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	11/21/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, observations, interviews, review of facility documentation and policy for the kitchen and dumpster areas, and for 11 of 17 residents, (#10, #37, #38, #49, #77, #88, #90, #101, #107, #125, #133) that resided on three (3) of five (5) nursing units reviewed for physical environment, the facility failed to ensure an effective pest control program was maintained. The findings included:1. An observation during a tour of the Kitchen on 11/17/25 at 9:45 AM identified the following: a. An observation of food preparation tables starting from the left side of the kitchen to the right then to the dish room identified several areas on the floors under the sinks, appliances, furniture, around the grease traps, table legs, appliance legs, and where the floors met the baseboards/walls were noted to have a thick, dark colored, built up of grime. Additionally, these floor areas were noted to have trash and Styrofoam cups built up at the back near the walls. b. The far wall to the left of the stove hood had a wall mounted knife holder. Both the holder and wall behind had dried splashes of an unknown substance. c. Below the knife holder was cart covered with foil that was noted to have a build-up of some unknown substance, and a bottle of honey on the lower shelf of the cart had its cover ajar on top with dried drips of the contents down the sides of the container. Additionally, next to the honey, there were small partially opened paper bags containing dry condiments. The Dietary Manager indicated these were used by the cook during food preparation. The Dietary Manager could not recall when the cart was last cleaned or when the foil had last been changed. d. A portable steam table located to the far right of the room had a clear barrier window on the front that had dry splashes of liquid/food which the Dietary Manager indicated needed to be cleaned. The Dietary Manager indicated there was not an assignment of cleaning duties with a sign-off sheet to ensure cleaning was completed in the kitchen. e. The dish room had a large stand-up fan, not in operation, with a noted thick dust built up on the fan cage and blades. The base of the fan contained a large build-up of substances that looked like ground beef. Two small flying insects were noted to be present. A large grease trap under the sink area had a buildup of grease/grime on the surrounding floor, which also covered the top and sides. The Dietary Manager indicated the grease trap was no longer in use. f. During the observation of the exterior of the back of the facility from outside the back door near the kitchen and the food supply room, out to the dumpster and the shed areas with the Maintenance Manager on 11/17/2025 starting at 11:10 AM identified piles of green trash bags with contents, pallets, broken equipment, scattered papers, and a biohazardous container with a red bag lining the inside, scattered around the area. A request for the pest control logs was made due to small flying (continued on next page)

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
	075264	A. Building B. Wing	11/21/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	insects noted in the kitchen dish room. The Maintenance Manager indicated pest control services the facility monthly. Interviews and review of photos taken in the kitchen, outside the back of the building, and dumpster area during the time of the 11/17/2025 observations were conducted and reviewed with the CEO, regional nurse RN #11, the Administrator, and Housekeeping and Dietary Managers. Review of the pest control visit log dated 11/14/2025 (3 days prior to the tour of the kitchen on 11/17/25) indicated in part, rodent activity was found in the kitchen storage area and heavy rodent activity was noted on the outside of the building. Flies had exploded in population in the kitchen dishwashing area spreading throughout the kitchen, hallways, and storage room. Additionally, the dishwashing area had been a constant source of filth for years allowing the fly population to flourish. Pest control was informed by facility staff that a deep cleaning of the kitchen was scheduled for the weekend. The Administrator indicated housekeeping had completed a deep cleaning during the weekend of 11/15 to 11/16/25. The Housekeeping Manager indicated that over the weekend the kitchen floor was pressure washed, however, due to an inability to move furniture, they were unable to clean the other areas. The CEO stated that a deep cleaning of the kitchen was still needed and would be completed. Subsequent to surveyor inquiry, the kitchen was deep cleaned and the dumpster area cleaned. 2. On resident living spaces, the following was identified: 1. Resident #10 was admitted to the facility March 2025 and had diagnoses of Parkinson's Disease, dementia, chronic obstructive pulmonary disease (COPD), and congestive heart failure.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had a Brief Mental Interview for Mental Status (BIMS) of ten (10) indicative of moderate cognitive impairment. The MDS further identified Resident #10 needed extensive assistance with bed mobility and transfers. Review of Resident #10's RCP dated 10/14/25 identified impaired cognitive function related to dementia. Interventions directed to administer medications as ordered, cue, reorient, and supervise as needed. Additionally, the care plan identified a goal for Resident #10 to remain safe in his/her home.2. Resident #37 was admitted to the facility April 2025 and had diagnoses of COPD, hyperlipidemia, and primary hypertension.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #37 had a Brief Mental Interview for Mental Status (BIMS) of nine (9) indicative of intact cognition. The MDS further identified Resident #37 was independent with toileting, personal hygiene, and transfers.Review of Resident #37's RCP dated 11/11/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers.3. Resident #38 was admitted to the facility in June 2015 and had diagnoses that included dementia, anxiety, and essential hypertension.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #38 did not have a Brief Mental Interview for Mental Status (BIMS) conducted as resident was rarely/never understood. The MDS further identified Resident #38 was dependent for personal hygiene and required substantial/maximal assistance with tub/shower transfers. Review of Resident #38's RCP dated 11/4/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. 4. Resident #49 was admitted to the facility November 2018 and had diagnoses of chronic kidney disease, peripheral vascular disease, and essential hypertension.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #49 had a Brief Mental Interview for (continued on next page)

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	11/21/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Mental Status (BIMS) of fifteen (15) indicative of normal cognitive function. The MDS further identified Resident #49 was dependent for personal hygiene and transfers.Review of Resident #49's RCP dated 10/7/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. 5. Resident #77 was admitted to the facility June 2024 and had diagnoses of chronic kidney disease, depression, and essential hypertension.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #77 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of normal cognitive function. The MDS further identified Resident #77 needed setup or clean-up assistance with personal hygiene and was independent with eating and transfers. Review of Resident #77's RCP dated 10/14/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. Interview and with Resident #77 on 11/19/25 at 10:45 AM identified he/she observed mice in his/her room frequently, as recent as the morning of 11/19/25. Resident #77 indicated he/she observed mice running along the wall, in his/her clothes, behind his/her bed, and eating food on his/her roommates tray table. Resident #77 identified that the mice have been around for a long time and had reported the issue to unit nurse aids, unit nurses, housekeeping staff, and the Administrator. Observation identified numerous small, black granular pellets approximately the size of grains of rice in Resident #77's room underneath the radiator, behind and under bed, on top of nightstand, on top of clothes in the dresser, and windowsill. 6. Resident #88 was admitted to the facility in March 2025 and had diagnoses of congestive heart failure, hyperlipidemia, and muscle weakness.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of normal cognitive function. The MDS further identified Resident #88 required partial to moderate assistance with personal hygiene and transfers. Review of Resident #88's RCP dated 8/27/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. 7. Resident #90 was admitted to the facility September 2024 and had diagnoses of congestive heart failure, type two (2) diabetes mellitus, and chronic kidney disease.Review of the significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of normal cognitive function. The MDS further identified Resident #90 was dependent for personal hygiene and transfers. Review of Resident #90 's RCP dated 11/4/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. Interview and observation with Resident #90 on 11/20/25 at 6:23 AM identified that mice were seen in his/her room on the night of 11/19/25. Resident #90 indicated the mice were running around room and climbing the curtain between the beds. Resident #90 indicated that he/she informed unit nurse aids and unit nurses on multiple occasions over the last few months. Resident #90 requested the surveyor to look under his bed near the wall where a large hole approximately 5X5 inches was observed. (continued on next page)

