STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION **Complaint Investigation: 2025-AHP-42181, 42183, 42186, 42187**		Date Completed: 8/18/2025
Name of Facility: HILLHOUSE, INC. Administrator: PETER MANSFIELD LEVEL IV RESIDENTIAL CARE FACILITY Total Capacity: 56 License Number: RCD485	Address: 166 WHISKEAG RD BATH, ME 04530-4135	
Summary Statement of Deficiencies	**Plan of Correction**	**Completion Date**

Hillhouse Inc., a Level IV Residential Care Facility, is not in compliance with 10-144, Chapter 113, Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level IV Residential Care Facilities and Infection Prevention and Control. The following requirements were not met:

5 RESIDENT RIGHTS

5.25 Mandatory report of rights violations. Any person or professional who provides health care, social services or mental health services or who administers a long term care facility or program who has reasonable cause to suspect that the regulations pertaining to residents' rights or the conduct of resident care have been violated, shall immediately report the alleged violation to the Department of Human Services ((800) 383-2441) and to one or more of the following:

Disability Rights Center (DRC), pursuant to Title 5 M.R.S.A. § 19501 through § 19508 for incidents involving persons with mental illness; the Long Term Care Ombudsman Program, pursuant to Title 22 M.R.S.A. § 5107-A for incidents involving elderly persons; the Office of Advocacy, pursuant to Title 34-B M.R.S.A. § 1205 for incidents involving persons with mental retardation; or Adult Protective Services, pursuant to Title 22 M.R.S.A. § 3470 through § 3487.

 Signature of Administrator: _____ Date: _____ MGF (11/2018)
(Signature binding on all 3 Complaint Investigation page(s))

Reporting suspected abuse, neglect and exploitation is mandatory in all cases. Documentation shall be maintained in the facility that a report has been made.

Mandated reporters shall contact the Department of Health and Human Services ((800) 383-2441) immediately after receiving and/or obtaining information about any rights violations. [Class IV]

This has not been met as evidenced by:

Based on record review and interviews, the provider failed to ensure suspected violations of resident rights or violations of conduct of care were immediately reported to the Department of Health and Human Services, Division of Licensing and Certification, for 2 out of 2 resident records reviewed.

Finding:

On 8/11/2025, the Division of Licensing and Certification received cases of suspected violations of residents' rights involving Employee #1 and Residents #1 and Resident #2.

On 8/15/2025, review of Resident #1 and Resident #2's incident reports dated 8/11/2025 was completed which indicated the following:

1. On 7/27/2025, Employee #2 witnessed Employee #1 use excessive force when they were providing care to Resident #1 after Resident #1 became combative.

2. On 8/7/2025, Employee #3 witnessed Employee #1 use a physical restraint when they were providing care to Resident #2 after Resident #2 became combative.

On 8/15/2025, an interview was completed with the facility's Business Manager and RN, who reported that the incident involving Resident #1 occurred on 6/23/2025. It was confirmed that Employee #2 and Employee #3 did not report these incidents to management until 8/11/2025.

These findings were confirmed at the time of the survey with the facility's Business Manager and RN, and via email correspondence on 8/18/2025 with the facility's Business Manager.