STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075268	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRINITY HILL CARE CENTER	**151 HILLSIDE AVE HARTFORD, CT 06106**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, a review of the facility documentation, staff interviews and a review of the facility policy for one of two sampled residents (Resident #2), who was reviewed for an allegation of mistreatment, the facility failed to ensure the resident was free from abuse. The findings include: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified intact cognition, independent with transfers, ambulation and locomotion. The resident care plan dated 7/21/20 identified an [DIAGNOSES REDACTED] disease with interventions that included standard precautions, administer anti-infective medications as ordered, and monitor for signs and symptoms of infection. Resident #2's [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified severe cognitive impairment, total dependence with bed mobility and transfers. The resident care plan dated 8/12/20 identified [MEDICAL CONDITION] disorder with hallucinations (the resident would often have conversations with individuals who were not present), depression, and anxiety, with interventions that included one to one visits with the social worker, monitor the residents symptoms, and psychiatric consultation for symptom control and medication management. Review of the reportable event form dated 9/19/20 at 2:50 PM identified the charge nurse went into Resident #2's room and observed Resident #2 engaged in an intimate encounter with Resident #1. The residents were immediately separated and Resident #1 was placed on constant observation. The nurse's noted dated 9/19/20 at 3:30 PM identified Resident #2 was in bed and remained confused. A full body assessment was conducted. The conservator and the physician were notified and Resident #2 was send to the hospital for an evaluation. The nurse's note dated 9/19/20 at 7:02 PM identified a resident to resident altercation. LPN #1 went to Resident #2's room to administer scheduled medications. Upon arrival LPN #1 noticed the curtain was closed. LPN #1 called out Resident #2's name to notify the resident she was entering the room. When LPN #1 pulled the curtain back, she observed Resident #1 and Resident #2 engaged in a sexual act. Resident #1 was removed from Resident #2's room. The nurse's note dated 9/19/20 at 11:09 PM identified Resident #2 was transferred back from the hospital on [DATE] at 10:45 PM. The hospital documentation indicated they were unable to reach the conservator therefore they did not conduct a sexual assault examination. The nurse's note dated 9/20/20 at 4:44 PM, identified Resident #2 was sent to the hospital on [DATE] for a sexual act perpetrated against Resident #2 by Resident #1 who had an [DIAGNOSES REDACTED] disease. Resident #2 was unable to recall the event. Based on the hospital report, the hospital was unable to provide [MEDICATION NAME] treatment ([MEDICAL CONDITION] medication), due to the inability of the hospital to reach Resident #2's conservator for approval. The psychiatric evaluation dated 9/20/20 identified Resident #2 was involved in a sexual encounter with Resident #1 in the facility. Resident #2 was alert and oriented, however his/her insight and judgement were impaired. Resident #2 was transferred to an alternate floor in the facility. The resident evaluation checklist dated 9/21/20 identified Resident #2 was unable to fully consent to a sexual relationship due to his/her mental capacity. Furthermore, Resident #2 did not want a consensual relationship with Resident #1 and could not fully consent. Resident #2 did not recall the incident on 9/19/20 with Resident #1. One to one observation for Resident #1 was implemented to prevent nonconsensual sexual activity. Physicians orders for Resident #2 dated 9/21/20 at 12:30 PM directed the administration of Tivicay ([MEDICAL CONDITION] medication) 50 milligrams (mg) by mouth daily for 4 weeks, and [MEDICATION NAME]/Emtricitabine/Tenofovir (a [MEDICAL CONDITION] inhibitor) 200mg/300 mg by mouth daily for 4 weeks. [DIAGNOSES REDACTED] serum testing and a basic metabolic panel was ordered. Review of the social work progress note dated 9/21/20 at 3:05 PM identified Resident #1 and Resident #2 engaged in an intimate situation. The staff redirected Resident #1, and Resident #2 was moved to alternate floor. Resident #2 believed that he/she lived at college and he/she moved dorm rooms. Resident #2 liked his/her new room and did not recall the incident. The conservator was informed of the incident and provided authorization to administer [MEDICAL CONDITION] medications and obtain laboratory testing to check for infectious or [MEDICAL CONDITION] conditions. Interview with Resident #1 on 9/23/20 at 10:10 AM identified he/she went into Resident #2's room to speak with the resident and his/her roommate. Resident #1 indicated Resident #2 initiated the intimate encounter and Resident #2 acquiesced. Resident #1 indicated LPN #1 came into the room