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	05/22/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 3 residents (Resident #5 and 36) reviewed for accidents, for Resident #5 the facility failed to implement the comprehensive care plan for a resident with a history of repeated falls and for Resident #36 the facility failed to develop a comprehensive care plan related to the resident's behavior of flailing arms. The findings include: 1. Resident #5 had diagnoses that included schizophrenia and bipolar disorder. The quarterly MDS dated [DATE] identified Resident #5 had moderate cognitive impairment and required one person assist with ambulation and toileting. The care plan dated 3/12/25 identified Resident #5 was at risk for falls related to a history of unsteady gait and noncompliance with asking for assistance. Interventions included ambulation with assist of one with a walker and do not leave the resident unattended when out of bed during the day. Physician's order dated 3/25/25 directed assist of one with two wheeled rolling walker for transfers and ambulation. A facility reported event dated 4/7/25 identified at 11:15 AM Resident #5 was observed lying on the floor in his/her room on the left side. Resident #5 reported he/she was walking to use the bathroom, lost balance and fell. Resident #5 denied hitting his/her head and there were no injuries noted on assessment. The physician and resident representative were notified. An accident follow up statement dated 4/7/25 identified NA #1 was assigned to Resident #5, who was last seen at 10:00 AM when the resident was provided toileting assistance. NA #1 was later notified by a co-worker Resident #5 was observed on the floor in h/her room. An interview with the DNS on 5/22/25 at 7:59 AM identified the root cause of the fall resulting from NA #1 leaving Resident #5 in h/her room unattended according to the care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #1 on 5/22/25 at 12:26 PM identified he was the assigned nurse aide during the 7:00 AM to 3:00 PM shift on 4/7/25. Resident #5 had eaten in the dining room earlier in the day and could not recall if he or another aide had brought the resident back to his/her room. NA #1 later observed Resident #5 sitting alone in his/her room and provided toileting assistance. Afterward, NA #1 left Resident #5 sitting on his/her bed and was informed a short time later the resident was observed on the floor. NA #1 indicated he was unaware Resident #5 was not to be left unattended in his/her room during the day and routinely left Resident #5 unattended in his/her room during the day. NA #1 further identified following the incident, he was instructed by the DNS to keep a close eye on Resident #5. A review of the facility policy for fall prevention directed the facility to identify residents at risk for falling, evaluate the factors that places the resident at risk and implement measures to prevent falls. 2. Review of the hospital discharge documentation dated 4/21/23 through 4/29/23 identified Resident #36 was brought into the hospital by the resident representative for multiple falls. The resident representative indicated Resident #36 had 1 unwitnessed fall on 4/20/23 and another unwitnessed fall on 4/21/23 at the assisted living facility. Resident #36 was diagnosed with several fractures including a left wrist carpal bone fracture, left distal radial fracture, left ulnar fracture, left wrist/hand fractures. Resident #36 was admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, fracture of left wrist carpal bone, fracture of left pubis, and repeated falls. The care plan dated 10/13/24 identified Resident #36 had an activity of daily living (ADL) self-care performance deficit related to dementia and was totally dependent on caregiver. Interventions included to transfer with a mechanical lift to a customized wheelchair with assist of two. The quarterly MDS dated [DATE] identified Resident #36 had severely impaired cognition and was dependent on staff for transfers with two persons physical assist. A physician's order dated 1/1/25 directed to transfer out of bed via mechanical lift to customized wheelchair with pelvic positioning belt, head rest and leg rests with assist of two. The nurse's note dated 1/14/25 at 11:03 AM identified Resident #36 was noted to have a pink rash area on left forearm and was scratching the area. House lotion applied with good effect. The nurse's note failed to reflect documentation of a thorough assessment to the left forearm. The reportable event form dated 1/15/25 identified at approximately 9:45 AM Resident #36 was noted to have a slightly red left wrist area (injury of unknown origin). An x-ray of the left arm was ordered which identified a distal ulna fracture with mild displacement, and mild soft tissue swelling. The APRN was notified of the x-ray results with order for an orthopedic consultation. Investigation initiated. Resident #36 was unable to verbalize what happened, had no falls or unusual incidents in the last week. