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	04/14/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident (Resident #1) was free from physical abuse. The findings include: a. Resident #1's diagnoses included vascular dementia and schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, alert and disoriented, no behaviors and was dependent for wheelchair mobility. The Resident Care Plan (RCP) dated 3/26/2025 identified Resident #1 had dementia and an alteration in mobility. Interventions directed to administer medications as ordered, and custom modified wheelchair for mobility. b. Resident #2's diagnoses included dementia, paranoid schizophrenia, and schizoaffective disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was severely cognitively impaired, alert and oriented to self only, had no behaviors, and was independent with ADLs and ambulation. The Resident Care Plan (RCP) dated 2/13/2025 identified Resident #2 had the potential to be physically aggressive related to dementia. Interventions directed to administer medications as ordered, and psychiatry follow up as indicated. Facility reportable event dated 3/25/2025 identified at 12:45 PM, NA #1 witnessed Resident #2, unprovoked, slap Resident #1. Resident #1 was sitting in a wheelchair in the hall when Resident #2 walked up to Resident #1 and slapped the left side of his/her face. Residents were separated and assessed, and Resident #1's face was observed to be reddened. Resident #2 was placed on one-to-one (1:1) monitoring and transferred to the hospital for evaluation. The facility summary dated 3/27/2025 identified Resident #2 returned from the hospital and remained on 1:1 observation until psychiatry visit. Record review identified Resident #2 had prior resident to resident altercations on 6/19/2024 at 2 PM, 8/18/2024 at 10:10 AM, and 10/18/2024 at 1 PM. Review of NA #1's statement dated 3/25/2025, identified she was collecting lunch trays when a non-staff member notified her that Resident #1 was hit. NA #1 then looked at Resident #1 and observed Resident #2 hit Resident #1 a second time. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documentation with NA #1 on 4/14/2025 at 11:57 AM identified she heard a non-staff member yell, hey don't do that. NA #1 stated she looked down the hall and saw Resident #1 sitting in hallway, and observed Resident #2 slap Resident #1 for the second time on the left side of the face with his/her right hand. Interview, clinical record and facility documentation review with SW #1 and SW #2 on 4/14/2025 at 12:56 PM identified Resident #2 was on a waitlist for an evaluation for an in-patient psychiatric stay due to a history of refusing to take medications prior to the 3/25/2025 altercation with Resident #1, and remained on the wait list for that facility. Resident #2 was independently mobile, continued on every 15-minute checks, and was followed by psychiatric services until he/she is accepted for transfer to another facility. On 4/14/2025 at 2:22 PM interview, clinical record and facility documentation review with the DNS, the Administrator and RN #1 identified that there were two witnesses to Resident #2 slapping Resident #1 on the face. The first witness was Lab Tech #1, however although Lab Tech #1 reported the incident, he/she refused to provide a witness statement, and NA #1 was the second witness. RN #1 identified that Resident #2 had a similar occurrence several months prior when Resident #2 was not taking his/her medication and Resident #1 was not specifically targeted by Resident #1. The DNS stated the hospital administered a faster onset anti-psychotic medication and made additional medication adjustments for Resident #2 Resident #2 remained on every 15-minute checks and was followed by psychiatric services. RN #1 identified there was physical contact made by Resident #2 to Resident #1 but the facility did not consider it willful contact by Resident #2. Review of facility Abuse Policy directed in part, abuse was defined as the willful infliction of injury, and included physical abuse. Physical abuse was defined as hitting, slapping, pinching and kicking. The Policy directed residents will not be subjected to abuse by anyone, including but not limited to facility staff, other residents, or other individuals. Review of facility Abuse Policy directed in part residents will not be subjected to abuse by anyone, including but not limited facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends or other individuals.