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	11/21/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. Resident #101 was admitted to the facility April 2023 and had diagnoses of type two (2) diabetes mellitus, depression, and peripheral vascular disease.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #101 had a Brief Mental Interview for Mental Status (BIMS) of one (1) indicative of severe cognitive impairment. The MDS further identified Resident #101 was dependent for personal hygiene and transfersReview of Resident #101's RCP dated 9/16/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. 9. Resident #107 was admitted to the facility February 2009 and had diagnoses of heart failure, dementia, and type two (2) diabetes mellitus.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #107 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of normal cognitive function. The MDS further identified Resident #107 was independent for eating, personal hygiene and transfers. Review of Resident #107's RCP dated 10/14/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. 10. Resident #125 was admitted to the facility September 2025 and had diagnoses of type two (2) diabetes mellitus, hyperlipidemia, and anxiety.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #125 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of normal cognitive function. The MDS further identified Resident #125 required substantial to maximal assistance for personal hygiene and partial to moderate assistance for transfers.Review of Resident #125's RCP dated 10/14/25 identified a potential alteration in well-being with a goal that resident would be cared for with dignity. Interventions included providing resident with supportive care and services to promote a sense of safety, well-being, and positive self-image. 11. Resident #133 was admitted to the facility February 2023 and had diagnoses of dementia, chronic kidney disease and major depressive disorder.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #133 was unable to complete the Brief Mental Interview for Mental Status (BIMS) and had moderate cognitive impairment. The MDS further identified Resident #133 was dependent of staff for eating, personal hygiene, and transfers. Review of Resident #133's RCP dated 10/14/25 identified he/she likes to store food in room. Interventions directed to educate resident/family on safe food storage to avoid pests and to keep food in the proper location, such as refrigerator, freezer, or storage containers. Observation on 11/19/25 at 10:50 AM identified Resident #10, #37, #38, #49, #77, #88, #101, #107, #125, and #133's rooms had numerous small, black granular pellets approximately the size of grains of rice in the corners, underneath radiators, behind nightstands and dressers, and under beds. Additionally, the observations identified numerous small holes in the residents' rooms. Review of the facility contracted pest management service reports dated April 2024 through November 2025 identified the pest control services were provided monthly. The most recent service was performed on 11/14/25 and identified rodent activity around the building and in kitchen storage. The 11/14/25 visit included inspection, rebaiting of rodent stations as needed, and placement of additional rodent stations. Although there had been sightings of rodents in the residential areas of the facility, the pest control vendor had not serviced those areas of the facility in September, October or November 2025 indicating that extra service time was needed if service calls were to be scheduled on (continued on next page)

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	11/21/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident wings. Interview and observation with the Administrator on 11/19/25 at 11:33 AM identified that she was aware of the mice concerns. The Administrator indicated that the mice issue has been an ongoing problem and was related to the facility being close to wetlands and woods. The Administrator indicated that the facility had a log with resident concerns about mice which was presented to pest control when they treated monthly. The Administrator indicated that pest control inspects and treats the facility monthly per the pest control contract agreement but can come out more if requested. The Administrator failed to identify why pest control had not been requested to go to the facility more frequently when there were numerous resident concerns and sightings of mice in the facility. Interview and observation with the Administrator on 11/20/25 at 9:15 AM identified numerous holes in walls of Resident #10, #37, #38, #49, #77, #88, #90, #101, #107, #125, and #133's rooms and that she was unaware. The Administrator indicated that she was unaware the holes were open, that the holes in the walls were not covered so that pest control could put bait inside and should have steel wool in them to prevent mice from exiting. Interview with the Pest Control Vendor, Person #1 on 11/21/25 at 9:08 AM identified that there was a monthly contract agreement with the facility for monthly pest control visits. Additionally, Person #1 indicated that the facility had not requested additional pest control visits for resident units. Subsequent to surveyor inquiry, the holes in the walls were filled with steel wool. A facility policy regarding pest control was requested but the Maintenance Manager indicated the facility had no policy regarding pest control.

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	11/21/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, facility documentation, interviews and facility policies, the facility failed to ensure the use of beard restraints, failed to maintain a clean and sanitary kitchen environment free of pests, and failed to ensure refrigerator and freezer temperatures were maintained within acceptable ranges. The findings include:An observation during a tour of the Kitchen on 11/17/25 at 9:45 AM identified the following:1. Both the Dietary Manager and cook were noted with facial hair but without the benefit of using a beard restraint. The cook was at the food prep area where lunch was being prepared. Observation at the entrance to the kitchen indicated a lack of beard restraints available. The Dietary Manager stated that since the beard coverings were being enforced, he obtained beard restraints from the back room, provided 1 to the cook, and placed a beard restraint on himself.The Hair Restraint policy directed, in part, the purpose of the restraint was to prevent hair from contacting food and food equipment surfaces and deter food service employees from touching their hair. The hair restraints, such as hairnets and beard guards, would be provided at all times by the Food Service Director and be located just outside or just inside the entrance to the kitchen.2. a. An observation of food preparation tables starting from the left side of the kitchen to the right then to the dish room identified several areas on the floors under the sinks, appliances, furniture, around the grease traps, table legs, appliance legs, and where the floors met the baseboards/walls were noted to have a thick, dark colored, built up of grime. Additionally, these floor areas were noted to have trash and Styrofoam cups built up at the back near the walls. b. The garbage can was noted to be uncovered, and an eggshell was noted on the floor nearby. Flour was noted around the base of the stand lift mixer. The Dietary Manager indicated that this was a result of preparing breakfast several hours prior. c. The left side of the room had a food preparation table with a wire upper shelf above holding a metal fan noted with a thick buildup of a dust like material on the outer cage and on the blades of the fan that could potentially drop during food preparation.d. On top of the microwave oven single serving brown sugars containers were stored on a tray. The ceiling above was noted to have peeling paint which potentially could fall down onto food or the clean individual sugar containers. e. The ceiling to the left of the stove hood was noted to have peeling paint which potentially could drop down onto food items. f. The far wall to the left of the stove hood had a wall mounted knife holder. Both the holder and wall behind had dried splashes of an unknown substance. g. Below the knife holder was a cart covered with foil that was noted to have a build-up of some unknown substance, and a bottle of honey on the lower shelf of the cart had its cover ajar on top with dried drips of the contents down the sides of the container. Additionally, next to the honey, there were small partially opened paper bags containing dry condiments. The Dietary Manager indicated these were used by the cook during food preparation. The Dietary Manager could not recall when the cart was last cleaned or when the foil had last been changed. h. The smaller fixed steam table was noted to be missing a knob on the far left. The Dietary Manager indicated that the kitchen staff used a pair of pliers next to the missing knob to turn on the steam table. i. A portable steam table located to the far right of the room had a clear barrier window on the front that had dry splashes of liquid/food which the Dietary Manager indicated needed to be cleaned. j. The dish room had a large stand-up fan, not in operation, with a noted thick dust built up on the fan cage and blades. The base of the fan contained a large build-up of substances that looked like ground beef. Two small flying insects were noted to be present. A large grease trap under the sink area had a buildup of grease/grime on the surrounding floor, which also covered the top and sides. The Dietary Manager indicated the grease trap was no longer in use. Although the Dietary Manager indicated the fans were cleaned, he was unable to provide documentation or the date of when the fans or the surrounding areas had last been cleaned in the dish room. Additionally, the Dietary Manager indicated there was no cleaning schedule or list of items to be cleaned on a daily or weekly basis or assignments to be signed, but was sure that cleaning of all areas in the kitchen had taken place.3. A (continued on next page)