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 1/15/25 identified Resident #36 presents with swollen, red left forearm, and a left ulna fracture. Intervention included orthopedic consultation, medication for pain as needed, and padding applied to side rails on bed. Review of a statement written by NA #6 dated 1/15/25 identified she was assigned to Resident #36 on 1/13/25 on the 3:00 PM - 11:00 PM shift and 1/14/25 on the 3:00 PM - 11:00 PM shift. NA #6 indicated on 1/14/25 on the 3:00 PM - 11:00 PM shift she reported to RN #2 that Resident #36 was scratching his/her arm, and when clothing was being removed, he/she yelled. NA #6 indicated RN #2 indicated she had taken care of it this morning and someone had already reported it. NA #6 indicated she and NA #9 continued to provide care. The APRN progress note dated 1/16/25 at 7:49 AM identified Resident #36 was found to have a swollen area on the left forearm distally. Resident #36 has a history of a left wrist fracture that was radial in nature. X-ray was done and a distal left ulnar fracture was found. Recommendations included orthopedic consultation, non-weight bearing to left arm, therapy as needed, and Tylenol for pain as needed. Review of the orthopedic consultation form dated 1/17/25 identified Resident #36 has a diagnoses of left ulna shaft fracture. Recommendations include short arm EXO brace on at all times, follow up in 4 weeks, repeat x-ray, and non-weight bearing to left upper extremity. The nurse's note dated 1/17/25 at 1:40 PM identified Resident #36 had an orthopedic appointment this morning and returned with an EXO brace on left wrist. The resident has a follow-up appointment on 2/3/25. Review of a statement written by NA #1 dated 1/17/25 identified he worked on 1/13/25 on the 7:00 AM - 3:00 PM shift and 1/15/25 on the 7:00 AM - 3:00 PM shift. NA #1 indicated Resident #36 had no behavioral issues, and no pain during his shift on 1/13/25. NA #1 indicated on 1/15/25 he was informed by a co-worker that Resident #36 wrist was discolored and slightly swollen. Review of a statement written by RN #2 dated 1/17/25 identified she worked on 1/13/25 on the 7:00 AM - 3:00 PM shift and 1/14/25 on the 7:00 AM - 3:00 PM shift, and the 3:00 PM - 11:00 PM shift. RN #2 indicated she was not aware of anything that occurred with Resident #36 that may have led to this injury. RN #2 indicated there was some small pink area on the left wrist which appeared to look like irritation. RN #2 indicated lotion was applied to the area, no swelling was noted. The summary report dated 1/17/25 at 3:04 PM identified Resident #36 is confused, non-ambulatory, transfers with a mechanical lift and assist of 2 persons. All staff were questioned. No unusual events occurred. The resident is fidgety when in bed. The resident had a medication change on 1/10/25 when the Escitalopram (used to treat depression and anxiety disorder) was decreased from 15mg to 10mg daily. Side rail pads were added to the side rails, a body pillow was added to the left side of the bed to prevent the resident from rolling out of bed. As a result of this investigation, there was no clear understanding of how this injury occurred. Interview with Person #1 on 5/21/25 at 9:47 AM identified Resident #36's left arm/wrist was slightly swollen on 1/14/25. Person #1 indicated he/she did not tell the staff of the swelling. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 5/21/25 at 10:13 AM identified he was assigned to Resident #36 on 1/15/25 on the 7:00 AM - 3:00 PM shift. NA #1 indicated after morning care he was dressing Resident #36 and when he guided his/her left hand to put it through the shirt Resident #36 was saying ouch, ouch. NA #1 indicated the left arm was not swollen at that time. NA #1 indicated he told the nurse that Resident #36 had pain in the left arm. NA #1 indicated he does not remember who the nurse was. NA #1 indicated Resident #36 has a habit of grabbing your hands during care or anything near and swinging (flailing) his/her arms. NA #1 indicated now the side rails are padded and a pillow is placed by the side rails. Interview with RN #4 on 5/21/25 at 10:45 AM identified she does not remember the incident because it was so long ago and indicated to read her statement. RN #4 indicated Resident #36 used to be fidgety and would flail his/her arms. Interview with LPN #1 on 5/21/25 at 11:06 AM identified she worked on 1/13/25, 1/14/25, and 1/15/25 from 8:00 AM - 5:30 PM. LPN #1 indicated she remembered NA #1 brought Resident #36 to the dining room for breakfast. LPN #1 indicated Resident #36's left forearm looked swollen and she immediately notified RN #1 who assessed the resident. LPN #1 indicated she did not get report from the 11:00 - 7:00 AM nurse that Resident #36's left arm was swollen. LPN #1 indicated Resident #36 used to flail his/her arms constantly but not anymore. LPN #1 indicated she did not document in the resident record when Resident #36 flailed his/her arms. Interview with the DNS on 5/21/25 at 12:38 PM identified she was not aware of