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	05/20/2025

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 - Immediate jeopardy to resident health or safety 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** Based on a review of clinical records, facility documentation, facility policy, and interviews for one of three residents (Resident #3) reviewed for abuse, the facility failed to ensure the residents were free from abuse and failed to ensure adequate supervision to prevent a resident-to-resident altercation with an injury. These failures resulted in a finding of Immediate Jeopardy. The findings include: a. Resident #1's diagnoses included anxiety and schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen, indicative of moderate cognitive impairment, and was self-mobile in a wheelchair. The Resident Care Plan (RCP) dated 11/25/2024 identified Resident #1 had a potential for aggressive behaviors toward other residents. Interventions directed every 15-minute checks as indicated, administer medications as ordered, counseled to seek assistance of staff for issues with peers, psychiatric and social services follow up as indicated, when resident becomes agitated intervene before agitation escalates, guide away from source of distress, and if aggressive to staff to walk away calmly and reapproach later. Record review identified Resident #1 had prior resident-to-resident altercations. On 9/16/2023 Resident #1 hit his/her roommate, in a bathroom that was shared by both residents, on the head with a trash bin causing the bin to break into pieces and caused two (2) abrasions to the other resident's leg. The care plan was updated to move the roommate to another room. On 12/3/2023 Resident #1 slapped another resident, at the nursing station, and a scratch was noted on the other resident. The care plan was updated to include every 15-minutes checks until cleared by psychiatry and social work was to follow up. On 2/19/2024 Resident #1 slapped another resident at the nurse's station. The care plan was updated to direct every 15-minute checks until cleared by psychiatry, staff to monitor Resident #1 by constant community awareness, and psychiatry and social service follow up as needed. On 11/25/2024 when Resident #1 attempted to transfer into a chair at the nurse's station, another resident moved the chair and Resident #1 then pushed the other resident. The care plan was updated to direct every 15-minute monitoring, and the chair was removed from the nurse's station. b. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Trinity Hill Care Center	151 Hillside Ave Hartford, CT 06106

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2's diagnoses included anxiety, dementia, schizoaffective disorder, and bipolar disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a BIMS score of ten out of fifteen, indicative of moderate cognitive impairment, and was self-mobile in a wheelchair. The RCP dated 11/14/2024 identified dementia. Interventions directed to administer medications as directed and ask yes/no questions to determine resident needs. Facility reportable event dated 1/20/2025 at 4:30 PM identified Resident #1 reported Resident #2 said bad words and Resident #1 hit Resident #2, then Resident #2 hit Resident #1. Resident #1 was noted with an abrasion to the left side of his/her face, and orders were obtained for bacitracin to the area and left open to air. The residents were immediately separated and placed on every 15-minute monitoring. Resident #2 was moved to another unit. Record review identified that every 15-minute monitoring was discontinued by psychiatry on 1/25/2025. The facility summary dated 1/22/2025 identified no additional interventions. c. Resident #3's diagnoses included atrial fibrillation and dementia. The quarterly (MDS assessment dated [DATE] identified that Resident #3 had a BIMS score of five out of fifteen, indicative of severe cognitive impairment, had no behaviors, required assistance with wheelchair mobility, and identified English was not Resident #3's preferred language. The RCP dated 4/15/2025 identified impaired cognition and a pacemaker due to atrial fibrillation. Interventions directed to administer medications as ordered and ask yes/no questions to determine resident needs. Physician order dated 4/9/2025 directed Eliquis (blood thinner) 5 milligrams (mg) tablet, one (1) tablet by mouth, two (2) times a day, and Clopidogrel (Plavix) (blood thinner prevents blood clotting) 75 mg, one (1) tablet by mouth, one time a day. Facility reportable event dated 4/20/2025 at 12:30 PM identified Resident #3 was hit in the face by Resident #1 (unwitnessed by staff). Staff responded to both residents talking loudly in the hallway and noted Resident #3 had a two (2) centimeter (cm) laceration to the temporal area (near the ear) with bleeding. Resident #1 stated he/she hit Resident #3 because Resident #3 stole toilet paper from his/her bathroom. The report further indicated that Resident #3 was dependent on staff for bathroom use and unable to use the bathroom independently. The residents were separated. Resident #1 was placed on 1:1 monitoring until transfer to the hospital for evaluation. Neurological assessment was completed for Resident #3, who was transferred to the hospital for evaluation. Nursing note for Resident #1 dated 4/20/2025 at 12:14 PM identified Resident #3 was in Resident #1's way in the hallway. Resident #3 did not move, and Resident #1 hit Resident #3 in the face causing an open area to the temporal area. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing note for Resident #3 dated 4/20/2025 at 1:42 PM identified that an RN assessment was completed after the resident-to-resident physical altercation. Resident #3 was alert, oriented to self with confusion at baseline, and did not state what happened. Redness was noted to the left eye and left upper eyelid. Unequal pupillary reaction/constriction was noted during assessment, the right eye had a brisk response, the left eye had a sluggish response, and active bleeding was observed from the left temporal region and oozing/running down the left side of face. A left temporal region laceration was noted, measuring approximately 2 by 0.1 cm and 0.75 cm in depth. Direct pressure was applied to the lacerated area, but persistent bleeding. The APRN was notified, and Resident #3 was transferred to the hospital for evaluation. Facility incident summary dated 4/24/2025 identified the facility as unable to substantiate that abuse occurred because there was no willful or deliberate action against Resident #3. The summary identified Resident #3 was admitted to the hospital with a subdural hematoma (bleeding near the brain that can occur after trauma), related to medication regime of anticoagulants. The summary further indicated that upon Resident #1's return from the hospital with a no harm letter, Resident #1 was placed on enhanced observation. A virtual APRN visit was conducted on 4/21/2024 with medication adjustments and a plan for continued enhanced monitoring. Education was also provided to residents to have staff assist with resident-to-resident conflicts. Record review identified that monitoring (1:1 monitoring and every 15-minute checks) was discontinued as of 4/28/2025. Review of Resident #3's hospital history and physical dated 4/20/2025 identified Resident #3 was diagnosed with a hyperacute right temporo-parieto-occipital subdural hematoma (a complex area where the temporal, parietal and occipital brain lobes meet; area has a crucial role in integrating sensory information, attention, language, reasoning and memory) and was admitted to the intensive care unit (ICU). Hospital records identified Resident #3 was treated with a craniotomy (surgical opening into the skull to relieve pressure on the brain/remove the hematoma) on 4/28 and 5/6/2025. Further review identified that Resident #3 remained at the hospital during the time of the survey (30 days after the incident). Hospital medicine progress note dated 5/19/2025 identified Resident #3 had a principle problem of subdural hematoma. Resident #3 underwent craniotomy with evacuation of the subdural hematoma followed by MMA embolization (Middle Meningeal Artery embolization is a minimally invasive procedure used to block blood supply to the area affected by a subdural hematoma). Resident #3 was still encephalopathic (medical term that describes a general condition where the brain does not function properly). Interview with Resident #1 on 5/14/2025 at 12:58 PM identified that he/she had garbled speech and stated he/she hit a resident in the bathroom in the past. Resident #1 denied hitting another resident in the hallway or near the nurse's station. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, clinical record review, and hospital record review with MD #1/attending MD on 5/14/2025 at 11:29 AM identified that trauma, such as a hit to the head, could cause a subdural hematoma, and Resident #3 had a visible injury to the left side of the head. MD #1 stated an injury on the left side of the head could cause an injury on the right side of the brain (the opposite side) as the brain moves within the skull in a coup and contrecoup effect (rebound/recoil effect with the internal injury on the opposite side of the external force). Further, MD #1 stated Resident #3's injury was caused by the hit on the side of the head, because of how quickly Resident #3 had the bleeding after the injury occurred, he stated in his opinion, the hyperacute right temporo-parieto-occipital subdural hematoma was likely ninety percent certain caused by the trauma. Interview, clinical record review, and facility documentation review on 5/14/2025 at 2:39 PM with the DNS identified that Resident #1 admitted to hitting Resident #3 on 4/20/2025. The DNS stated Resident #1 was initially unable to provide a clear explanation regarding the incident, and then Resident #1 indicated Resident #3 took toilet paper from Resident #1's bathroom, however, Resident #3 did not use the bathroom and required total care for toileting. The DNS stated Resident #1 should not have hit Resident #3, and the facility did not substantiate abuse because Resident #1 did not willfully seek out Resident #3, and because Resident #1's story of the incident changed. The interview failed to identify the facility substantiated the abuse based on Resident #1 hitting Resident #3, and the subsequent diagnosed injury that required an extensive hospital admission. Interview, review of clinical record on 5/14/2025 at 8:55 AM with APRN #1 identified that Resident #1 had good motor control and did not have a lack of coordination or issues with swinging his/her arms. APRN #1 indicated Resident #1 was able to navigate hallways independently in a wheelchair and had full purposeful use of extremities (did not have uncontrolled