.

- Resident #1's Summary Sheet did not contain the following required information: dentist's name, address, and telephone number, and language spoken/communication method.
- Resident #2's Summary Sheet did not contain the following required information: marital status, date of admission, religious affiliation, duly authorized licensed practitioner's address and telephone number, and dentist's name, address, and telephone number.

These findings were confirmed with the facility's RN at the time of the survey and with the Administrator at the exit interview on 11/13/2025.

AGENCY PLAN OF CORRECTION:

Required Summary Sheet information will be completed at the time of admission and included with the Individual Record. Complete an audit of existing resident individual records to identify and obtain missing information. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance across all departments, including specific items in this POC.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/16/2026	Nurse Consultant and Administrator

8(A)(2)(b)

Section 8. Administrative and Resident Records

A. Individual records required. The facility must maintain information pertaining to a resident centralized in an individual record that is chronologically organized and legible. The record must contain the following, where applicable: [Class IV]

2. A listing of all personal property of significant value to the resident that includes such things as clothing, jewelry, radios, television sets, dentures, appliances, and other valuables: [Class IV]

b. The record must be signed and dated by the resident or his/her legal representative.

This has not been met as evidenced by:

Based on review of personal property inventories and staff interview, the facility failed to ensure that all personal property inventories included the date and signature of the resident or his/her legal representative (Residents #2 and #3).

Date Completed:

Initially submitted 12/19/2025
Rev-1, 1/6/2026
Rev-2, 1/7/2026

Findings:

Review of personal property inventories revealed incomplete documentation for the following residents:

- **Resident #2:** Personal property inventory did not include the date and signature of the resident or their legal representative.
- **Resident #3:** Personal property inventory did not include the date and signature of the resident or their legal representative.

These findings were confirmed with the facility's RN at the time of the survey and with the Administrator at the exit interview on 11/13/2025.

AGENCY PLAN OF CORRECTION:

Personal property inventory shall be completed and signed with the resident and/or their legal representative during the admission process. The signed personal property inventory shall be included in the individual record. Existing personal property inventories shall be audited and corrected. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance, including specific items in this POC.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/16/2026	Social Services Supervisor

9(F)(6)

Section 9 Staffing Requirements

F. Employee records. Facilities must maintain individual records on all employees. Records may be computerized.

6. Job description

This has not been met as evidenced by:

Based on review of employee records and interview, the facility failed to ensure that current job descriptions in employee records accurately reflect their assigned role as CRMAs for 3 out of 5 employee records reviewed (Staff #2, Staff #3, and Staff #5).

Findings:

On 11/13/2025, a review of employee records revealed that Staff #2, Staff #3, and Staff #5, all Certified Residential Medication Aides (CRMAs), had incorrect job descriptions in their files; each file contained only a CNA/PSS job description, which does not reflect current CRMA duties.

These findings were confirmed with the facility's Business Manager at the time of the survey and with the Administrator at the exit interview on 11/13/2025.

AGENCY PLAN OF CORRECTION:

Audit employee individual records to identify staff who have changed roles and need to sign current job descriptions. Employees shall review and sign current job description when an employee changes or adds an assigned work role. Signing a new job description shall be added to the payroll authorization process. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance across all departments, including specific items in this POC.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/2/2026	Supervisors and Managers, Administrator confirmed

13(B)(5)(6)(9)(10)(11)(13)

Section 13. Standards for Resident Care

B. Resident assessment. Within 30 calendar days of admission, the facility must assess residents for the following: [Class III]

5. Need for assistance with legal or financial problems.

6. Ability to manage personal affairs, use the telephone, handle finances, read and write correspondence, express likes and dislikes and register to vote.

9. Need for assistance with securing necessary health care, including medical, nursing, dental, day treatment, psychological, mental health or substance use disorder services, qualified sign language interpreters and other communication assistance.

10. Need for arranging transportation to meet medical, social, and business needs.

11. Need for assistance to be independent in the community, including need for supervision related to unsafe wandering from the facility.

13. Need for discharge planning.

This has not been met as evidenced by:

Based on record review and interview the facility failed to assess a resident in the areas above for 1 out of 3 resident records reviewed (Resident #2).

Finding:

On 11/13/2025 a review of Resident #2's assessment dated 9/4/2025 was completed. The assessment dated 9/4/2025 lacked documentation in multiple required areas, including legal/financial assistance, functional abilities, health care coordination, transportation needs, community independence, and discharge planning.