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	11/21/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the facility document labeled Kitchen Refrigerator/Freezer Temps for November 2025 with the Dietary Manager identified that the acceptable refrigerator temperatures were below 39 degrees Fahrenheit (F) and the acceptable freezer temperatures were below 0 degrees F. Review of the refrigerator temperatures identified the following: a. Walk in refrigerator- (acceptable less than 39 F) 11/13/25 40 degrees F (AM)b. Reach in refrigerator- (acceptable less than 39 F)11/6, 11/7,and 11/8/25 40 degrees F (AM)11/9/25 41 degrees F (AM)c. Milk refrigerator left- (acceptable less than 39 F) 11/2 and 11/3/25 40 degrees F (AM) 11/4/25 40 degrees F (PM) 11/15/25 40 degrees F (AM)d. Milk refrigerator right- (acceptable less than 39 F) 11/1/25 40 degrees F (AM)11/4/25 40 degrees F (PM) 11/16/25 40 degrees F (AM)e. Walk in Freezer- (acceptable less than 0 F) 11/3 and 11/4/25 4 degrees F (PM) 11/6/25 and 11/08/25 4 degrees F (AM) 11/15/25 10 degrees F (AM) 11/16/25 16 degrees F (AM)For 17 out of 32 morning and evening entries, the refrigerator/freezer temperatures were found to be outside of the acceptable ranges. The Dietary manager indicated staff should have rechecked the temperatures and followed the guidance at the bottom of the form as follows:Temperatures must be checked and logged when the kitchen is first opened and just prior to the kitchen being closed.If temperatures are not within acceptable ranges ensure the refrigerator/freezer door is kept closed for 10 minutes and recheck the temperature.If temperatures remain out of the acceptable range, contact the Food Service Director and/or Maintenance and attempt to move food to a working refrigerator or freezer. If that is not possible keep the door closed to maintain best temperatures.On 11/19/2025 at 10:35 AM the Dietary Manager and the regional nurse Registered Nurse (RN) #11 provided for view, cleaning schedules for the kitchen to show it was being cleaned. Interviews and review of photos taken of the kitchen, outside the back of the building, and dumpster area during the 11/17/25 surveyor observations were conducted and reviewed with the CEO, regional nurse RN #11, the Administrator, and Housekeeping and Dietary Managers. Review of the pest control visit log dated 11/14/2025 (3 days prior to kitchen observations on 11/17/25) indicated in part, rodent activity was found in the kitchen storage area and filth flies had exploded in population in the kitchen dishwashing area spreading throughout the kitchen, hallways, and storage room. Additionally, the dishwashing area had been a constant source of filth for years allowing the fly population to flourish and the pest control narrative indicated that pest control was informed by facility staff that a deep cleaning was scheduled for the weekend. The Administrator indicated housekeeping had completed a deep cleaning during the weekend of 11/15 to 11/16/25. The Housekeeping Manager indicated that over the weekend the kitchen floor was pressure washed, however, due to an inability to move furniture, they were unable to clean the other areas. The CEO stated that a deep cleaning of the kitchen was still needed and would be completed.A subsequent observation on 11/20/25 at 11:35 AM of the kitchen with the Dietary Manager found all areas had been steam cleaned, base boards, the base of the table legs, the outsides of the grease traps, the fans were taken out of service, and the wire rack was cleaned. The wall and ceiling to the left of the cooking hood were cleaned and painted the Dietary Manger indicated the other area of peeling ceiling paint was going to be done as well. A walk through the food supply area was noted to be clean with no evidence of pests. The kitchen was overall improved in cleanliness as compared to the 11/17/2025 observations and the Dietary manager indicated a schedule to maintain the kitchen cleanliness would be put into place.The facility policy labeled Cleaning Schedule within the Dietary Services manual indicated the food service Director was responsible to identify, monitor and manage the cleanliness of their department. Areas to be cleaned would be identified by the frequency of cleaning needed: A 3-1 template schedule was provided, and the cleaning schedule was to be adjusted to the uniqueness of each facility's Dietary Department and labeled as to when the item was to be cleaned: after use, daily, weekly or monthly. 4. a. An observation and review of facility temperature log of Rehabilitation Unit nourishment room documentation on 11/20/25 at 2:00 with RN #10 identified out of range refrigerator and freezer temperatures as follows: Nourishment room refrigerator Rehab unit- (acceptable less than 39 degrees Fahrenheit (F)11/1/25 through 11/11/25 and 11/13 to (continued on next page)

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	11/21/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/18/25 refrigerator temperatures were 40 degrees F.11/12/25 43 degrees F. Nourishment room freezer Rehab unit (acceptable less than 0 F)11/3/25 2 degrees F.11/14-11/17/25 minus 20 degrees F.11/7-11/11/25, 11/13/25 and 11/18/25 0 degrees F.The temperature log labeled Nourishment Room (Rehabilitation) Refrigerator and Freezer Temperature Log for November 2025 indicated at the bottom of the form, the Food Service Director or maintenance must be notified if proper temperatures are not met with acceptable range for the refrigerator being less than 39 degrees (bi-metallic thermometers may vary plus or minus 3 degrees) and the acceptable temperature range for the freezer was less than 0 degrees (bi-metallic thermometers may vary plus or minus 3 degrees). RN #10 was unable to explain the meaning of plus or minus 3 degrees and indicated the Dietary Department was responsible for checking the refrigerator temperatures. b. An observation and interview on 11/20/25 at 2:10 PM with the nursing supervisor, RN #2 of the nourishment room on the main unit that serviced the Simsbury Right and Left units identified refrigerator temperatures on the log were not within acceptable range, she was unable to explain what was meant by the plus or minus 3 degrees referred to. The following temperatures were noted on the log:Nourishment room refrigerator Simsbury units (acceptable less than 39 degrees Fahrenheit (F)11/1 through 11/11/25 40 degrees F. 11/12/25 41degrees F.11/13/25 42 degrees F.11/14 through 11/18/25 40 degrees F.Nourishment room freezer Simsbury units- (acceptable less than 0 F)11/1 to 11/11/25 and 11/14 to 11/18/25 0 degrees F.Several food items brought in from outside the facility were found to lack dates and/or names. RN #2 disposed of two of the three items indicating the resident whom the third item belonged to did not allow staff to throw away his/her foods placed in the refrigerator. The untouched item was an opened package of hotdogs that were placed inside a zip lock bag labeled only with a name. The Dietary Manager was then notified of the non-labeled food items RN # 2 disposed of, and the undated hot dogs remaining in the refrigerator. The Dietary Manager indicated he would look into the matter.c. An observation on 11/20/25 at 2:15 PM of the Nourishment room refrigerator/freezer that serviced the Long-Term and Memory Care units was being cleaned by housekeeping staff. A copy of the refrigerator log was obtained noting refrigerator and freezer temperatures as follows: Nourishment room refrigerator long term care/memory units (acceptable less than 39 degrees Fahrenheit (F)11/1 to 11/3/25, 11/5 through 11/9/25 ,11/11/25, and 11/14 through 11/17/25 identified temperatures of 40 degrees F. 11/12/25 46 degrees F.11/18/25 42 degrees F.Nourishment room Freezer long term care/memory units- (acceptable less than 0 F).11/3/25, 11/5/25, and 11/7 through 11/8/25, 0 degrees F.An interview, review of the Nourishment Room temperature logs, and review of facility policy with the Dietary Manager on 11/20/25 at 2:20 PM for all 3 nourishment rooms indicated the temperature documentation of the nourishment room refrigerators on all 3 units had temperatures out of the acceptable range and temperatures had not been rechecked. The Dietary Manager was unable to explain the meaning of the bi-metallic thermometer statement on the temperature log indicating a variance of plus or minus 3 degrees, as this was not a part of the facility policy. The Dietary Manager further indicated the freezer documentation indicating 20 below zero on the Rehab unit had to be a mistake and dietary staff would be reeducated regarding the refrigerator/freezer temperature procedure.The facility policy labeled Refrigeration Temperature Recording, within the Dietary Services manual, indicated record keeping for temperature control of refrigeration equipment is necessary to ensure foods are maintained at optimum quality and to prevent spoilage and or foodborne illness. Acceptable temperature range for refrigerators is 35 to 38 degrees F. set to 3 degrees below the US food code of 41 degrees F to ensure temperatures are maintained during the opening and closing of refrigerator doors during the workday. Acceptable freezer temperatures were indicated to be 0 to -10 degrees F and food is solid. If Refrigerator temperatures are not within acceptable range, make a mental note of the bad temperature and ensure the door is closed for at least 10 minutes then return and check the temperature. If the temperature decreases check it periodically to ensure the temperature becomes compliant, if not, contact the person in charge, the Food Service Director and/or maintenance. Foods are able to be used before reaching 41 degrees (continued on next page)