during the interaction and separated the residents. Resident #1 indicated he/she was placed on one to one observation. Interview with Resident #2 on 9/23/20 at 10:20 AM identified Resident #2 was confused to time and place, and the resident's thoughts were disorganized. Resident #2 was unable to recall the incident from 9/19/20. Interview with LPN #1 on 9/23/20 at 11:20 AM identified she entered Resident #2's room to administer medications. As she entered Resident #2's room, the door was opened however the curtain was pulled. LPN #1 pulled the curtain open and identified Resident #1 and #2 were engaged in a sexual encounter. LPN #1 identified she told Resident #1 this interaction was inappropriate asked Resident #1 to leave the room. Resident #1 indicated he/she was sorry and would not do it again. LPN #1 reported the incident to the supervisor and placed Resident #1 on one to one observation immediately. Interview with Person #1 (Conservator) on 9/25/20 at 9:15 AM identified a consensual sexual relationship for Resident #2 at the facility was never discussed during the care conferences and Person #1 was never asked to consent for this type of relationship prior to the incident on 9/19/20. Person #1 indicated he/she would be opposed to a sexual relationship if there was a medical contraindication. The facility abuse policy directed in part, that residents would not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family member or legal guardians, friends or other individuals.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, and a review of the facility policy for one sampled resident (Resident #2), reviewed for medication administration, the facility failed to ensure a new medication order was transcribed in accordance with the facility policy. The findings include: Resident #2's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified severe cognitive impairment, total dependence with bed mobility and transfers and received antipsychotic, antianxiety, and antidepressant medication. The resident care plan dated 8/12/20 identified [MEDICAL CONDITION] disorder with hallucinations (the resident would often have conversations with individuals who were not present), depression, and anxiety, with interventions that included one to one visits with the social worker, monitor the residents symptoms, and psychiatric consultation for symptom control and medication management. The psychiatric consultation dated 9/15/20 identified Resident #2 was evaluated due to periods of increased agitation and aggression toward staff. During care Resident #2 scratched a staff members arm in several areas. Resident #2 had been increasingly restless and ripped off his/her brief. Resident #2 had an established [DIAGNOSES REDACTED]. Resident #2 was seen in bed, restless, fidgety, his/her speech was non-sensical. A recommendation was made to increase [MEDICATION NAME] to 25 milligrams (mg) three times daily. The physician's order dated 9/15/20 at 11:00 AM directed to discontinue [MEDICATION NAME] 12.5 mg twice

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

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.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) daily and directed to administer [MEDICATION NAME] 25 mg by mouth three times daily for [MEDICAL CONDITION] disorder, agitation and aggression. Review of the clinical record and medication administration record (MAR) dated September 2020 failed to reflect that [MEDICATION NAME] 25mg three times daily order was transcribed on 9/15/20, therefore the medication was not administered per physician's order from 9/15/20 through 9/23/20 (8 days and/or 24 doses). Interview and review of the clinical record with the Director of Nursing on 9/23/20 at 1:40 PM identified that an order for [REDACTED].#2 did not receive [MEDICATION NAME] as directed. The DON indicated on 9/15/20 the charge nurse assigned to the unit called out sick. The nursing supervisor was responsible for the unit and it was his/her responsibility to transcribe the order to ensure the medication was administered and she did not. Interview with RN #1 on 9/23/20 at 1:55 PM identified there were several new orders written that day, and many nurses were transcribing orders as it was very busy. RN #1 indicated she did not remember transcribing Resident #2's new order on 9/15/20. Subsequent to surveyor inquiry Resident #2 was evaluated by a physician and new order was obtained to discontinue all [MEDICATION NAME] orders, and administer [MEDICATION NAME] 25 mg by mouth at 9:00 AM, 5:00 PM and 9:00 PM. The facility policy entitled Medication Order Transcription directed in part that the prescriber would be responsible for initiating a complete order, including the name of the drug, the dose, the route of administration, and frequency. Upon signing the orders, the practitioner would raise the red flag on the chart that identified a new order and notify the nurse. The nurse would transcribe the complete order, including the name of medication, the dose, the route of administration, and frequency onto the MAR.