STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075431	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Maples Healthcare, Inc	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)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on clinical record reviews, review of facility documentation, facility policies, and interviews for eight (8) of ten (10) sampled residents (Resident #2, #3, #4, #5, #6, #7, #8, and #10) who were reviewed for the completion of a current Minimum Date Set assessment, the facility failed to ensure the assessments were completed within the fourteen (14) day timeframe requirement. The findings include: Resident #2 had a quarterly Minimum Data Set, dated dated dated [DATE] with the status of in process. Resident #3 had an annual Minimum Data Set, dated dated dated [DATE] with the status of in process. Resident #4 had a quarterly Minimum Data Set, dated dated dated [DATE] with the status of in process. Resident #5 had an annual Minimum Data Set, dated dated dated [DATE] with the status of in process. Resident #6 had an annual Minimum Data Set, dated dated dated [DATE] with the status of in process. Resident #7 had an annual Minimum Data Set, dated dated dated [DATE] with the status of in process. Resident #8 had an admission Minimum Data Set, dated dated dated [DATE] with the status of in process. Resident #10 had an annual Minimum Data Set, dated dated dated [DATE] with the status of in process. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Minimum Data Set (MDS) Coordinator, Registered Nurse (RN) #2, on 11/12/24 at 12:14 PM identified she was the person responsible for ensuring the MDS assessments are completed within the guidelines set forth in the Long-Term Care Facility RAI 3.0 User's Manual, Version 1.18.11 dated October 2023. RN #2 identified the facility does not have a specific policy regarding the MDS assessment completion but follows the guidance in the user's manual of completion within fourteen (14) days after the initiation of the assessment. RN #2 identified the assessments should have been completed. Interview with the Director of Nursing (DON) on 11/12/24 at 1:06 PM identified the facility does not have a policy on timely completion of the MDS, but they follow the guidance in the Long-Term Care Facility RAI 3.0 User's Manual. The DON identified the MDS Coordinator, RN #2 was responsible to ensure the MDS assessments were completed according to the User Manual. The DON identified the MDS assessments for Residents #2, #3, #4, #5, #6, #7, #8 and #10 were overdue. The DON identified RN #2 works on a part-time basis and just got behind. Review of the Long-Term Care Facility RAI 3.0 User's Manual, Version 1.18.11 dated October 2023 directed, in part, the admission assessment, the MDS completion date must be no later than thirteen (13) days after the entry date. Additionally, the Manual identified for the other comprehensive MDS assessments, the Care Area Assessment (CAA) Completion Date must be no later than 14 days from the Assessment Reference Date (ARD).