movements of his/her extremities). Subsequent to surveyor inquiry, Resident #1 was placed on one-to-one (1:1) observations on 5/14/2025. Review of the facility Abuse Policy dated 3/20/2024 directed in part, physical abuse included hitting, slapping, pinching, kicking, etc. The Policy further directs that residents will not be subjected to abuse by anyone, including other residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #3) reviewed for abuse, the facility failed to develop a comprehensive care plan for a resident receiving anticoagulant medication (blood thinners). The findings include: Resident #3's diagnoses included atrial fibrillation. Physician's order for Resident #3 dated 4/9/2025 directed Eliquis (blood thinner) 5 mg tablet, one (1) tablet orally two (2) times a day related to atrial fibrillation and Clopidogrel (Plavix) (prevents blood clotting) 75 mg, one (1) tablet orally, one time a day related for atrial fibrillation. Record review identified Resident #3 was on Eliquis and Plavix upon admission to the facility during 5/2024. The quarterly MDS assessment dated [DATE] identified Resident #3 was admitted during 5/2024, had a BIMS score of five out of fifteen, indicative of severe cognitive impairment, had no behaviors, and received anticoagulants during the prior seven (7) days. The RCP dated 4/15/2025 identified impaired cognition and a pacemaker due to atrial fibrillation. Interventions directed to administer medications as ordered and ask yes/no questions to determine resident needs. Additional record review failed to identify Resident #3 had a care plan for Eliquis and Plavix use and risk of bleeding. Interview and record review with the DON on 5/20/2025 at 1:15 PM identified Resident #3 should have a care plan for bleeding risk related to the anticoagulant use, and was unable to identify a care plan for Eliquis and Plavix use and risk of bleeding. Subsequent to surveyor inquiry, the DON provided a care plan for Eliquis and Plavix use and risk of bleeding and was unable to identify when the care plan was written. Interview, clinical record and facility documentation review on 5/20/2025 at 2:04 PM with (RN #2)/MDS Coordinator identified when Resident #3 was admitted to the facility, he/she was receiving Eliquis and Plavix. RN #2 stated Resident #3 should have a care plan for risk of bleeding. Interview identified RN #2 created the risk of bleeding care plan on 5/20/2025. RN #2 stated during prior admissions, Resident #2 had a care plan for risk of bleeding due to Eliquis and Plavix use, but stated the facility had a different electronic medical record system at that time. RN #2 stated the electronic medical record system in use currently did not have an option for risk of bleeding, and he did not create the care plan for Resident #3. RN #2 stated he should have created the care plan, and he forgot to do it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Care Plan Policy directed in part, to develop a comprehensive person-centered plan of care. The Policy further directed, within seven days of completing the MDS and CAA's (Care Area Assessments), to develop and review the plan of care to ensure it is person-centered and individualized to meet the needs of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, facility policy, and interviews for one of three residents (Resident #3) reviewed for abuse, the facility failed to ensure adequate supervision for a resident with known aggressive behaviors directed toward others, and to prevent a resident-to-resident incident with a resident injury. The findings include: a. Resident #1's diagnoses included anxiety and schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen, indicative of moderate cognitive impairment, and was self-mobile in a wheelchair. The Resident Care Plan (RCP) dated 11/25/2024 identified Resident #1 had a potential for aggressive behaviors toward other residents. Interventions directed every 15-minute checks as indicated, administer medications as ordered, counseled to seek assistance of staff for issues with peers, psychiatric and social services follow up as indicated, when resident becomes agitated intervene before agitation escalates, guide away from source of distress, and if aggressive to staff to walk away calmly and reapproach later. Record review identified Resident #1 had prior resident-to-resident altercations. On 9/16/2023 Resident #1 hit his/her roommate in a bathroom that was shared by both residents on the head with a trash bin causing the bin to break into pieces and caused two (2) abrasions to the other resident's leg. The care plan was updated to move the roommate to another room. On 12/3/2023 Resident #1 slapped another resident, at the nursing station, and a scratch was noted on the other resident. The care plan was updated to include every 15-minutes checks until cleared by psychiatry and social work was to follow up. On 2/19/2024 Resident #1 slapped another resident at the nurse's station. The care plan was updated to direct every 15-minute checks until cleared by psychiatry, staff to monitor Resident #1 by constant community awareness, and psychiatry and social service follow up as needed. On 11/25/2024 when Resident #1 attempted to transfer into a chair at the nurse's station, another resident moved the chair and Resident #1 then pushed the other resident. The care plan was updated to direct every 15-minute monitoring, and the chair was removed from the nurse's station. On 1/20/2025 Resident #1 reported another resident said bad words in the hallway, and both residents hit each other. Resident #1 was noted with an abrasion on the left side of his/her face. The residents were placed on every 15-minute monitoring and the other resident was moved to another unit. Record review identified Resident #1's every 15-minute monitoring was discontinued by psychiatry on 1/25/2025. b. Resident #3's diagnoses included atrial fibrillation and dementia. The quarterly (MDS assessment dated [DATE] identified Resident #3 had a BIMS score of five out of fifteen, indicative of severe cognitive impairment, had no behaviors, required assistance with wheelchair mobility, and identified English was not Resident #3's preferred language. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RCP dated 4/15/2025 identified impaired cognition and a pacemaker due to atrial fibrillation. Interventions directed to administer medications as ordered and ask yes/no questions to determine resident needs. Physician order dated 4/9/2025 directed Eliquis (blood thinner) 5 milligrams (mg) tablet, one (1) tablet by mouth, two (2) times a day, and Clopidogrel (Plavix) (blood thinner prevents blood clotting) 75 mg, one (1) tablet by mouth, one time a day. Facility reportable event dated 4/20/2025 at 12:30 PM identified Resident #3 was hit in the face by Resident #1 (unwitnessed by staff). Staff responded to both residents talking loudly in the hallway and noted Resident #3 had a two (2) centimeter (cm) laceration to the temporal area (near the ear) with bleeding. Resident #1 stated he/she hit Resident #3 because Resident #3 stole toilet paper from his/her bathroom. The report further indicated that Resident #3 was dependent on staff for bathroom use and unable to use the bathroom independently. The residents were separated. Resident #1 was placed on 1:1 monitoring until transfer to the hospital for evaluation. Neurological assessment was completed for Resident #3, who was transferred to the hospital for evaluation. Nursing note for Resident #1 dated 4/20/2025 at 12:14 PM identified Resident #3 was in Resident #1's way in the hallway. Resident #3 did not move, and Resident #1 hit Resident #3 in the face causing an open area to the temporal area. Nursing note for Resident #3 dated 4/20/2025 at 1:42 PM identified an RN assessment was completed after the resident-to-resident physical altercation. Resident #3 was alert, oriented to self with confusion at baseline, and did not state what happened. Redness was noted to the left eye and left upper eyelid. Unequal pupillary reaction/constriction was noted during assessment, the right eye had a brisk response, the left eye had a sluggish response, and active bleeding was observed from the left temporal region and oozing/running down the left side of face. A left temporal region laceration was noted, measuring approximately 2 by 0.1 cm and 0.75 cm in depth. Direct pressure was applied to the lacerated area, but persistent bleeding. The APRN was notified, and Resident #3 was transferred to the hospital for evaluation. Facility incident summary dated 4/24/2025 identified the facility as unable to substantiate that abuse occurred because there was no willful or deliberate action against Resident #3. The summary identified Resident #3 was admitted to the hospital with a subdural hematoma (bleeding near the brain that can occur after trauma), related to medication regime of anticoagulants. The summary further indicated that upon Resident #1's return from the hospital with a no harm letter, Resident #1 was placed on enhanced observation. A virtual APRN visit was conducted on 4/21/2024 with medication adjustments and a plan for continued enhanced monitoring. Education was also provided to residents to have staff assist with resident-to-resident conflicts. Record review identified that monitoring (1:1 monitoring and every 15-minute checks) was discontinued as of 4/28/2025. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's hospital history and physical dated 4/20/2025 identified Resident #3 was diagnosed with a hyperacute right temporo-parieto-occipital subdural hematoma (a complex area where the temporal, parietal and occipital brain lobes meet; area has a crucial role in integrating sensory information, attention, language, reasoning and memory) and was admitted to the intensive care unit (ICU). Hospital records identified Resident #3 was treated with a craniotomy (surgical opening into the skull to relieve pressure on the brain/remove the hematoma) on 4/28 and 5/6/2025. Further review identified that Resident #3 remained at the hospital during the time of the survey (30 days after the incident). Hospital medicine progress note dated 5/19/2025 identified Resident #3 had a principle problem of subdural hematoma. Resident #3 underwent craniotomy with evacuation of the subdural hematoma followed by MMA embolization (Middle Meningeal Artery embolization is a minimally invasive procedure used to block blood supply to the area affected by a subdural hematoma). Resident #3 was still encephalopathic (medical term that describes a general condition where the brain does not function properly). Please cross reference F600. Interview with Resident #1 on 5/14/2025 at 12:58 PM identified that he/she had garbled speech and stated he/she hit a resident in the bathroom in the past. Resident #1 denied