STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075264	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Bloomfield	140 Park Ave Bloomfield, CT 06002

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 and interviews for one (1) of five (5) residents (Resident #3), reviewed for wnaderguards, the facility failed to ensure that Resident #3 had a physician's order directing to check placement and functionality of the Wanderguard. The findings include: 1. Resident #3's diagnoses included cerebral infarction (blood flow to the brain is interrupted causing brain tissue to die), dementia without behavioral disturbances and mild cognitive impairment. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition and was independent with bed mobility, transfers and ambulation. Additionally, it identified that Resident #3 utilized a wander/elopement alarm. The Resident Care Plan (RCP) dated 1/10/25 identified that Resident #3 is at risk for elopement due to limited insight into his/her illness or abilities with interventions that included to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, and a Wanderguard was in place and staff were to observe and monitor placement and function of the Wanderguard per facility policy. Review of physician's orders dated 8/1/24 through 1/29/25 failed to identify orders for the Wanderguard, including to check the placement and function of the device. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for Resident #3 for December 2024 and January 2025 failed to identify documentation regarding a Wanderguard. Observation of Resident #3 on 1/29/25 at 3:03 PM identified the resident with a Wanderguard intact to the right wrist. Interview and observation with LPN #5 on 1/29/25 at 3:18 PM identified that although Resident #3 had a Wanderguard intact to his/her right wrist, and she was unable to locate a physician's order or a task for the Wanderguard on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) to verify the device was in place or functioning. She reported that she was aware the resident was a flight risk but stated she could not recall checking for the device in the past and was unsure why there was no physician's order for the Wanderguard when there should have been. (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry a physician's order dated 1/29/25 at 4:50 PM directed that Resident #3 had a Wanderguard in place to the upper extremity and nursing was to check for placement every shift. If the Wanderguard was not in place, nursing was to update the Supervisor on duty. A physician's order dated 1/29/25 at 6:45 PM directed for Recreation to check the functionality once weekly and document the functionality using the Wanderguard device. Interview with the DNS and RN #3 (Regional) on 2/3/25 at 3:56 PM identified that although they didn't have a policy on Wanderguards, the wanderguard there should be a physician's order to be checked for placement every shift and function weekly. .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation and interviews for one (1) of five (5) residents (Resident #3), reviewed for wnaderguards, the facility failed to ensure that Resident #3 had a physician's order directing to check placement and functionality of the Wanderguard. The findings include: 1. Resident #3's diagnoses included cerebral infarction (blood flow to the brain is interrupted causing brain tissue to die), dementia without behavioral disturbances and mild cognitive impairment. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition and was independent with bed mobility, transfers and ambulation. Additionally, it identified that Resident #3 utilized a wander/elopement alarm. The Resident Care Plan (RCP) dated 1/10/25 identified that Resident #3 is at risk for elopement due to limited insight into his/her illness or abilities with interventions that included to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books, and a Wanderguard was in place and staff were to observe and monitor placement and function of the Wanderguard per facility policy. Review of physician's orders dated 8/1/24 through 1/29/25 failed to identify orders for the Wanderguard, including to check the placement and function of the device. Review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for Resident #3 for December 2024 and January 2025 failed to identify documentation regarding a Wanderguard. Observation of Resident #3 on 1/29/25 at 3:03 PM identified the resident with a Wanderguard intact to the right wrist. Interview and observation with LPN #5 on 1/29/25 at 3:18 PM identified that although Resident #3 had a Wanderguard intact to his/her right wrist, and she was unable to locate a physician's order or a task for the Wanderguard on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) to verify the device was in place or functioning. She reported that she was aware the resident was a flight risk but stated she could not recall checking for the device in the past and was unsure why there was no physician's order for the Wanderguard when there should have been. Subsequent to surveyor inquiry a physician's order dated 1/29/25 at 4:50 PM directed that Resident #3 had a Wanderguard in place to the upper extremity and nursing was to check for placement every shift. If the Wanderguard was not in place, nursing was to update the Supervisor on duty. A physician's order dated 1/29/25 at 6:45 PM directed for Recreation to check the functionality once weekly and document the functionality using the Wanderguard device. Interview with the DNS and RN #3 (Regional) on 2/3/25 at 3:56 PM identified that although they didn't have a policy on Wanderguards, the wanderguard there should be a physician's order to be checked for placement every shift and function weekly. (continued on next page)

