

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Trinity Hill Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, review of facility documentation and interviews, the facility failed to ensure resident rooms were in good repair and painted and failed to ensure proper ventilation in resident rooms that do not have an in-room air conditioning unit. The findings included: Observations on all days of the survey 5/27, 5/28, 6/1, 6/2 and 6/3/26 identified the majority of the resident rooms on the second floor identified walls that had been spackled but not painted, baseboard molding detached and peeling off of the walls, some damage to walls like holes or scrapes and marks to the walls, and exposed sheetrock that was in need of repair. All windows in the facility were nailed shut preventing them from being able to be opened. Inside building temperatures on 5/27/26 reached 81 degrees (which was within the range for regulatory expectations for internal temperature). External temperatures that day reached 85 degrees. The windows were not able to be opened for the provision of ventilation. Observations on these days also identified there was an HVAC system with ventilation in the hallways but not in all resident rooms. Additionally, the vents on the 2nd floor hallway (Rooms 201 through 215) were not blowing any air and there was a window air conditioner at the end of the hallway that was in use. Interview with LPN#3 on 6/1/26 at 9:42 AM identified that, at some point, someone may have tried to jump out of a window, and the windows were nailed shut. LPN#3 indicated that the 2nd floor gets hot and that there are only some rooms with air conditioners. She further identified that if there is a complaint, the facility will get a fan for the resident. Additionally, LPN#3 identified that maintenance completes repairs but there is a lot that is not kept up. Interview with the Director of Maintenance on 6/1/26 at 3:25 PM identified that he has worked at the facility for about a year and noted that the building was not fully equipped with air conditioning. He identified that the hallways have air conditioning and only some of the rooms due to the electrical load. The Director of Maintenance indicated that there had been a transition in maintenance assistants and due to the building being large and needing repairs, he needed more time to complete all the tasks that needed to be completed. The Director of Maintenance identified he was directed by management to ensure the windows were not able to be opened due to random people jumping the back fence and selling drugs at the windows and indicated that he was told by his supervisor and corporate person that the nails were to remain in place. Interview with NA#2 on 6/2/26 at 5:48 AM identified that the 2nd floor gets hot and could not identify whether there was central air in the building and indicated that the windows were not able to be opened. Interview with NA#3 on 6/2/26 at 6:04 AM identified the resident room windows were not able to be opened and indicated that at times, the resident rooms get very warm if they don't have an air conditioner in place. NA#3 further identified that many residents are bed bound and cannot easily move to get cool but indicated the facility provides fans if requested. Interview with the Director of Maintenance on 6/3/26 at 11:35 AM identified there were two nonfunctional air conditioner units that controlled the 1st and 2nd floor hallways (from rooms 101 through 115 and Rooms 201 through 215). The Director of Maintenance indicated that the 2nd floor had a window air conditioner at the end of the hallway but that most rooms did not have air conditioners in them because the circuit breaker load was not able to handle all rooms having an air conditioner. The Director of Maintenance identified that the mechanical services company came to service the air (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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conditioners but that two units were still not functional. The Director of Maintenance identified that he had a plan to go through the building to patch and repair all items that needed it and then go through and paint everything but that it got away from him. He indicated that he had a change in maintenance staff and that there were other items that jumped to the top of the priority list. The Director indicated that maintenance had completed two rooms on the first floor that needed repairs and were going to be working on the rest of the facility although there was no formal plan. The Director of Maintenance identified that all work had to be approved by corporate and, at times, the approval is delayed. Observation of the 1st and 2nd floor hallways without functional hallway air conditioning with the Director of Maintenance on 6/3/26 at 11:48 AM identified resident rooms #202, 208, 209, 210, and 211 had air conditioners in the room windows (this was 5 out of 15 resident rooms on the 2nd floor wing for Rms 201-215). Observation of the 1st floor unit hallway without functional air conditioning (rooms 101 through 115) with the Director of Maintenance on 6/3/26 at 12:00 noon identified resident rooms #106 and 110 had room air conditioners. This is 2 out of 14 resident rooms (one of the rooms is used with the therapy room and not as a resident room) that has an air conditioner. Interview with Person #3, representative from the mechanical service for AC repair on 6/4/26 at 10:40 AM identified that the company had been to the facility several times to fix items but that they did not go there regularly for maintenance of the AC units, which could contribute to them not functioning. Person #3 indicated that the facility had been in receipt of the recommendations for repair of the non-functioning AC units since 4/9/26 and had not approved the repairs to date.		

