

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  10/09/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</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

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  10/09/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who had a history of wandering throughout the facility and self-ambulated with a walker, the facility failed to implement the Missing Person Policy when Resident #1 was not accounted for. The findings include:Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who had a history of wandering throughout the facility and self-ambulated with a walker, the facility failed to implement the Missing Person Policy when Resident #1 was not accounted for. The findings include: Resident #1's diagnoses included vascular dementia, hemiplegia, and insomnia. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had short and long-term memory recall deficits and was independent with ambulation with the use of a walker. The Resident Care Plan dated 7/23/25 identified Resident #1 wandered into other resident's rooms and was an elopement risk. Interventions directed use of a wander guard in the tennis ball placed on the walker because the resident removed the wander guard when placed on his/her body, to redirect the resident out of other's rooms, remind resident to use walker when ambulating. The Wander risk assessment dated [DATE] identified Resident #1 was not exit seeking. Resident #1 wandered on the unit and sometimes into other residents' rooms, continuously removed the wander guard which was inside the tennis ball off the walker, and the facility planned to trial Resident #1 without the wander guard and monitor behavior for exit seeking. The nurse's note dated 10/4/25 at 8:16 AM identified the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #2, was alerted around 5:15 AM that Resident #1 was not on the unit. The note indicated Resident #1 was last seen at 4:30 AM. The interior and perimeter of the building were searched. The Director of Nursing (DON) was notified at 6:00AM and the state police were called at 6:03 AM and Resident #1 was found at 6:40 AM. Resident #1 was transferred to the hospital for further evaluation and Resident #1 was discharged back to the facility with diagnoses of skin tear to the left hand, contusion of the left lower extremity and contusion to the right lower leg. Interview with the 11PM-7AM nurse aide, Nurse aide (NA) #2, on 10/7/25 at 12:05 PM and on 10/8/25 at 8:40 AM identified on 10/4/25 at approximately 5:00 AM another nurse aide, NA #1, approached her and reported she did not know where Resident #1 was. NA #2 explained she and NA #1 proceeded to check the bathrooms and notify the 11PM-7AM nursing supervisor, Registered Nurse (RN) #2, when they were unable to locate Resident #1. NA #2 identified RN #2 initiated the search protocol and after searching the entire inside of the building, she proceeded to go outside through the employee exit to search the grounds. NA #2 identified after she was unable to locate Resident #1, RN #2 contacted the police. Interview with the Director of Nursing (DON) on 10/7/25 at 1:30 PM and 10/8/25 at 9:20 AM identified Resident #1 was evaluated as an elopement risk initially. The DON indicated on 10/4/25, Resident #1 exited the building. The DON identified the search for Resident #1 was initiated at 5:15 AM on 10/4/25 and the police were not contacted until 6:03 AM, forty-five minutes later, which exceeded the directions in the facility Missing Person Policy which required notification to the police within ten (10) minutes of discovering a resident was missing. The DON stated she was not notified until 6:00 AM that Resident #1 was missing. Interview with RN #2 on 10/7/25 at 1:48 PM and on 10/8/25 at 8:47 AM identified she last saw Resident #1 at 4:30 AM on 10/4/25 seated in a chair next to another resident by the doors on the unit closest to the lobby and at 5:00 AM, NA #1 asked her if she had seen Resident #1. RN #2 explained a search was initiated of the interior and exterior of the building, the DON and administrator were notified at 6:00 AM and the police were notified at 6:03 AM. Interview with the Administrator on 10/8/25 at 9:30 AM and on 10/9/25 at 11:00 AM identified an elopement drill was done on 6/1/25 with facility staff and documentation identified RN #2 participated in the drill. Interview with Housekeeper #1 on 10/9/25 at 10:25 AM identified on 10/4/25 when he came to work at 5:30 AM, he was informed Resident #1 was missing and he immediately began to assist with the search and discovered Resident #1 at 6:40 AM. The facility Missing Person Policy identified when a resident was missing the police would be notified within ten (10) minutes.</p>		