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Touchpoints at Bloomfield	140 Park Ave Bloomfield, CT 06002

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for unauthorized leave, the facility failed to ensure that when a resident was identified as missing from the facility by staff, the missing person protocol was initiated which allowed the resident to walk 3.6 miles in 27 degree weather passing multiple major intersections and having to cross main roads to get to his/her destination. The findings include: Resident #1 had diagnoses including schizophrenia and alcohol abuse. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of twelve (12) indicative of moderately impaired cognition and was independent with bed mobility, transfers, toileting and ambulation. Review of the Capacity to Meet Minimal Basic Needs Interview dated 10/10/24 identified that the resident does not have the capacity to meet minimal basic needs in the community and does not have a history of, or other known behaviors which could place them at risk of, seeking unescorted exit from a supervised setting. Review of the clinical record failed to identify a Leave of Absence (LOA) order. A nurse's note dated 12/13/24 at 3:02 PM identified that Resident #1 left the facility without proper notification. It identified that the APRN was notified, Person #1 (emergency contact) was aware and that the resident was currently with a family member. A nurse's note dated 12/13/24 at 6:17 PM identified that Resident #1 returned from unauthorized leave with his/her family member. It reported that the resident was alert and oriented, a body assessment was completed with no abnormal findings and education was provided to the resident regarding signing out when he/she was leaving the facility. A nurse's note dated 12/14/24 at 8:06 AM identified that the resident returned to the facility complaining of generalized pain, and Tylenol (pain reliever) was administered with good effect. It reported that every fifteen (15) minute checks continued. A nurse's note dated 12/16/24 at 1:25 PM identified that a Wanderguard was placed to Resident #1's right-arm to help prevent unauthorized leave from the facility and the resident was made aware of the reason for the device. A Resident Care Plan (RCP) was initiated dated 12/16/24 identified Resident #1 was an elopement risk/wanderer due to impaired safety awareness and a history of attempts to leave the building unattended with interventions that included to identify a pattern of wandering, a picture is to be kept at the front desk to help ensure the resident's safety from leaving the building and a Wanderguard was in place and staff were to check the function and location per facility policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Person #1 on 1/29/24 at 10:36 AM identified that he/she was notified just before 3:00 PM on 12/13/24 by his/her family member, that Resident #1 was found at a restaurant in a nearby town. Person #1 identified that he/she called the facility and questioned Resident #1's whereabouts and the facility stated that they were unaware that the resident was missing. Person #1 identified that his/her family member went to pick up the resident, who was wearing pants and a long sleeve shirt, and brought Resident #1 to his/her house and they provided him/her with a winter coat stating that the resident did not appear injured and voiced no complaints. Person #1 reported they returned the resident to the facility a few hours later (unable to recall the time). Interview with Resident #1 on 1/29/25 at 1:05 PM identified that he/she walked to the restaurant in a nearby town on 12/13/24. The resident reported that he/she left the facility around 12:00 PM, walking by the Receptionist unnoticed and that it took him/her about three (3) hours to walk there, stating he/she wore a sweater and although it was cold, the resident made it to his/her destination without issues. Review of the restaurant address identified that it was 3.6 miles away from the facility. Interview with Nurse Aide (NA) #1 on 1/30/25 at 10:04 AM identified that she last saw the resident around 11:00 AM in his/her room, and at around 1:00 PM she was unable to locate him/her and notified Licensed Practical Nurse (LPN) #1, stating she was unaware of what happened after that. Interview with NA #3 on 1/30/25 at 11:08 AM identified that at lunchtime on 12/13/24 she was assigned to the dining room and NA #1 had come