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	11/21/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F.The facility policy labeled Family/Visitor Provided Food directed food to be consumed at a later time will be stored by the nurse or their designee and will take the food or beverage and label the product received with a general description of the food, the resident name and room number and the date the product was received and store the food in the appropriate storage space (refrigerator/freezer). To maintain sanitary conditions and resident safety it is the facility's discretion to discard resident food if observed or evidenced to be spoiled. The Nursing, Dietary, and Housekeeping staff is responsible to discard foods outside of expiration dates, showing signs of spoilage or received more than 3 days prior.

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	11/21/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, and interviews for the only sampled resident (Resident #42) reviewed for dignity, the facility failed to ensure the resident was dressed in a dignified manner. The findings include: Resident #42?s diagnoses included Alzheimer's disease, abnormal posture, and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated [DATE] failed to identify cognitive status was assessed using a Brief Interview of Mental Status exam (due to inability), that long- or short-term memory was assessed or that Resident #42 was exhibiting any behaviors. Further, Resident #42 was totally dependent on staff for eating, bathing, hygiene and dressing. The Resident Care Plan (RCP) in effect from 8/23/25 through 11/18/25 identified Resident #42 required assistance for all Activities of Daily Living (ADL's). Interventions included to position the resident in a custom wheelchair daily with pelvic positioning belt to maintain alignment. The RCP failed to indicate the use of a sock for the resident's hand.Review of the physician's orders for November 2025, failed to direct the placement of a sock to the right hand.Review of nursing notes from 3/1/24 to 11/18/25 indicated one instance, on 7/10/24, of Resident #42 scratching him/herself.Observations of Resident #42 in his/her room on 11/17/25 at 9:30 AM and in the resident lounge on 11/18/25 at 2:20 PM identified him/her with a sock on his/her right hand. Interview with Licensed Practical Nurse (LPN) #5 on 11/18/25 at 2:23 PM identified Resident #42 wore a sock on his/her hand right hand due to behaviors of starching him/herself and that he/she had been exhibiting these behaviors for quite a while. LPN #5 indicated that NA's place sock on residents' right hand but was unsure if there were any physician orders or RCP interventions directing the use of a sock.Interview with DNS on 11/18/2025 at 2:50 PM identified that any resident with self-scratching behaviors, should have a RCP and a physician order for the application of an intervention (sock) to the hand.Subsequent to inquiry SBAR communication Form dated 11/18/25 and signed at 3:37 PM described itching behaviors.Interview with DNS on 11/19/2025 at 10:15 AM failed to identify a physician order of a RCP directing the need for a sock to be placed on Resident #42's right hand. The Resident's [NAME] of Rights policy (revised 1/15/24) indicated in part You have the right to be treated with consideration, respect and full recognition of your dignity.

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	11/21/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for 1 of 2 sampled residents (Resident #10), reviewed for pressure ulcers, the facility failed to notify the physician of a significant weight gain according to the physician's order. The findings include:Resident #10's diagnoses included a stage 3 pressure ulcer, congestive heart failure (chronic condition of a weakened heart muscle causing fluid retention), and hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had a Brief Interview of Mental Status (BIMS) score of 7 indicating severely impaired cognition, required moderate assistance with rolling left and right and chair/bed-to-chair transfers, and required set up assistance with eating. The Resident Care Plan (RCP) in effect from 9/23/25 through11/21/25 identified Resident #10 had a nutritional problem related to diabetes, congestive heart failure, coronary artery disease, and hypertension. Interventions included obtaining weights as ordered and to monitor/record/report to the physician, signs and symptoms of significant weight loss. Further review failed to identify a care plan for congestive heart failure.Physician orders in effect from 9/23/25 to 11/21/25 directed weights to be obtained weekly on Mondays during the day shift and to notify the physician for a greater than 5 pound weight gain in one week.The undated Nurse Aid (NA) Care Card (directs NA care) identified Resident #10 was to have weekly weights obtained.Review of the clinical record identified Resident #10's weight on 10/6/25 was 172 pounds, and on 11/3/25 was 186 pounds (a 14 pound, 8.4% weight gain in 1 month).Interview on 11/21/25 at 10:39 AM with Licensed Practical Nurse (LPN) #4 identified Resident #10 had a physician order for weekly weights to be taken, but weekly weights were missing on 9/29/25, 10/13/25, and 11/21/25. LPN #4 indicated that the dietician was responsible for monitoring significant weight changes and nursing did not monitor trending increases in weights for residents unless on fluid restrictions.Interview on 11/21/25 at 11:31 AM with the Assistant Director of Nursing (ADNS) identified that it was the expectation of the dietician to notify the Nursing Department of any significant weight change for a resident, and nursing would then notify the physician. She stated nursing had not been notified by the dietician of Resident #10's weight gain. The ADNS indicated that she would have wanted to have been notified as Resident #10 should have been assessed for any symptoms of fluid overload and the physician should have been notified of his/her increase in weight. Interview with Physician #1 on 11/21/2025 at 11:53 AM identified he had not been notified of Resident #10's significant weight gain, a 14 pound, 8.4% weight increase in 1 month. but would have wanted to have been. Had he been notified, he would have changed Resident 10's plan of care to include a physician's order for a chest X-ray, laboratory work, and would have potentially changed his/her medications and treatment. Physician #1 stated he was coming to the facility immediately to assess Resident #10 for potential fluid overload due to his/her significant weight increase and diagnosis of congestive heart failure.Attempts to contact the dietician for an interview were unsuccessful. Review of the facility's Weight policy identified in part that the physician and responsible party will be notified when there is a significant weight fluctuation of five percent more or less and the resident plan of care will be updated.

