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	02/03/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the privacy and confidentiality was maintained of the resident's personal and medical records and did not text resident information on the employee's personal cell phone. The findings include:Resident #1's diagnoses included cerebral infarction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment, and was dependent with ADLs and transfers. The Resident Care Plan (RCP) dated 12/23/2025 identified a risk for falls and alteration in mobility. Interventions directed to assist with ADLs, call bell in reach, determine causative factors of falls, and to monitor and administer pain medication as ordered, and Resident #1 used an electric wheelchair independently. The nurse's note dated 1/7/2026 at 6:55 AM identified the Nurse Aide (NA) reported Resident #1 was refusing assistance during transfer into the wheelchair van for a scheduled appointment, and Resident #1 fell backwards out of his/her wheelchair. Observed laying supine on the pavement near the wheelchair van. Resident #1 stated he/she fell backwards while getting into van and hit back of his/her head. A facility reportable event form dated 1/7/2026 identified at 6:50 AM during transport into the wheelchair accessible van, resident's wheelchair became caught on an object, resulting in the wheelchair tilting and tipping over while resident was seated. An RN assessment was completed, resident denied pain or discomfort and insisted on going to the scheduled appointment. Resident #1 initially refused hospital transport after the fall but agreed to go to the hospital upon return from his/her scheduled medical appointment. Hospital diagnostic imaging identified a spinal fracture (L2 (lumbar vertebra number 2) transverse process fracture). Review of facility summary dated 1/13/2026 identified during transport into a wheelchair accessible van, the resident's wheelchair became caught on an object resulting in the wheelchair tilting and tipping over while the resident was seated. Resident returned to the facility and will have follow up with orthopedic and physical/occupational therapy for evaluation on balance and strengthening, pain management and education and reminders to wait for assistance. Interview and record review with RN #2 on 2/3/2026 at 1:10 PM interview, record review with RN #2 identified he texted the APRN using his personal cell phone to notify the APRN of the fall. RN #2 stated he was the night shift supervisor on 1/7/2026 when he was notified at approximately 7 AM that Resident #1 fell backwards out of the wheelchair during a transfer into the wheelchair van for a scheduled medical appointment. RN #2 stated Resident #1 returned into the building, and he assessed Resident #1 (vital signs and neurological assessment were included) and he informed Resident #1 of the risks of leaving the building for the scheduled appointment. RN #2 stated he informed Resident #1 that he/she needed monitoring after a fall with head strike, however Resident #1 was insistent to go to the scheduled appointment and independently used his/her electric wheelchair to leave for the appointment. RN #1 stated he (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified the facility APRN via a text message using his personal cellular phone before Resident #1 left for the appointment, and stated he received a text response back that indicated thank you for update. He stated that facility did not have a facility cell phone and he did not call the APRN using the facility phone. RN #1 further stated that he included Resident #1's name and clinical information in the text message, using his personal cell phone, that his cell phone was not encrypted, and he was unable to identify if the text sent was secure. Review of RN #2's text message dated 1/7/2026 at 7:46 AM identified it was sent to an APRN. The text message sent to the APRN stated his name and the name of the facility, then stated Resident #1 (listed by name) fell outside this morning while getting into the wheelchair van. He/she hit his/her head and had a raised area to the back of his/her head. No other injuries noted. Neuros were intact. He/she refused to stay at the facility for close monitoring despite education being provided on risks and insisted on leaving to go to his/her appointment. Initial vital signs taken. And the facility fall protocol was initiated. The text message response received by RN #2 from the APRN stated ok, thank you for the update. Text message received from RN #2 on 2/3/2026 at 4:21 PM indicated text message was sent to the APRN on 1/7/2026 at 7:46 AM regarding the resident fall that occurred approximately 6:55 AM. Further, the text message stated I would like for it to be noted that I sent the text only after attempting to call the Optim on-call system without success. No additional identifiers were included in the message and all care and notifications were documented in the medical record. Interview and record review with the DNS and RN #3 (corporate) on 2/3/2026 at 2:37 PM identified Resident #1 used a motorized (electric) wheelchair independently. On 1/7/2026 at 7 AM Resident #1 was leaving the facility to go to a scheduled appointment with a transport Nurse Aide (NA #1) when Resident #1 was using his/her motorized wheelchair and attempted to go up the ramp into the wheelchair van independently and Resident #1 refused help from NA #1. NA #1 indicated the wheelchair tilted and tipped, and Resident #1 landed on ground. The supervisor (RN #2) assessed Resident #1 and wanted Resident #1 to come back into the facility and possibly go to hospital. Resident #1 was alert and oriented, and was adamant about going to the appointment. When Resident #1 returned from the appointment, he/she then consented to be transferred to the hospital for evaluation. Resident #1 was diagnosed with an acute (new) displaced fracture of L2 (lumbar 2nd vertebrae) transverse process. Although RN #3 stated the facility APRN had encrypted text communication on her phone, RN #3 was unable to identify if the RN supervisor (RN #2) had encrypted/secure text messages on his personal cell phone that he used to text the APRN. Although RN #3 stated the APRN had tiger text (a secure, HIPAA-compliant messaging app designed for healthcare), interview failed to identify if RN #2 should have texted resident information using his personal cell phone or should have used a phone with encryption capabilities. The facility failed to ensure confidentiality was safeguarded including information on a device, from unauthorized disclosure. Although requested facility did not provide a facility policy regarding use of personal cellular devices to communicate resident/patient information.