Resident #36 flailing his/her arms. The DNS indicated if she was aware of the behavior she would have initiated a care plan and put interventions in place. The DNS indicated the nursing staff had not informed her of the behavior of flailing. Interview with MD #1 on 5/22/25 at 9:16 AM identified he was aware of the incident on 1/15/25 with Resident #36's left distal ulna fracture. MD #1 indicated the ulna bone is located on the pinkie side of the forearm. MD #1 indicated a distal ulna fracture comes from a direct blow or from a fall landing on the forearm or landing on an outstretched arm. MD #1 indicated the resident had to hit the forearm somewhere to obtain the fracture. MD #1 indicated he was not aware of Resident #36 flailing his/her arms. MD #1 indicated there is a possibility flailing of the arms can indeed cause a fracture of the forearm. MD #1 indicated there are risk factors with distal ulna fracture such as osteoporosis, post-menopausal women, and history of falls. Interview with RN #1 on 5/22/25 at 8:20 AM identified the DNS is responsible for initiating care plans and updating care plans. RN #1 indicated the licensed nurses do not initiate or update care plans. RN #1 indicated there will be new processes put into place. Review of the care plan dated 10/13/24, which was in effect on 1/15/25 when the resident began exhibiting pain in the left wrist, failed to reflect documentation or interventions to address the resident's behavior of flailing his/her arms. Review of the nurse's notes dated 1/1/25 - 1/31/25 failed to reflect documentation of Resident #36's behavior of flailing of arms. Although attempted, an interview with RN #2, APRN #2, NA #8 was not obtained. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a facility care plan policy was not provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #5) reviewed for accidents, the facility failed to revise the care plan following a fall for a resident with a history of repeated falls. The findings include: Resident #5 had diagnoses that included schizophrenia, bipolar disorder and overactive bladder. The quarterly MDS dated [DATE] identified Resident #5 had moderate cognitive impairment and required one person assist with ambulation and toileting. The care plan dated 3/12/25 identified Resident #5 was at risk for falls related to a history of unsteady gait and noncompliance with asking for assistance. Interventions included ambulation with assist of one with a walker and do not leave the resident unattended when out of bed during the day. Physician's order dated 3/25/25 directed assist of one with two wheeled rolling walker for transfers and ambulation. A facility reported event dated 4/7/25 identified at 11:15 AM Resident #5 was observed lying on the floor in his/her room on the left side. Resident #5 reported he/she was walking to use the bathroom, lost balance and fell. Resident #5 denied hitting his/her head and there were no injuries noted on assessment. The physician and resident representative were notified. An accident follow up statement dated 4/7/25 identified NA #1 was assigned to Resident #5, who was last seen at 10:00 AM when the resident was provided toileting assistance. NA #1 was later notified by a co-worker Resident #5 was observed on the floor in h/her room. A review of the post-accident report and care plan failed to identify the care plan had been revised after the 4/7/25 fall to prevent future falls. An interview with the DNS on 5/22/25 at 7:59 AM identified the root cause of the fall was identified as NA #1 leaving Resident #5 in his/her room unattended. The DNS further identified the care plan had not been updated as the interdisciplinary team ran out of interventions to put in place to prevent future falls. A review of the facility policy for fall prevention directed the facility to identify residents at risk for falling, evaluate the factors that places the resident at risk and implement measures to prevent falls.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #41) reviewed for quality of care, the facility failed to ensure staff maintained current CPR (cardiopulmonary resuscitation) certification. The findings include: Resident #41 had diagnoses that included Parkinson's disease, and hypertension. The quarterly MDS dated [DATE] identified Resident #41 had moderate cognitive impairment required two person assist with bed mobility, transfers and toileting. The care plan dated [DATE] identified Resident #41 had advance directives specifying full code status meaning all life saving measures were to be implemented in the event of a medical emergency. Physician's order dated [DATE] directed full code status. A late entry nurse's note dated [DATE] at 9:00 PM identified between 8:00 PM and 8:30 PM, Resident #41 vomited a large amount twice and had a large bowel movement. A nurse's note dated [DATE] at 9:53 PM identified RN #4 was notified by the medication nurse, that Resident #41 was not breathing and the pulse was not palpable on assessment. Resident #41's status was verified