hitting another resident in the hallway or near the nurse's station. Interview, clinical record review, and hospital record review with MD #1/attending MD on 5/14/2025 at 11:29 AM identified that trauma, such as a hit to the head, could cause a subdural hematoma, and Resident #3 had a visible injury to the left side of the head. MD #1 stated an injury on the left side of the head could cause an injury on the right side of the brain (the opposite side) as the brain moves within the skull in a coup and contrecoup effect (rebound/recoil effect with the internal injury on the opposite side of the external force). Further, MD #1 stated Resident #3's injury was caused by the hit on the side of the head, because of how quickly Resident #3 had the bleeding after the injury occurred, he stated in his opinion, the hyperacute right temporo-parieto-occipital subdural hematoma was likely ninety percent certain caused by the trauma. Interview, clinical record review, and facility documentation review on 5/14/2025 at 2:39 PM with the DNS identified that Resident #1 admitted to hitting Resident #3 on 4/20/2025. The DNS stated Resident #1 was initially unable to provide a clear explanation regarding the incident, and then Resident #1 indicated Resident #3 took toilet paper from Resident #1's bathroom, however, Resident #3 did not use the bathroom and required total care for toileting. The DNS stated Resident #1 should not have hit Resident #3, and the facility did not substantiate abuse because Resident #1 did not willfully seek out Resident #3, and because Resident #1's story of the incident changed. The interview failed to identify if adequate supervision was provided for a resident with known behaviors directed toward others to prevent a resident injury. Subsequent to surveyor inquiry, Resident #1 was placed on one-to-one (1:1) observations on 5/14/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Close Observation Policy dated 4/17/2024 directed in part, the facility will provide staff with guidance in applying close observation levels for the purpose of ensuring resident safety. The Policy further directed, there are several conditions or circumstances that may indicate a possible risk of harm or injury to the resident or others; risk factors include de-compensated mental status (i.e. impulsivity, impaired judgment, agitation).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for two of three residents (Resident #1 and #2) reviewed for abuse, the facility failed to ensure the residents were seen by a physician/designee with orders reviewed and renewed at least once every 60 days. The findings included: a. Resident #1's diagnoses included anxiety and schizophrenia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen, indicative of moderate cognitive impairment and was self-mobile in wheelchair. The Resident Care Plan (RCP) dated 11/25/2024 identified Resident #1 had a potential to be aggressive. Interventions directed every 15-minute checks, administer medications as ordered, counseled to seek assistance of staff for issues with peers, psychiatric and social services follow up, when resident becomes agitated intervene before agitation escalates, guide away from source of distress, if aggressive to staff walk away calmly and approach later. Record review identified Resident #1 was on a 60-day schedule for review and renew of physician orders. Record review identified although physician orders were signed by MD #1 on 11/2/2024, review identified the record had no additional physician orders signed until 3/8/2025 (127 days after they were last signed). b. Resident #2's diagnoses included anxiety, dementia, bipolar disorder and schizoaffective disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #2 had a Brief Interview for Mental Status (BIMS) score of ten out of fifteen, indicative of moderate cognitive impairment and was self-mobile in wheelchair. The Resident Care Plan (RCP) dated 11/14/2024 identified Resident #2 had a self-care performance deficit related to dementia. Interventions directed encourage to participate to the fullest extent possible. Record review identified Resident #1 was on a 60-day schedule for review and renew physician orders. Record review identified although physician orders were signed by MD #1 on 11/2/2024, review identified the record had no additional physician orders signed until 3/8/2025 (127 days after they were last signed). Interview and review of record with DNS and Administrator on 5/14/2025 at 2:39 PM DNS identified the facility was unable to provide documentation that Resident #1 and Resident #2's physician orders were signed at least every 60 days. The DNS stated the orders should have been signed and was unable to identify why the orders were not signed timely. (continued on next page)

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	05/20/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with MD #1/Medical Director on 5/14/2025 at 11:29 AM identified that he signs the resident orders monthly, and that he began signing orders electronically as of November 2024. He indicated that Resident #1 and Resident #2's orders should have been signed, but it was possible that he missed them. MD #1 further indicated he had not signed the April 2025 orders yet and was behind in signing resident orders. Although the surveyor requested a policy regarding medical visits, a policy was not provided for surveyor review.