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 02/19/2026
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy and interviews, for one (1) of three (3) residents (Resident #1) reviewed for grievances, the facility failed to ensure a complaint made by a resident regarding a staff member was referred to the designated grievance official, investigated, and documented with findings and resolution. The findings include:Resident #1's diagnoses included Traumatic Brain Injury (TBI), dementia with behavioral disturbances, conduct disorder, anxiety disorder and psychosis.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 7), required substantial assistance with bed mobility and was dependent on staff for personal hygiene, toileting and transfers.The Resident Care Plan (RCP) dated 1/29/26 identified Resident #1 had impaired cognitive function/dementia or impaired thought processes due to a TBI/head injury, impaired decision making and made allegations and inappropriate comments towards staff members, yelled and swore at staff, had angry outbursts, raised his/her fist in anger towards others and had poor social boundaries. Interventions included providing the resident with necessary cues and stopping interactions/care and returning if agitated, providing a calm approach, anticipating and meeting needs, assisting the resident to develop more appropriate methods of coping and interacting, staff to provide a calm but firm approach with resident when having angry outbursts and redirecting the resident as needed.A Behavior Note written by the Director of Social Services dated 2/13/26 at 10:57 AM identified she was made aware that Resident #1 was heard making inappropriate comments towards a staff member that was assisting other residents and other residents were disturbed by the behavior. She identified she met with Resident #1, discussed the behavior and provided emotional support, reassurance and assistance with Resident #1's needs.Interview with Resident #1 on 2/19/26 at 11:22 AM identified NA #5 is mean to him/her and he/she does not want NA #5 near him/her. Resident #1 was unable to provide specific examples and could not recall the 2/13/26 incident but reported staff knows to keep NA #5 away from him.Interview with NA #5 on 2/19/26 at 12:17 PM identified up until 2/13/25, he was Resident #1's primary NA on the 7:00 AM to 3:00 PM shift. He reported on 2/13/25 the DON notified him Resident #1 made generalized allegations against him and he would no longer be assigned to Resident #1. NA #5 identified he was shocked, never had issues with Resident #1 and Resident #1 never complained directly to him about anything. NA #5 reported he was not asked by the DON or other administrative staff to write a statement related to the complaint.Interview with the Director of Social Services on 2/19/26 at 12:38 PM identified she was aware of the 2/13/26 incident and met with Resident #1 following the incident. She was not aware that Resident #1 made a complaint regarding NA #5 following her initial encounter. She identified a grievance should have been initiated and the complaint should have been investigated. She reported that if she were notified of Resident #1's complaint, she would have met with Resident #1 again and asked him/her questions regarding (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
	075431	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Maples Healthcare, Inc	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the complaint, provided emotional support to Resident #1 and followed up with him/her daily for three (3) days and as needed.Interview with the DON on 2/19/26 at 1:18 PM identified following the 2/13/26 incident, she met with Resident #1, who reported to her that he/she was upset because NA #5 was a chump but did not obtain any further details as to what that implied. The DON reported Resident #1 had a history of making allegations toward staff and there were no prior complaints regarding NA #5. She reported she spoke with NA #5 and determined the complaint was unsubstantiated. The DON reported she did not document Resident #1's complaint as a grievance, obtain statements, conduct an investigation, document why she determined the complaint was unsubstantiated, or notify the Director of Social Services for further follow up.Review of the Grievance policy (undated) directed, in part, that complaints shall be referred to the appropriate Department Head who will then investigate the complaint, document his/her findings, document the resolution to the problem and is responsible for addressing any issues or concerns. The Social Worker is designated as the grievance official and will be responsible for preparing a written investigative report, contacting the complainant with the problem resolution as necessary and the written report will be forwarded to the Administrator for review and filing.