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	11/21/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, interviews, and facility policy for 1 of 2 residents (Resident #31) reviewed for abuse, the facility failed to follow their abuse policy for removal of a staff member from the schedule. The findings include:Resident #31' s diagnosis included Cerebral infarction, anxiety, and depression.The annual Minimum Data Set (MDS) dated [DATE] identified Resident #31 had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required substantial/maximal assistance going from lying to sitting on the side of the bed and chair to bed to chair transfers and was independent with mobility in his/her wheelchair.The Resident Care Plan in effect on 9/17/25 indicated Resident #31 may make statements that are not real and say things that are not true but believed to be true. Interventions included listening to determine if there is any truth in what was said, offer 1:1 visits with the social worker, provide 2 staff members at all times with care. A Reportable Event form dated 10/29/25 at 1:00 PM identified an allegation of misappropriation (theft) that had occurred on 10/20/25 during a physician visit outside of the facility. Resident #31 indicated that money and a bank card were stolen from his/her bag by NA #4. The only statement obtained and attached to the abuse packet had been written on 10/29/25 written by NA #4.Interviews, clinical record review, and review of the Reportable Event form with the Corporate Registered Nurse (RN) #1 on 11/20/25 at 10:36 AM and later with the Director of Nursing Services (DNS) at 11:50 AM identified that NA #4 accompanied Resident #31 to his/her medical appointment on 10/20/25. After arriving at the appointment location, Resident #31 wanted to go into the gift shop. NA #4 remained outside the door of the gift shop when Resident #31 left to make a purchase, returned, and they then proceeded to the appointment. Following the appointment, NA #4 left the resident alone to buy herself a sandwich and on return, the resident was missing. Resident #31 was found outside, returning to the building, and once inside, smelled of smoke. NA #4 indicated that Resident #31 had purchased cigarettes and a lighter while in the gift shop. According to the DNS and RN #1, NA #4 indicated that Resident #31 asked her if the incident would be reported when they returned to the facility, and the DNS indicated that NA #4 did report the incident. NA #4 reported Resident #31 had requested to see her indicating she owed him/her 15 dollars for the confiscated smoking materials and when NA #4 indicated she owed the resident nothing, Resident #31, said he/she would be reporting NA #4 for stealing his/her bank card. Although the DNS indicated that NA #4 was taken off the schedule, she was unable to identify the time or date.Interview and review of NA #4's statement with NA #4 on 11/21/25 at 11:48 AM identified that she accompanied Resident #31 to a physician appointment outside of the facility on 10/20/25. A few days later while working, Resident #31 requested to see her privately and subsequently told her that she owed him/her 15 dollars for the confiscated smoking materials. When NA #4 told the resident that she did not owe him/her anything, Resident #31 indicated that he/she was going to report NA #4 had stolen money from him/her. NA #4 indicated that she immediately reported the allegation to RN #2, the nursing supervisor, and wrote a statement dated 10/25/25. NA #4 indicated that on 10/30/25 she was asked to come into the facility early to rewrite her original statement written from 10/25/25. Re-interview with RN #1 on 11/21/25 at 9:40 AM identified that although NA #4 indicated she had reported and written a statement on 10/25/25 that Resident #31 had alleged she had stolen money from him/her, RN #1 was unable to determine which day Resident #31 reported the incident, 10/25/25 or 10/29/25 (the day the Reportable Event was completed). Interview with RN #2, the nursing supervisor on 11/21/25 at 12:30 PM identified that she was unable to recall the day that Resident #31 made the allegation or the day she had requested NA #4 to write her statement. Review of NA #4's time clock in and out records identified she worked on 10/25/25 from 2:53 PM to 10:55 PM (the day NA #4 indicated she reported the allegation of stealing and wrote a statement), on 10/29/25 from 6:53 AM until 2:56 PM (remaining in the facility 1 hour and 56 minutes after the Reportable Event identified the allegation), on 10/30/25 (continued on next page)

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	11/21/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from 1:53 PM until 10:55 PM (the date NA #4 the date she was asked to re-write her statement), and on 10/31/25 from 8:56 AM until 10:54 PM. Review of the facility submitted Summary of Findings to the State Agency dated 10/30/25 indicated that the employee accompanied Resident #31 to a physician appointment. It was determined that The employee stayed with Resident #31 throughout the appointment and that Resident #31 had his/her pocketbook at all times. Employee denies this allegation.Review of the Abuse CT policy indicated, in part, that misappropriation of resident property is prohibited. The investigation will be initiated within 24 hours of its finding, and the staff member would be taken off the schedule during this time, statements would be obtained from staff and witnesses.

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	11/21/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, interviews, and facility policy for 1 of 2 residents (Resident #31) reviewed for abuse, the facility failed to follow their abuse policy conducting an investigation. The findings include:Resident #31' s diagnosis included Cerebral infarction, anxiety, and depression.The annual Minimum Data Set (MDS) dated [DATE] identified Resident #31 had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required substantial/maximal assistance going from lying to sitting on the side of the bed and chair to bed to chair transfers and was independent with mobility in his/her wheelchair.The Resident Care Plan dated 9/10/25 indicated Resident #31 may make statements that are not real and say things that are not true but believed to be true. Interventions included listening to determine if there is any truth in what was said, offer 1:1 visits with the social worker, provide 2 staff members at all times with care. A Reportable Event form dated 10/29/25 at 1:00 PM identified an allegation of misappropriation (theft) that had occurred on 10/20/25 during a physician visit outside of the facility. Resident #31 indicated that money and a bank card were stolen from his/her bag by NA #4. The only statement obtained and attached to the abuse packet had been written on 10/29/25 written by NA #4.Interviews, clinical record review, and review of the Reportable Event form with the Corporate Registered Nurse (RN) #1 on 11/20/25 at 10:36 AM and later with the Director of Nursing Services (DNS) at 11:50 AM identified that NA #4 accompanied Resident #31 to his/her medical appointment on 10/20/25. After arriving at the appointment location, Resident #31 wanted to go into the gift shop. NA #4 remained outside the door of the gift shop when Resident #31 left to make a purchase, returned, and they then proceeded to the appointment. Following the appointment, NA #4 left the resident alone to buy herself a sandwich and on return, the resident was missing. Resident #31 was found outside, returning to the building, and once inside, smelled of smoke. NA #4 indicated that Resident #31 had purchased cigarettes and a lighter while in the gift shop. According to the DNS and RN #1, NA #4 indicated that Resident #31 asked her if the incident would be reported when they returned to the facility, and the DNS indicated that NA #4 did report the incident. NA #4 reported Resident #31 had requested to see her indicating she owed him/her 15 dollars for the confiscated smoking materials and when NA #4 indicated she owed the resident nothing, Resident #31, said he/she would be reporting NA #4 for stealing his/her bank card. Although the DNS indicated that NA #4 was taken off the schedule, she was unable to identify the time or date.Interview and review of NA #4's statement with NA #4 on 11/21/25 at 11:48 AM identified that she accompanied Resident #31 to a physician appointment outside of the facility on 10/20/25. While working a few days after the appointment, Resident #31 requested to see her privately and subsequently told her that she owed him/her 15 dollars for the confiscated smoking materials after NA #4 had reported the incident. When NA #4 told the resident that she did not owe him/her anything, Resident #31 indicated that he/she was going to report NA #4 had stolen money from him/her. NA #4 indicated that she immediately reported the allegation to RN #2, the nursing supervisor, and was asked to write a statement of what had occurred, stating she did so on 10/25/25. NA #4 indicated that on 10/30/25 she was asked to come into the facility early to rewrite her original statement written from 10/25/25. NA #4 indicated she did not speak to and had not been contacted by the local police as part of the investigation. Re-interview with RN #1 on 11/21/25 at 9:40 AM identified that although NA #4 indicated she had reported and written a statement on 10/25/25 that Resident #31 had alleged she had stolen money from him/her, RN #1 was unable to determine which day Resident #31 reported the incident, 10/25/25 or 10/29/25 (the day the Reportable Event was completed). RN #1 indicated she was unable to find a statement from Resident #31 as part of the facility investigation and that the investigation was incomplete because there was no resident statement, no timeline of events, no documentation of the event in Resident #31's clinical record, and no indication of what the police said or did, to assist in making a conclusion.Interview (continued on next page)