full code and CPR was initiated. EMS was called at approximately 8:50 PM. Resident #41 was pronounced at 9:21 PM by the ED Physician. An interview with RN #4 on [DATE] at 9:12 AM identified Resident #41 had a vomiting episode and loose bowel movement earlier in the evening and later the resident had an explosive bowel movement. RN #4 went to assess the resident who was somewhat responsive but did not look well. RN #4 went to get the emergency cart. Upon return, Resident #41 was unresponsive with no pulse. RN #4 indicated she began chest compressions until the emergency medical response team arrived and took over. RN #4 identified she was unable to provide documentation of current CPR certification. An interview with the DNS on [DATE] at 12:45 PM identified she was responsible for maintaining CPR certifications for staff but had not maintained one for RN #4 as an oversight. Subsequent to surveyor inquiry, RN #4 obtained an updated CPR certificate. A review of the facility policy for CPR directs that CPR will be performed by a CPR certified licensed nurse. Although requested, a copy of RN #4's previous CPR certification was not provided. Attempts to interview NA #7 were unsuccessful.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation, the facility assessment, and interview, the facility failed to ensure intravenous (IV) therapy certifications and competencies were completed for 6 of 11 licensed nursing staff. The findings include: Review of the IV Therapy Certifications and Infusion Medications Administration Competencies binder failed to identify the following: RN #7 (hired on 5/2/15) was certified in IV therapy or had completed an Infusion Medications Administration Competency. RN #4 (hired on 4/24/18) was certified in IV therapy or had completed an Infusion Medications Administration Competency. RN #5 (hired on 11/29/21) was certified in IV therapy or had completed an Infusion Medications Administration Competency. RN #2 (hired on 5/27/22) was certified in IV therapy or had completed a 2024 annual Infusion Medications Administration Competency; competency was last completed on 8/8/23. RN #6 (hired on 7/6/22) was certified in IV therapy or had completed a 2024 annual Infusion Medications Administration Competency; competency was last completed on 8/12/23. LPN #4 (hired on 2/21/25) was certified in IV therapy or had completed an Infusion Medications Administration Competency. Interview and review of facility documentation with the DNS on 5/21/25 at 9:42 AM identified that she was responsible for overseeing the IV therapy program, as well as the nursing staff's education and competencies for IV therapy, and that there were 6 licensed nurses with no IV therapy certification or annual competency on file. The DNS indicated that their IV therapy certifications were old and therefore the facility did not have a copy on file. The DNS identified that IV therapy was not part of the nursing orientation, and while there was no documentation of a competency and/or annual competency being completed, she observed and validated each of the nurses administering IV medication or fluids. The DNS further indicated that it was not often that the facility had residents requiring IV therapy, but the 6 nurses had administered IV medications or fluids, on residents. The DNS identified that currently there were no residents in the facility receiving IV therapy, and she planned to have IV competencies completed for all licensed and unlicensed nursing staff, in June. The DNS further identified that while she did not have a policy that speaks to IV therapy certifications and competencies, the facility's practice was to have nursing staff complete an annual IV therapy competency. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Assessment 2025 Synopsis directs all staff to receive the following education and testing of competency: specialized care-catheterization, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post-op care, IV-line care, tube feedings, wound care/dressings, and dialysis care. The Facility Assessment further directs the following will be conducted on licensed nursing staff annually: medication administration-injectable, oral, subcutaneous, topical, and intravenous. Although requested, a facility education for IV therapy policy was not provided.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, facility policy and interviews, the facility failed to complete annual nurse aide performance evaluations. The findings include: Interview and review of facility documentation identified the facility employs a total of 25 nurse aides for all three shifts (7:00 AM - 3:00 PM shift, 3:00 PM - 11:00 PM shift, and 11:00 PM - 7:00 AM shift). Review of the personnel files of NA #1, NA #7, and NA #8 failed to reflect that annual performance evaluations had been completed. Interview with the DNS on 5/21/25 at 12:12 PM identified she has been employed by the facility for 7 years. The DNS indicated she has not completed nurse aide performance evaluations since she has been in the position. The DNS indicated annual nurse aide performance evaluations had not been completed in 2021, 2022, 2023, 2024, and 1/1/25 - 5/21/25. Interview with the Administrator on 5/21/25 at 12:20 PM identified he was not aware that the DNS had not completed nurse aide performance evaluations in 7 years. Review of the facility employee handbook identified performance improvement the facility will make efforts to periodically review the employee work performance. The performance improvement process will take place on an annual basis, or as needs dictate. The performance improvement process is a means for increasing the quality and value of the employee work performance.