These findings were confirmed with the facility RN at the time of the survey and with the Administrator at the exit interview on 11/13/2025.

AGENCY PLAN OF CORRECTION:

Management (nurse consultants and administrator) shall review and update the resident assessment process and update checklists to compile required assessments and assistance needs. Assessments shall be shall be completed within 30 days of admission.
The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance across all departments, including specific items in this POC.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/16/2026	Nurse Consultant, Administrator confirmed

13(C)(2)

Section 13. Standards for Resident Care

C. Service plan. Within 30 calendar days of admission, the facility must develop and implement a service plan for each resident based upon the findings of the resident's assessment: [Class III]

2. The resident and, as applicable, the resident's legal representative and others chosen by the resident, must be actively involved in the development of the service plan, as demonstrated by signature on the service plan, unless the resident, legal representative, and/or others chosen by the resident are unable or unwilling to participate;

This has not been met as evidenced by:

Date Completed:

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	Based on record review and interview, the facility failed to ensure that residents or their legal representatives were actively involved in the development of the service plan, as evidenced by missing signatures (Resident #2 and Resident #3) **Findings:** On 11/13/2025, a review of Resident #2 and Resident #3 service plans was completed. There is no evidence that Resident #2 and Resident #3 were actively involved in the development of their service plans, as neither the residents nor their legal representatives signed the service plans. These findings were confirmed by the facility's RN at the time of the survey and with the Administrator at the exit interview on 11/13/2025.
	AGENCY PLAN OF CORRECTION: Legal representatives are consulted prior to service plan meetings about resident participation. Residents, when able, and their legal representatives shall sign the meeting notes. It shall be noted whether the resident attended or did not attend the service plan (care plan) meeting. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance, including specific items in this POC.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/16/2026	Nurse Consultant

13(C)(3)	**Section 13. Standards for Resident Care** **C. Service plan.** Within 30 calendar days of admission, the facility must develop and implement a service plan for each resident based upon the findings of the resident's assessment: [Class III] **3.** The facility must maintain documentation in the resident's record identifying who participated in the development of the service plan and the ability and willingness of the resident and, as applicable, the resident's legal representative and others chose by the resident to participate. This has not been met as evidenced by: Based on record review and interview, there is no evidence that the residents and/or their legal representatives participated in the development of their service plans for 2 of 3 resident records reviewed (Resident #2 and Resident #3). **Findings:** On 11/13/2025, review of Resident #2 and Resident #3 service plans revealed: • **Resident #2:** Service plan dated 10/23/2025. • **Resident #3:** Service plan dated 10/30/2025. The records contained no documentation identifying who participated in the development of the service plan, nor documentation of the ability and willingness of the resident, their legal representative, or others chosen by the resident to participate. These findings were confirmed with the facility RN at the time of the survey and with the Administrator at the exit interview on 11/13/2025

	AGENCY PLAN OF CORRECTION: Legal representatives are consulted prior to service plan meetings about resident participation. Residents, when able, and their legal representatives shall sign the meeting notes. It shall be noted whether the resident attended or did not attend the service plan (care plan) meeting. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance across all departments, including specific items in this POC.
DATE COMPLETED 1/16/2026	TITLE OF PERSON RESPONSIBLE: Nurse Consultant

13(C)(4)	**Section 13. Standards for Resident Care** **C. Service plan.** Within 30 calendar days of admission, the facility must develop and implement a service plan for each resident based upon the findings of the resident's assessment: [Class III] **4.** The facility must offer a copy of the service plan to the resident or legal representative and maintain documentation in the resident's record that a copy was offered to the resident or legal representative; This has not been met as evidenced by: Based on record review and interview, the facility did not ensure that a copy of the service plan was offered to the resident or legal representative, nor was documentation maintained in the resident's record for two of three resident records reviewed (Resident #2 and Resident #3). **Findings:** On 11/13/2025, a review of the service plans for Resident #2 and Resident #3 was completed. • Resident #2 had a service plan dated 10/23/2025. • Resident #3 had a service plan dated 10/30/2025. Neither resident's record contained documentation that a copy of the service plan was offered to the resident or the resident's legal representative. On 11/13/2025, an interview with the facility's RN confirmed that a copy of the service plan was not offered to the resident or the resident's legal representative. These findings were confirmed with the Administrator at the exit interview on 11/13/2025.
	AGENCY PLAN OF CORRECTION: The service plan shall be developed within 30 days of admission based on the service plan meeting with resident and their legal representative and applicable follow up items. Once complete, the developed service plan shall be provided to resident and their representative for signatures to document their inclusion. A copy with their signatures shall be given to the resident and their representative. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance across all departments.
DATE COMPLETED 1/30/2026	TITLE OF PERSON RESPONSIBLE: Nurse Consultant, Administrator confirmed