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	11/21/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with RN #2, the nursing supervisor on 11/21/25 at 12:30 PM identified that she was unable to recall the day that Resident #31 made the allegation or the day she had requested NA #4 to write her statement. RN #2 denied being the staff member who requested NA #4 re-write her statement.Review of NA #4's time clock in and out records identified she worked on 10/25/25 from 2:53 PM to 10:55 PM (the day NA #4 indicated she reported the allegation of stealing and wrote a statement), on 10/29/25 from 6:53 AM until 2:56 PM (remaining in the facility 1 hour and 56 minutes after the Reportable Event identified the allegation), on 10/30/25 from 1:53 PM until 10:55 PM (the date NA #4 the date she was asked to re-write her statement for the investigation), and on 10/31/25 from 8:56 AM until 10:54 PM. Review of the facility submitted Summary of Findings to the State Agency dated 10/30/25 indicated that the employee accompanied Resident #31 to a physician appointment. It was determined that The employee stayed with Resident #31 throughout the appointment and that Resident #31 had his/her pocketbook at all times. Employee denies this allegation.Review of the Abuse CT policy indicated, in part, that misappropriation of resident property is prohibited. The investigation will be initiated within 24 hours of its finding, and the staff member will be taken off the schedule during this time; statements would be obtained from staff and witnesses, and consultation with local law enforcement.

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	11/21/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews, for the only sampled resident (Resident #138) reviewed for discharge, the facility failed to notify the State Ombudsman's office of the discharge per the requirement. The findings include: Resident #138's diagnosis included right knee replacement, difficulty in walking, and osteoarthritis.The discharge Minimum Data Set (MDS) assessment dated [DATE] identified Resident #138 had a Brief Interview of Mental Status score of 15, indicating intact cognition, and was independent with personal hygiene, upper and lower body dressing, and putting on/taking off footwear.The Resident Care Plan dated 8/25/25 identified a discharge to home was anticipated. Interventions included nursing and social work would coordinate, facilitate, and communicate all plans for follow-up and future care needs.Review of the clinical record identified a nurses note that Resident #138 was discharged home on 9/5/25.Interview with Social Worker (SW) #1 on 11/21/25 at 11:49 AM identified the facility had not notified the State Ombudsman's office of Resident #138's planned discharge. SW #1 further indicated that the facility had just begun reporting discharges to the Ombudsman at the end of September, and that she was now the responsible staff member for reporting.Interview with the regional Behavioral Health Director on 11/21/25 at 11:52 AM identified that the facility had not notified the State Ombudsman's office for residents discharged prior to 9/23/25 due to being unaware of the requirement until they were notified by the Ombudsman to send monthly documentation of all discharges. Review of the Discharge-Planning policy, revised 9/25/25, indicated, in part, that a copy of the written notification of discharge will be submitted to the CT Long Term Care Ombudsman's Office Reporting portal.

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	11/21/2025

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 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 observations, interviews, review of the clinical record, and facility policy for 1 of 2 residents reviewed for pressure ulcers (Resident #10), for 1 of 6 residents (Resident #90) reviewed for infection control, and for the only sampled resident (Resident #133) reviewed for physical restraints, the facility failed to update the Resident Care Plan. The findings include: 1.Resident #10's diagnoses included a stage 3 pressure ulcer, fracture of the left femur, and dementia. The Resident Care Plan (RCP) dated 6/26/2025 and in effect at the time of survey identified Resident #10 had a Stage 2 pressure ulcer on his/her left heel. Interventions included administering treatments as ordered and monitoring for effectiveness. The RCP failed to indicate that he/she was on EBP for a pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had a Brief Interview of Mental Status (BIMS) score of 7 indicating severely impaired cognition, required moderate assistance with rolling left and right and chair/bed-to-chair transfers, and had developed a Stage 2 pressure ulcer while at the facility. 2. Resident #90's diagnoses included diabetic foot ulcer, congestive heart failure, and type 2 diabetes. The Resident Care Plan (RCP) dated 10/31/2025 identified Resident #10 had a diabetic foot ulcer on his/her left heel. Interventions included treatments as ordered and identify potential causative factors and eliminate/resolve when possible. The RCP failed to indicate that he/she was on EBP for a diabetic foot ulcer. The Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, was dependent with rolling left and right and chair/bed-to-chair transfers and had a diabetic foot ulcer. Interview on 11/19/2025 at 11:24 AM with Registered Nurse (RN) #4 (Infection Preventionist) identified that the facility used EBP for all residents with a portal of entry including G-tubes, catheters, chronic wounds, diabetic foot ulcers, and multi drug resistant organism (MDRO) infections. He indicated chronic wounds included pressure ulcers, wounds that required a dressing, and any wound that was present for greater than 30 days. Interview on 11/21/2025 with the Assistant Director of Nursing identified Residents' care plans should be updated when there were changes to the MDS or any new interventions for a Resident's problem had been initiated. Further the ADNS identified Residents #10 and #90 did not have EBP within their care plans and should have. Second Interview on 11/21/2025 at 11:17 AM with RN #4 (Infection Preventionist) identified he was responsible for including EBP in the care plans for Resident #10 and Resident #90, an EBP problem and intervention should have been included within the Residents' care plans, and he failed to enter EBP into the care plans due to an oversight by him. Review of the facility's Enhanced Barrier precautions policy identified in part that a care plan will be (continued on next page)

