

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Twin Maples Healthcare, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 809 New Haven Road #r Durham, CT 06422	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826</p> <p>Based on clinical record reviews, facility documentation, facility policies and interviews for one of three sampled residents (Resident #2) who required staff assistance with daily living skills and was reviewed for an allegation of mistreatment, a staff member failed to immediately report the allegation of mistreatment by another staff member while providing care to Resident #2 therefore the alleged perpetrator worked for three (3) days. The findings include:</p> <p>Resident #2's diagnoses included vascular dementia, hallucinations, blindness left eye and glaucoma right eye, depression, and incontinence.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 made poor decisions regarding tasks of daily life, experienced hallucinations, exhibited behaviors not directed towards others, and required maximum assistance for hygiene, dressing, and bathing.</p> <p>The Resident Care Plan dated 6/27/24 identified Resident #2 had a cognitive impairment, was hard of hearing, had periods of insomnia, had a self-care deficit, and exhibited behaviors such as making racially inappropriate comments, yelling out and swearing.</p> <p>Interventions directed medications as ordered, assistance of one (1) with bathing, announce self when providing care due to blindness, assist resident with coping skills, explain process step by step, when agitated offer use of bathroom, and psychiatric evaluation as needed.</p> <p>A physician's order dated 7/2/24 directed to administer (a sedative medication) Trazadone 50 milligrams (mg) take half (1/2) tablet every twenty-four (24) hours as needed for insomnia for fourteen (14) days.</p> <p>The nurse's note dated 7/16/24 at 1:34 PM identified a call was placed to Resident #2's family member informing him/her it was reported by staff Resident #2 may have been roughly handled by a staff member on Saturday evening 7/13/24. A complete body check was done, and no areas of concern were noted. The note indicated other statements of giving Resident #2 an inappropriate over the counter medication was also being investigated.</p> <p>The nurse's note dated 7/17/24 at 5:48 AM identified Resident #2 was calling out on and off in the early part of the shift and slept for approximately three (3) to four (4) hours in the chair.</p> <p>(continued on next page)</p>

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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NAME OF PROVIDER OR SUPPLIER Twin Maples Healthcare, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 809 New Haven Road #r Durham, CT 06422	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with a 3-11PM nurse aide, Nurse Aide (NA) #1, on 8/13/24 at 11:45 AM she identified on 7/13/24 another nurse aide, NA #2, made a comment to her stating I guess I am going to sleep tonight because I am going to give Resident #2 liquid Melatonin (a hormonal supplement that plays a role in sleep). NA #1 indicated when NA #2 was assisting Resident #2 with a shower although Resident #2 was yelling stop she did not see NA #2 act rough towards Resident #2. NA #1 stated she did not report her concerns right away, she called the 3-11PM charge nurse at home the next day to report her concerns.</p> <p>Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, identified NA #1 did not report any concerns to her until Sunday evening 7/14/24, after she had left the facility. LPN #1 stated she did not report the allegation, because she was not sure what she was supposed to do. LPN #1 identified on 7/15/24 she realized NA #2 was scheduled to work from 7-11PM so she reported NA #1's allegation to the Nursing Supervisor and NA #2 was removed from the facility pending an investigation.</p> <p>Interview with NA #2 on 8/13/24 at 12:25 PM identified he did assist Resident #2 with a shower on 7/13/24 and Resident #2 was yelling in the shower which was a typical behavior for him/her. NA #2 denied being rough during care and making a comment about giving Resident #2 Melatonin.</p>		