Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075268	A. Building B. Wing	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Hill Care Center	151 Hillside Ave Hartford, CT 06106

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation review, facility policy review and interviews for one of three residents (Resident #2) reviewed for accidents, the facility failed to maintain a complete and accurate medical record to include offering and refusals of support services. The findings include: Resident #2 was admitted with diagnoses that included substance abuse disorder with an opioid addiction, cervical spine degeneration with disc compression and muscle weakness. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #2 was alert, oriented and walked independently. The Resident Care plan (RCP) identified Resident #2 had a substance abuse disorder and was actively using substances prior to admission, with a goal to not use alcohol, or illegal substances. The RCP directed to encourage to participate in the facilities substance use recovery services, provide supervised visits until comfortable in the recovery process and resident would not use alcohol or illegal substances through the next review. Interview with the Director of SW (SW #2) on 11/30/2023 at 1:00 PM identified Resident #2 refused to attend the Recovery Program groups at the facility twice a week as part of the recovery services offered at the facility. SW #2 was unable to provide documentation of the offering or refusal to attend, and indicated the offering or refusals should be documented in the social services notes. Interview with the DON on 11/30/2023 at 1:30 PM identified that if a resident refused interventions identified in a resident's plan of care, the refusal should be documented in the medical record. Interview and review of the medical record with the Clinical Director on 11/30/2023 at 2:30 PM identified that the medical record lacked documentation for offered recovery program groups and lacked documentation of Resident #2's refusal to attend. Although requested, a facility documentation policy was not provided for surveyor review during the survey.

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