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	11/21/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated for all residents that require EBP and will be discontinued when applicable. 3. Resident #133 's diagnoses included mild dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #133 was severely cognitively impaired, did not present any behavioral symptoms, and was totally dependent on staff with eating, personal care, and chair to bed transfers. The Resident Care Plan in effect on 11/17/25 failed to identify Resident #133 had a Resident Care Plan in place for the use of a pelvic positioning device. A review of physician's orders failed to direct the use of a pelvic positioning belt. Observations of Resident #131 on 11/17/25 at 10:17 AM and 11/17/25 at 11:17 AM identified a pelvic belt in place while the resident was sitting in his/her wheelchair. Interview with the charge nurse, Licensed Practical Nurse (LPN) #4 on 11/17/25 at 11:41 AM indicated Resident #133 occasionally flipped him/herself (out) while sitting in the wheelchair but she had not witnessed any recent occurrences. Additionally, LPN #4 stated that the pelvic positioning belt was placed on by a Nurse Aid (NA) and that Resident #133 was unable to release the belt independently. Interview with NA #2 (Resident #133's assigned NA) on 11/17/25 at 1:28 PM indicated that she placed the lap belt on as a precaution to prevent Resident #133 from falling from his/her wheelchair. Interview with Director of Rehabilitation on 11/19/25 at 8:57AM indicated that Resident #133 was assessed due to concerns with his/her alignment in the wheelchair and it was deemed appropriate for the use of a pelvic positioning belt. A paper copy of the original assessment dated [DATE] was provided from medical records. The Director of Rehabilitation reported it was the responsibility of the Interdisciplinary Team (IDT) to update the Resident Care Plan but was unable to identify the reason the Resident Care Plan had not been updated. Interview with DNS on 11/19/25 at 10:17 AM indicated that Resident Care Plan should be updated immediately after screenings were completed and was unsure why there was a delay in updating Resident #133 Resident Care Plan. Subsequent to surveyor inquiry, the Resident Care Plan was updated to include the use of a pelvic positioning belt, and a physician's order was updated to include a custom tilt in space wheelchair with pelvic positioning belt to maintain proper hip alignment Review of the Care Plan policy, dated 10/15/25, identified in part, that the facility will develop a comprehensive person-centered plan of care for its residents that is consistent with residents' rights in order for them to attain and/or maintain their highest practicable level of physical, mental, and psychosocial well-being. The care plan contains resident's goals, strengths, preferences, identified problems, measurable realistic goals, and the interventions to be utilized to reach the goals. Information is utilized from the MDS, clinical records, and any other assessments that are performed to develop and update the care plan and the Interdisciplinary Team (IDT), develops, review, and revises the plan of care to insure it is person- centered and individualized to meet the needs of the resident.

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	11/21/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 1 of 2 sampled residents (Resident #54) reviewed for tube feeding, the facility failed to clarify a duplicate physician's order for the administration of a tube feeding. The findings include:Resident #54 ?s diagnoses included dysphagia, aphasia, hemiplegia and hemiparesis and stroke.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #54 was cognitively impaired and was dependent on oral care, personal hygiene and chair to bed transfers. The Resident Care Plan dated 11/5/25 identified Resident #54 required tube feeding related to dysphagia, stroke, and traumatic brain injury. Interventions included tube feedings and flushes as orderedA physician's order dated 9/22/25 directed to administer Jevity 1.5 at 85 cubic centimeters (cc) per hour. Turn off the tube feeding at 4:00 AM to rest the gut for 6 hours, once daily.An additional physician order dated 10/10/25 directed to administer Jevity 1.5 at 85 cc per hour twice daily. Turn off the tube feeding at 1:00 AM for 6 hours to rest the gut and turn back on at 7:00 AM.Review of the Medication Administration Record (MAR) indicated that both orders were being signed off as completed for the month of November. Observation on 11/20/25 at 4:00 AM of Residents #54 identified his/her tube feeding had been turned off per the physician orders.Interview with Licensed Practical Nurse (LPN) #5 on 11/20/25 at 10:39 AM indicated that she has been following the most recent order (10/10/25) as well as being in communication with the 11:00 PM to 7:00 AM shift nurse (LPN #4) as to the correct time to stop Resident #54's tube feeding to ensure the appropriate gut rest time. Interview with LPN #4 on 11/20/25 at 10:57 AM identified that she has been following the most recent order dated 10/10/25 directing a 1:00 AM stop time. LPN #4 indicated that she had previously reported the issue of conflicting orders but was unable to recall to whom this was reported and was unable to give a rational for signing both orders on the MAR. Interview with Registered Nurse (RN) #5 on 11/20/25 at 11:53 AM indicated that there should have only been one order and that the order from 9/22/25 should have been discontinued when the new order was written. RN #5 believed that Resident #54's duplicative order might have been an oversight.Interview with the Assistant Director of Nursing Services on 11/20/25 at 11:53 AM indicated that, if there were concerns related to physician orders, the expectation was to bring it to the attention of the RN Supervisor immediately. Additionally, staff should not have signed off that they had followed a physician's order that was not in use. The ADNS reported that concerns related to duplicate orders were brought to her attention today.Subsequent to surveyor inquiry the physician order dated 9/22/25 was discontinued.Facilities Physician order revised 8/21/24 policy indicates in part that Physician orders will be transcribed by licensed nurse and followed through in a manner consistent with quality standard of care practices, call the attending physician to confirm orders

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	11/21/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, and facility policy for 2 of 2 sampled residents (Resident #140 and Resident #141) reviewed for Infection Control practices and who were receiving intravenous antibiotics, the facility failed to obtain physician's orders for a central line (catheter residing in a large vein with the tip ending near the heart) intravenous flushing, for external catheter length measurement, and for Resident #140 measurement of arm circumference. The findings include:1. Resident #140's diagnoses included streptococcal (bacteria) infection, osteomyelitis (bone infection) of both feet and ankles, and Type 2 Diabetes.The admission Minimum Data Set assessment (MDS) dated [DATE] identified Resident #140 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition independence with eating, toileting and personal hygiene and was receiving intravenous medications.The Resident Care Plan dated 11/12/25 identified Resident #140 was currently on IV antibiotics via a peripherally inserted central catheter. Interventions included administering antibiotics per the physician order and performing dressing changes per the facility policy.A physician's order dated 11/13/25 directed to administer Vancomycin (antibiotic) 2000 milligrams (mg) 3 times a day for osteomyelitis.A physician's order dated 11/13/25 directed to use Heparin 5 milliliters (ml) after a normal saline flush post medication administration. (Without the benefit of a normal saline flush prior to medication administration).A physician's order dated 11/13/25 directed to change the central line catheter dressing and securement device every 7 days.A review of Resident #140's physician's orders failed to identify a physician's order instructing to measure Resident #140's arm circumference (to assess for potential swelling or clots), or external catheter length (to ensure the internal tip of the catheter has not become displaced), and failed to direct a normal saline flush prior to antibiotic administration.2. Resident #141's diagnoses included gangrene, non-pressure chronic ulcer of the foot and Type 2 Diabetes.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #141 had a Brief Interview of Mental Status (BIMS) score of 00 indicating severe cognitive impairment, was independent with eating and personal hygiene, but required partial/moderate assistance with toileting. The Resident Care Plan dated 11/11/25 identified Resident #141 had an infection to his/her bilateral feet and gangrene on part of the left foot. Interventions included administering antibiotics per the physician orders and following the facility policy and procedures for reporting infections. A physician's order dated 11/5/25 directed to change the central line catheter dressing, securement device, and measure the arm circumference every 7 days.A physician's order dated 11/6/25 directed to administer Cefepime (antibiotic) 2 grams (gm) every 48 hours and Daptomycin (antibiotic) 350mg every 48 hours for osteomyelitis. A review of the physician's orders failed to identify a physician's order instructing to measure Resident #141's external catheter length (to ensure the internal tip of the catheter has not become displaced), failed to identify a physician's order directing to flush the IV line with normal saline prior to medication administration, and failed to identify a physician's order to flush the central line with normal saline then heparin after medication administration.Interview and record review with Infection Prevention Registered Nurse (RN) #4 on 11/19/25 at 10:34 AM identified it was the facility policy to have orders to flush central lines which included normal saline before the IV medication was administered, followed by normal saline after the IV medication was administered followed by a heparin flush. Additionally, RN #4 identified it was the facility policy that any residents receiving intravenous therapy through a central line have orders for weekly measurements for both the arm circumference and external catheter length. A review of Resident #140's physicians orders with RN #4 identified that he/she was receiving intermittent IV antibiotic therapy, had orders to flush the IV after medication administration, but there were no orders to flush the IV line with normal saline prior to medication administration, to measure arm circumference, or to measure the external length of the catheter. A review of Resident #141's physician's orders with RN #4 identified he/she was receiving IV antibiotic (continued on next page)