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to discard Insulin 28 days after it was opened according to professional standards. The findings include: Observation on [DATE] at 10:43 AM of a medication cart with LPN #1 identified the following. A vial of Novolog Insulin 100 units/ml 10 ml approximately ¾ full with an open date of [DATE], and a sticker that the Insulin was good for 28 days once opened. A vial of Lantus Insulin approximately ¼ full with an open date of [DATE], and a sticker indicating to discard 28 days after opening. Two vials of Aspart Insulin 100 units/ml 10 ml approximately 1/3 full with an open date of [DATE], and a sticker that indicated discard 28 days after opening. A vial of Lantus Insulin 100 units/per ml approximately ¼ full with an open date of [DATE] and a sticker that indicated discard 28 days after opening. Interview with LPN #1 on [DATE] at 10:48 AM indicated that she was the full-time charge nurse and administered medications, including Insulin to residents on both units. LPN #1 indicated that she administered the Insulin with a [DATE] and [DATE] open date yesterday and today. LPN #1 indicated that the Insulin once opened was only good for 28 days and then discarded. LPN #1 indicated that she did not check the dates on the Insulin vials prior to using them. LPN #1 indicated that she would discard the 4 vials and replace them. Interview with RN #2 on [DATE] at 10:52 AM indicated the charge nurse was responsible to date the Insulin vials when opened and discard them after 28 days. RN #2 indicated that there was new Insulin available. Interview with the DNS on [DATE] at 8:51 AM indicated that when the charge nurse opens a new vial of Insulin she is responsible to date it. The DNS indicated the nurses should be looking at the expiration date prior to each use and discard expired Insulin. Review of the vials and ampules of injectable medication policy identified expiration dates for unopened vials expire based on manufacturers expiration date. Opening a vial triggers a shortened expiration date. Although requested, the facility failed to provide a policy on the length of time Insulin can be used after being opened.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #15 and 78) reviewed for unnecessary medications, the facility failed to ensure pharmacy recommendations were addressed in a timely manner. The findings include: 1. Resident #15 was admitted to the facility in December 2024 with diagnoses that included dementia with mood disturbances, hyperlipidemia, and spiral fracture of arm. The care plan dated 12/17/24 identified Resident #15 had impaired cognition due to dementia. Interventions included cues, supervise, and reorient resident as needed. The admission MDS dated [DATE] identified Resident #15 had moderately impaired cognition and exhibited no hallucinations or delusions. Resident #15 did not show any physical or verbal behaviors directed towards others and had not rejected care. Resident #15 was receiving antipsychotic, antidepressant, and diuretic medications. A physician's order dated 1/31/25 directed to administer Seroquel (antipsychotic medication) 25 mg in the morning and 50 mg at bedtime for vascular dementia with moderate mood disturbances. Review of the progress notes dated 1/1/25 to 2/28/25 failed to reflect Resident #15 was seen by the pharmacist for a monthly medication review. A physician's order dated 3/20/25 directed to administer Seroquel 25 mg once in the afternoon for vascular dementia with moderate mood disturbances. The Pharmacracy Monthly Medication Review dated 3/24/25 identified Resident #15 had a recent fall. A review of medications indicates Resident #15 is receiving the following which may be causative or contributing to the falls. If no change is indicated, please note that the medication is necessary and potential risk versus therapeutic benefit of current Seroquel therapy in the next progress note. Additionally, consider monitoring orthostatic blood pressures each shift for 3 days and report systolic changes greater than 20 mm/Hg or diastolic changes greater than 10 mm/Hg to the provider. The Pharmacy Monthly Medication Review dated 5/8/25 (46 days later) identified the psychiatric APRN indicated she would reevaluate the Seroquel for a possible gradual dose reeducation. Resident #15 has poor safety awareness, does not ask for assistance and there are no reports that Resident #15 was drowsy or sedated. Interview with the DNS on 5/21/25 at 10:58 AM indicated pharmacy recommendations should be responded to by the physician or APRN within 2 weeks of receiving the recommendation. Further, after clinical record review, the DNS indicated there was no documentation that Resident #15 was seen by the pharmacy for a medication regimen review in February 2025. (continued on next page)