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observation, review of facility documentation and interviews the facility failed to ensure adequate ventilation by means of opened windows, or mechanical ventilation, or a combination of the two was in place consistently in the building. The findings include: Observations on all days of the survey 5/27, 5/28, 6/1, 6/2 and 6/3/26 identified all windows in resident rooms on the 1st, 2nd and 3rd floors had screws in the windows that prevented them from being opened at all. There are no screens in the resident room windows. Inside building temperatures on 5/27/26 ranged from 77 degrees to 81 degrees (which was within the range for regulatory expectations for internal temperature). External temperatures that day reached 85 degrees. Observations on these days also identified there was an HVAC system with ventilation in the hallways but not in resident rooms and only some resident rooms contained air conditioners. Additionally, the vents on the 2nd floor hallway (Rooms 201 through 215) were not blowing any air and there was a window air conditioner at the end of the hallway that was in use. Interview with LPN#3 on 6/1/26 at 9:42 AM identified working at the facility for about 30 years and indicated that not much had changed in the building. LPN#3 identified that, at some point, someone may have tried to jump out of a window and the windows were screwed shut. LPN#3 indicated that the 2nd floor does get hot and that there are only some rooms with air conditioners, but identified that if there is a complaint, the facility will get a fan for the resident. Interview with the Director of Maintenance on 6/1/26 at 3:25 PM identified he has worked at the facility for about a year and indicated the building was not fully equipped with air conditioning. The Director of Maintenance hallways have air conditioning and only some of the rooms due to the electrical load not being able to handle running air conditioner units in every resident room. The Director of Maintenance identified he was directed by the management to ensure the windows were not able to be opened due to random people jumping the back fence and selling drugs at the windows and indicated that although he was told by BFSI to remove the screws, he was told by his supervisor and corporate person that the screws were to remain in place. Interview with NA#2 on 6/2/26 at 5:48 AM identified that the 2nd floor does get hot and could not identify whether there was central air in the building but did indicate the windows were not able to be opened. Interview with NA#3 on 6/2/26 at 6:04 AM identified the resident room windows were not able to be opened and indicated that, at times, the resident rooms do get very warm if they aren't the rooms with the AC. NA#3 identified that many residents are bed bound and cannot easily move to get cool but indicated the facility provided fans if requested. Interview with the Director of Maintenance on 6/3/26 at 11:35 AM identified there were two non-functional air conditioner units that controlled the 1st and 2nd floor hallways (from rooms 101 through 115 and Rooms 201 through 215). The Director of Maintenance indicated that the 2nd floor had a window air conditioner at the end of the hallway but that most rooms did not have air conditioners in them because of the circuit breaker load was not able to handle all rooms having an air conditioner. The Director of Maintenance identified that the mechanical services company came to service the air conditioners but that two units were still not functional. The Director of Maintenance identified all work had to be approved by the corporate and, at times, it was delayed. Observation of the 1st and 2nd floor hallways without functional hallway air conditioning with the Director of Maintenance on 6/3/26 at 11:48 AM identified resident rooms #202, 208, 209, 210, and 211 had air conditioners in the room windows (this was 5 out of 15 resident rooms on the 2nd floor wing for Rms 201-215). Observation of the 1st floor unit hallway without functional air conditioning (rooms 101 through 115) with the Director of Maintenance on 6/3/26 at 12:00 noon identified resident rooms #106 and 110 had room air conditioners. This is 2 out of 14 resident rooms (one of the rooms is used with the therapy room and not as a resident room) that has an air conditioner. Interview with Person #3, representative from the mechanical service for AC repair on 6/4/26 at 10:40 AM identified that the company had been to the facility several times to fix items but that they did not go there regularly for maintenance of the AC units, which could contribute to them not functioning. Person #3 indicated that (continued on next page)		

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