to her and asked if she'd seen Resident #1, stating that she had not. She reported that the resident sometimes doesn't show up and eats in his/her room so she didn't think anything of it and then no one asked her about it again so she thought he/she had been located. Further, she identified that lunch is usually served around 12:30 PM in the dining room where Resident #1 often ate. Interview with NA #2 on 1/30/25 at 11:40 AM identified that she overheard NA #1 and NA #3 talking, stating that they were unable to locate Resident #1 and although Resident #1 was on her assignment, she did not check on him/her after last seeing the resident around 11:30 AM stating that she should have but that he/she is independent and ambulates all over the building. She reported that she could not recall if the resident's lunch-time meal was eaten, or if she had documented on the meal. She reported that she usually asks the dining room NA (NA #3) how much Resident #1 ate and then she will document it, but stated she couldn't recall speaking with NA #3 about his/her meal consumption that day. Interview with LPN #1 on 1/30/25 at 1:14 PM identified that she last saw the resident about 11:30 AM on 12/13/24 in his/her room. She reported that the resident had no behaviors and appeared to be at baseline. She reported that at around 1:00 PM, a facility staff (could not recall who) had been looking for the resident and could not locate him/her. She identified that she spoke with the NA's, who also couldn't locate him/her, so she searched for the resident and was unable to locate him/her. She reported that she immediately notified the Assistant Director of Nursing Services (who was also acting as the nursing supervisor on 12/13/24) and the Receptionist who reported that he hadn't seen the resident, so she called a missing person code (Dr. Hunt) over the intercom. She reported that she immediately went to search for the resident but stated that she did not follow-up after she was unable to locate Resident #1 herself due to time constraints. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Receptionist #1 on 1/30/25 at 1:41 PM identified that the Receptionist is responsible for monitoring all residents entering and exiting the building and keeping an eye on the residents outside the front door on/near the benches but stated a vendor came into the building around 12:30 PM on 12/13/24 and obstructed the view of Resident #1 who, after the facility viewed the cameras, walked right by him unnoticed and did not notify any staff that he/she was leaving. He reported that at about 1:30 PM on 12/13/24, LPN #1 called him and reported that she could not locate Resident #1, and he stated he went out the front door and searched the front and was unable to locate the resident. He reported that LPN #1 then called a missing person code. Interview with Registered Nurse (RN) #5 (3:00 PM to 11:00 PM nursing supervisor) on 1/29/25 at 11:38 AM identified that shortly after she arrived for her 3:00 PM to 11:00 PM shift on 12/13/24, the ADNS notified her that Resident #1's family had called and reported that the resident was at a restaurant in a nearby town. She identified that Resident #1's family brought him/her back to the facility around 5:00 PM and the resident was noted to be alert and oriented and had no injuries or complaints. She reported that she offered to send the resident to the hospital to be evaluated and although she didn't document it, he/she refused. RN #5 identified that she could not recall if she placed the resident on every fifteen (15) minute checks but stated she kept an eye on him/her that shift and notified all the nurses and the Nursing Supervisor on the oncoming shift of the incident and that they needed to all put eyes on him/her frequently. Interview with the ADNS on 1/29/25 at 12:40 PM identified that on 12/13/24 she was the 7:00 AM to 3:00 PM supervisor on 12/13/24 and received a call from Person #1 around 3:00 PM stating that Resident #1 had walked to a restaurant in a nearby town. The ADNS identified that neither LPN #1 or any other staff had reported to her that Resident #1 was unable to be located, she only became aware when Person #1 called her and informed her around 3:00 PM. She further identified that a Dr. Hunt was not called on 12/13/24. Interview with the Director of Nursing Services (DNS) and RN #3 (Regional Nurse) on 1/30/25 at 10:23 AM identified that Resident #1 should have had an authorized Leave of Absence (LOA) pass to leave the building on 12/13/24. They identified that it is their expectation that the Receptionist monitors all residents entering and exiting the building and having them sign out at the desk or redirecting them back into the facility as necessary, and that after watching the cameras it was identified that the resident walked right behind a vendor that was at the front desk obstructing the Receptionist's view of Resident #1 leaving the building. They reported that is the Receptionist's responsibility to also monitor residents who are authorized to go outside on the facility grounds and to ensure they are within the Receptionist's