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  10/09/2025
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)
F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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  10/09/2025
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)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 3 sampled residents (Resident #2), reviewed for falls, the facility failed to transfer the resident per the physician's order, rehabilitation screen, and nurse aide assignment card, which resulted in a fall with multiple fractures. The findings include: Resident #2's diagnoses included Erb's paralysis due to birth injury, hemiplegia affecting the right dominant side and paralytic gait. A review of the Interdisciplinary Therapy Screen conducted by Occupational Therapist (OT) #1 dated 6/23/25 identified Resident #2 was assessed for transfers and was an assist of 2 staff members for Stand, Pivot, Transfer (SPT). The Resident Care Plan dated 6/24/25 identified Resident #2 was at risk for falls related to decreased independent mobility. Interventions included Occupational Therapy to evaluate and treat as ordered or as needed and transfer with assistance of 1 staff to wheelchair. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview of Mental Status (BIMS) score of 14 indicating intact cognition, required substantial/maximal assistance from staff with toileting hygiene, and was dependent on staff for all transfers. Additionally, the MDS identified Resident #2 had a functional limitation in range of motion impairment on one side. A review of the Fall Risk Evaluation dated 9/15/25 at 12:48 PM identified Resident #2 had a score of 10 indicating a high risk for falls. The Accident/Incident Report dated 9/28/25 identified that on 9/28/25 at 10:15 AM Resident #2 was being assisted to the bathroom, when his/her foot got caught on the lip of the bathroom and he/she fell to the floor. The physician's orders in effect on 9/28/25 directed Resident #2 to be provided with SPT and assistance of 2 staff members. A nurse's progress note dated 9/28/25 at 10:37 AM identified Resident #2 sustained a fall at 10:15 AM while transferring to the bathroom, was witnessed, but LPN #1, but was unable to get to Resident #2 in time. A nurse's progress note dated 9/28/25 at 10:52 AM identified LPN #1 was with Resident #2 when his/her foot got caught on the lip of the bathroom floor and fell. A review of the Fall Risk Evaluation dated 9/28/25 at 10:41 AM post fall identified Resident #2 had a score of 12 indicating a high risk for falls. The Fall Description Details dated 9/28/25 identified that on 9/28/25 at 10:15 AM Resident #2 had a witnessed fall to the floor while being transferred -assisted by staff per the care plan (Although the care plan identified Resident #2 was an assist of 1, a rehabilitation screen dated 6/23/25, physician's orders in effect on 9/28/25, and the Nurse Aide (NA) assignment card directed 2 staff for SPT). Additionally, Licensed Practical Nurse (LPN) #1 was assisting Resident #2 with a transfer when he/she got his/her foot caught on the lip of the bathroom floor and began to fall. LPN #1 was unable to lift him up/hold him up and Resident #2 twisted his/her leg in the process of falling. The care plan intervention was to remove the lip of the bathroom/resident room door. The Accident/Incident follow up statement dated 9/28/25 identified LPN #1 was assisting Resident #2 with a bathroom transfer on 9/28/25 at 10:15 AM when Resident #2's foot got caught on the lip of the bathroom causing his/her body to twist and he/she fell to the floor. Resident #2 was wearing rubber soled footwear at the time. The facility summary submission details sent to the State Agency dated 10/3/25 identified that prior to this incident Resident #2 required the assistance of 1 person with transferring, hygiene, toileting and toileting tasks, was non-ambulatory, alert and oriented with a Brief Interview of Mental Status score of 15 on 7/31/25. On 9/28/25 at 10:15 AM Resident #2 was transferring himself from the wheelchair to the toilet, with the nurse standing behind the wheelchair. The resident caught his/her foot on the lip to the door and sustained a fall to the floor. He/She was transferred to the hospital for evaluation, then was transferred to another hospital due to a right tibial shaft fracture, a right malleolus fracture, and a right humerus fracture. Review of the hospital Discharge summary dated [DATE] identified Resident #2, due to a mechanical fall, sustained a right proximal humerus (upper arm) fracture and right distal tibia (shin bone) and fibular (shin bone) shaft fractures. Resident #2 was taken to the operating room on 9/29/25 for an open repair internal fixation of the right tibial shaft fracture with placement of intramedullary nailing and right trimalleolar (3) ankle fracture with fixation of posterior malleolus. Interview with Resident #2 on 10/7/25 at 10:11 AM identified he/she was residing in a different room at the time of the fall. Resident #2 indicated that he/she activated the call light for assistance to the bathroom. LPN #1 came in to assist him/her with the transfer. Resident #2 was holding on to the grab bar in the bathroom while attempting to stand up and his/her foot got stuck on the lip which resulted in a fall. Additionally, Resident #2 identified that Licensed Practical Nurse (LPN) #1 was assisting him with the transfer, without the benefit of a gait belt even though he/she keeps telling staff to use one. Resident #2 never indicated the transfer was</p>		