13(C)(5)(b)	**Section 13. Standards for Resident Care** **C. Service plan.** Within 30 calendar days of admission, the facility must develop and implement a service plan for each resident based upon the findings of the resident's assessment: [Class III] **5**. The service plan must describe strategies and approaches to meet the resident's needs, including:

b. when and how often services will be provided.

This has not been met as evidenced by:

Based on record review and interview, the facility failed to ensure that service plans included the frequency with which services would be provided for each resident, for two out of three resident records reviewed (Resident #2, Resident #3).

Findings:

On 11/13/2025, a review of Resident #2 and Resident #3's service plans were completed:

- **Resident #2:** Service plan dated 10/23/2025 did not identify how often services would be provided for each goal.
- **Resident #3:** Service plan dated 10/30/2025, did not identify how often services would be provided for each goal.

On 11/13/2025, an interview with the facility's RN confirmed that each goal on Resident #2 and Resident #3's service plan did not specify how often services would be provided for each goal.

These findings were confirmed with the Administrator at the exit interview on 11/13/2025.

AGENCY PLAN OF CORRECTION:

Service Plans shall include the frequency with which services will be provided for each resident. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance across all departments, including specific items in this POC.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/30/2026	Nurse Consultant

15(F)

Section 15. Dietary Services

F. Diet manual. Each facility must have a diet manual, not more than five years old, that is recommended or approved by a qualified registered dietitian. When facilities utilize an online resource to meet this requirement, link(s) to the resource must be provided to the Department upon request.

This has not been met as evidenced by:

Based on observation and interview, the facility failed to ensure the diet manual was not more than five years old.

Findings:

On 11/19/2025 the facility diet manual was requested.

Diet manual provided was from 2019 and it was confirmed the facility was not utilizing an online resource.

These findings were confirmed with the Administrator at the time of observation and reviewed with the Administrator at exit interview on 11/19/2025.

Date Completed: Initially submitted 12/19/2025
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Rev-2, 1/7/2026

	AGENCY PLAN OF CORRECTION: The Diet Manual shall be reviewed and dietitian reviewed immediately and again within five years. The Administrator and department supervisors shall hold quarterly compliance review meetings to review and maintain compliance across all departments, including the diet manual.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/30/2026	Dietary Supervisor, Administrator confirmed

16 (F)(8)	**Section 16. Physical Plant Requirements** **F. Toilets and bathing facilities.** The facility must have toilet and bathing facilities that are indoors, safe, private, and kept in a clean and sanitary condition. 8. In order to accommodate resident privacy, doors or stalls must have privacy locks, unlockable by authorized persons from the exterior in case of emergency; This has not been met as evidenced by: Based on observation and interview, the facility failed to ensure bathroom doors had locks. **Findings:** On 11/19/2025 the facility was toured with the following observations: 1) Bathroom located between bedrooms M26 and M27 had no interior lock on either door. 2) Bathroom located between bedrooms M30 and M31 had no interior lock on door connected to bedroom M31. 3) Bathroom located between bedrooms M32 and M33 had no interior lock on door connected to bedroom M33. These findings were confirmed with the Administrator at the time of observation and reviewed with the Administrator at exit interview on 11/19/2025.
	AGENCY PLAN OF CORRECTION: One-way privacy locksets, unlockable by authorized personnel from the exterior in case of emergency, shall be installed and maintained at both doors of shared bathrooms of units M26/M27, M30/M31, and M32/M33, as required. There are no other shared bathrooms in the building. These doors shall be added to the life safety doors to be inspected annually.

DATE COMPLETED	TITLE OF PERSON RESPONSIBLE:
1/16/2026	Administrator

Initially submitted 12/19/2025

Date Completed: Rev-1, 1/6/2026
Rev-2, 1/7/2026