sight, stating that Resident #1 had privileges to sit out in the front entrance area, but that he/she is supposed to always notify the Receptionist first, stating he/she did not do that on 12/13/24. The DNS identified that upon return to the building on 12/13/24 the resident was placed on every 15 minute checks, however, she was unable to locate the documentation, and on 12/16/24 the resident was given a wanderguard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 1/30/25 at 10:41 AM identified that the resident is unable to live in the community independently but stated that Resident #1 was able to go out in the community unattended and that if he/she had requested a Leave of Absence (LOA) pass, they would have granted it and allowed him/her to ambulate to the restaurant independently. She identified that after watching the cameras, the resident was visualized walking out the front door around 12:30 PM and that an investigation was done, but she could not locate the investigation. She stated that she unaware that staff were unable to locate the resident around 1:00 PM until surveyor inquiry on 1/30/25. The Administrator identified that she wasn't made aware until after 3:00 PM when the family member called to inform the facility that the resident was found at a restaurant in a nearby town. The Administrator identified that if a resident is identified as missing the missing resident protocol would be initiated, however, the missing person code was never called over the intercom regarding Resident #1 on 12/13/24, reporting she was unsure why staff would have said that. She identified that she never looked at the camera surveillance beyond 12:30 PM on 12/13/24 when she observed Resident #1 exiting the main entrance on the cameras, stating the footage is deleted after seven (7) days and she was unsure if Receptionist #1 went outside to try and locate Resident #1 around 1:30 PM. Interview with NA #1, NA#2, NA #3, LPN #2, LPN #3 all working on 12/13/24 on the 7:00 PM to 3:00 PM shift on 1/30/25 at various times after 2:01 PM identified that they could not recall on a missing person being called over the intercom and could not recall participating in a search of the building regarding Resident #1. Interview with RN #4 on 1/30/25 at 2:29 PM identified that he was standing in the doorway of the Administrators office talking to her around 12:30 PM on 12/13/24 when it was later identified through camera surveillance that Resident #1 walked by him and Receptionist #1 exiting the building. He reported that a missing person code was never called, and he did not participate in a search of the building. Interview with the Social Worker on 1/29/25 at 3:36 PM identified that the resident had authorization to be on the facility grounds but should have signed out and let the Receptionist know. She reported that the resident had not asked for an LOA/Travel pass prior to the 12/13/24 incident so one had not been granted so he was not authorized to go out on an independent LOA that day. The SW further identified that the resident usually went LOA with family and she could not recall him/her having an independent travel pass in the past. The Authorized Leave of Absence policy dated 4/25/24 directed, in part, that if a resident's health allows, and the resident's doctor agrees, a resident can spend time away from the facility visiting family or friends during the day or overnight, called a leave of absence or a travel pass. A physician's order is required for all non-medical leave of absences. The order will indicate whether the resident needs to be accompanied by a responsible person. The Interdisciplinary Team will review each request in accordance with the resident's individual care needs and any special recommendations and safety needs will be documented by the team on the Travel Pass Request Form. A copy of the Travel Pass Request Form shall be given to the resident, a copy will be filed in the Travel Pass Record Book and the original form will be kept in the medical record. The resident or responsible party will sign out and list the time the resident will return and sign the facility Leave of Absence Log. If the resident has not returned to the facility and has failed to call, please refer to the Unauthorized Leave from the Facility Policy (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Missing Resident policy dated 11/18/23 directed, in part, that the staff member who cannot locate the resident will immediately notify the Charge Nurse and Nursing Supervisor. The Nursing Supervisor will then announce the following over the intercom system, May I have your attention please; Doctor Hunt in looking for 'Resident's Name'. If the resident is not located on the unit, the Nursing Supervisor alerts the staff to conduct a search of the building immediately. If the resident is not located, the Nursing Supervisor will notify the local police, Administrator and the DNS. While waiting for the police to arrive, the Nursing Supervisor will direct the staff in a search of the facility grounds. Although requested the facility stated that they do not have an elopement policy.