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	05/22/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DNS indicated she was responsible for implementing the physician's order for orthostatic blood pressures as per the pharmacy recommendation dated 3/24/25, however, it was not done. The DNS indicated that the psychiatric APRN did not receive the 3/24/25 pharmacy recommendation until 5/8/25, 6 weeks later, because she did not put the pharmacy recommendation in APRN communication book. Interview with the psychiatric APRN (APRN #1) on 5/21/25 at 11:15 AM identified she was responsible to respond to the pharmacy recommendations when she receives them in her communication book from the DNS. APRN #1 indicated that she did not receive the pharmacy recommendation from 3/24/25 until 5/8/25. APRN #1 indicated that when the pharmacist comes into the facility and makes recommendations she will reply to the recommendation on her next visit, and she is in the facility once every other week. APRN #1 indicated that her expectation was that the pharmacy recommendations would be completed within 2 weeks of the pharmacist visit. The interview MD #1 on 5/21/25 at 11:30 AM indicated that the pharmacy recommendations are addressed by the facility APRN for all medical concerns and by the psychiatric APRN for psychiatric medications. MD #1 indicated the DNS was responsible for getting the pharmacy reports and placing them into the white book for medical APRN who comes into the facility once a week. MD #1 indicated that his expectation was they would get done right away but he thinks they have a month to get them completed. MD #1 indicated that his expectation is it would be done in the week but no later than a month. Interview with Pharmacist #1 on 5/21/25 at 11:35 AM indicated that the providers have to complete the recommendations within a month. Although requested, a facility policy for pharmacy recommendations and pharmacy month reviews were not provided. 2. Resident #78 had diagnoses that included anxiety disorder and dementia. The quarterly MDS dated [DATE] identified Resident #78 was severely cognitively impaired and required two person assist with bed mobility and transfers. The care plan dated 11/3/24 identified Resident #78 required psychotropic medications related to depression and anxiety. Interventions included administering medications as ordered and arrange for psychiatric consultation as indicated. Physician's order dated 11/23/24 directed to administer Ativan 0.5mg every six hours as needed for anxiety with no stop date. Pharmacy recommendations dated 3/24/25 identified Resident #78 was receiving as needed psychotropic medication which was required to be re-evaluated after 14 days. Recommendations included noting the medical justification of the continued use of as needed Ativan and specifying the number of days the as needed order was to continue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 5/20/25 at 8:37 AM and 5/21/25 at 10:27 AM identified she was responsible for addressing all pharmacy recommendations. All recommendations were to be provided to medical or psychiatry with the expectation of a documented response. The DNS indicated that while hospice had been involved with Resident #78's care on a routine basis, she had not discussed the recommendations with them as an oversight. The DNS further indicated she did not maintain any record keeping of pharmacy recommendations after the pharmacy mailed them to the facility. The interview with MD #1 on 5/21/25 at 11:30 AM indicated that the pharmacy recommendations are to be addressed by the facility APRN's (medical or psychiatry). MD #1 indicated the DNS was responsible to place the pharmacy reports into the white book for the medical APRN who comes into the facility once a week. MD #1 indicated that his expectation is it would be done in the week but no later than a month. An interview with APRN #1 on 5/22/25 at 10:54 AM identified she had previously provided psychiatric services to Resident #78 prior to receiving hospice care and that no requests had been made to re-evaluate the use of as needed Ativan until surveyor inquiry. APRN #1 indicated she would normally prescribe an initial as needed dose of Ativan for 14 days followed by a re-evaluation, but that hospice would need to review the recommendations before its initiation. A review of the facility policy for psychotropic medication directed that the facility will administer medications, including PRN psychotropic medications according to state and federal guidelines and according to pharmacy policies.