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	11/21/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy but failed to identify orders for flushing the central line any time before or after medication administration and failed to identify any physician order to measure the external catheter length. RN #4 indicated that the missing orders should have been in place for both Resident #140 and Resident #141, was unable to indicate why the information was missing, and that he would be completing an audit of all the intravenous lines in use for compliance to the facility policy.Subsequent to surveyor inquiry RN #4 initiated orders for both Resident #140 and Resident #141 that included flushing of the central catheter before and after medication administration and for measuring arm circumference and external length of the catheter.The Intermittent Infusion Administration Policy revised 12/24 directed, in part, that venous access devices are to be flushed as ordered per Appendix B. Appendix B directed in part that intermittent medication through a central line should be flushed with 10 milliliters (ml) of normal saline prior to medication administration, then 10 ml of normal saline followed by 5 ml of heparin. Additionally, site maintenance was to include a transparent dressing change upon admission or 24 hours post insertion, then weekly and as needed, measure arm circumference and exterior catheter length with each dressing change and as needed.

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	11/21/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy for the only sampled Resident (#1) reviewed for specialized treatment, the facility failed to ensure physician's orders were obtained for the functioning and care of an Arteriovenous Fistula (AVF) (used for specialized treatment access). The findings include:Resident #1's diagnosis included cerebral infarction, diabetes, and end stage renal disease.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment, was independent with bed mobility, transfers, and wheelchair mobility, and was receiving specialized treatments. The Resident Care Plan (RCP) meeting notes and RCP dated 8/29/25 indicated Resident #1 had a left upper chest catheter and was receiving specialized treatments through the catheter twice weekly. Additionally, Resident #1 had an AVF placed to the right arm on 2/14/25 which was still healing, not yet used for specialized treatments, and required monitoring for a bruit (sound heard with a stethoscope) and thrill (vibration felt at the access site) for integrity (good blood flow).Review of physician orders dated 10/18/25 directed vital signs (pulse, respiratory rate, and blood pressure) monthly between the first and tenth of every month but failed to include avoiding the right arm.An interview and clinical record review with the regional nurse Registered Nurse (RN) #1 and the Director of Nursing Services (DNS) on 11/20/25 at 10:26 AM indicated Resident #1 had a left chest catheter being used for his/her specialized treatments and had a new AVF placed to the right arm. RN #1 indicated the physician orders should have included the location of the site, monitoring for bruit and thrill, and that Resident #1 was not to have any blood pressures taken from the right arm according to the facility policy.The specialized treatment policy dated 8/20/25 directed the facility to evaluate the access site every shift. The policy labeled Specialized Treatment-Care of the access site dated 5/5/25 indicated a fistula should be observed for signs and symptoms of infection, and a healthy fistula will have a bruit heard (with a stethoscope) over the venous side and a thrill can be palpated over the arterialized side as blood flows through the vein anything that reduces blood flow through the shunt increases the chance of a thrombosis (blood clot). The absence of a bruit and/or thrill needs to be reported.

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	11/21/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for 1 of 2 residents reviewed for pressure ulcers (Resident #10) and 2 of 6 residents (Resident #90 and Resident #140) reviewed for infection control, the facility failed to ensure appropriate Personal Protective Equipment (PPE) use during high contact care for residents who required Enhanced Barrier Precautions (EBP), additionally, for Resident #10, the facility failed to perform appropriate hand hygiene and glove changes during wound care. The findings include: Review of the Enhanced Barrier Precaution Policy identified that an orange dot would be placed next to the name outside of the door for residents requiring EBP. 1. Resident #10's diagnoses included a stage 3 pressure ulcer, fracture of the left femur, and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #10 had a Brief Interview of Mental Status (BIMS) score of 7 indicating severely impaired cognition, required moderate assistance with rolling left and right and chair/bed-to-chair transfers, and had developed a Stage 2 pressure ulcer while at the facility. The Resident Care Plan (RCP) in effect from 6/30/25 through11/19/25 identified Resident #10 had a pressure ulcer on his/her left heel. Interventions included administering treatments as ordered and monitoring for effectiveness. The Resident Care Card (used to direct Nurse Aid (NA) care) dated 11/19/2025 failed to indicate Resident #10 was on EBP. Observation and Interview on 11/19/25 at 9:31 AM with Licensed Practical Nurse (LPN) #5 identified an orange dot posted next to Resident #10's name on the door tag outside the door. Information on a rolling cart, located in the hallway, directed providers and staff to wear gloves and a gown for high contact activities for residents who required EBP. During observation of LPN #5 providing wound care to Resident #10 it was noted that she had failed to place a gown prior to providing the treatment. Further, LPN #5 failed to change gloves after removing Resident #10's old dressing (dirty) and prior to placing a clean bandage. LPN #5 stated she had a bad habit of not changing her gloves during Resident #10's wound care but knew her glove should have been changed. Interview on 11/19/25 at 9:55 AM with the Assistant Director of Nursing (ADNS) identified it was both her expectation and facility policy for nurses to change their gloves when moving from a dirty area, during wound care, to a clean area. The ADNS further indicated that LPN #5 should have changed her gloves after removing Resident #10's dirty bandage and before placing a clean bandage on him/her. Interview on 11/19/2025 at 10:01 AM with the Director of Nursing Services (DNS) identified that hand hygiene and glove changes should be performed when taking down a dirty bandage and before placing a clean bandage. The DNS stated that LPN #5 had received education on wound care and hand hygiene processes and should have changed her gloves during Resident #10's wound care. Interview on 11/19/2025 at 11:24 AM with Registered Nurse (RN) #4 (Infection Preventionist) identified that the facility used EBP for all residents with a portal of entry (opening allowing infection to enter the body) including feeding tubes, catheters, chronic wounds, diabetic foot ulcers, and for a multi drug resistant organism (MDRO) infection. He indicated chronic wounds include pressure ulcers, (continued on next page)

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	11/21/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds that require a dressing, and any wound that is present for greater than 30 days. Further, an orange dot was placed on the name on the door tag outside the door to indicate which residents required EBP (gloves and gown). A second interview with LPN #5 on 11/19/2025 2:20 PM identified she was aware that PPE should be worn prior to providing care to a resident in a room that was identified to require the use of EBP but stated she did not have to wear a gown when providing care to Resident #10 because he did not have a foley catheter or any other tubes. NA #5 failed to identify Resident #10 was on EBP due to the presence of his/her pressure ulcer requiring treatments. 2. Resident #90's diagnoses included diabetic foot ulcer, congestive heart failure, and type 2 diabetes. The Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #90 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, was dependent with rolling left and right and chair/bed-to-chair transfers and had a diabetic foot ulcer. The Resident Care Plan (RCP) in effect from 11/3/25 through 11/20/25 identified Resident #10 had a diabetic foot ulcer on his/her left heel. Interventions included treatments as ordered and to identify potential causative factors and eliminate/resolve when possible. The Resident Care Card dated 11/20/2025 failed to indicate Resident #90 was on EBP. Observation and Interview on 11/20/2025 at 6:23 AM with Physician #2 identified an orange dot on Resident #90's name on the door tag outside the door indicating EBP precautions. Information on a rolling cart, located in the hallway, directed providers and staff to wear gloves and a gown for high contact activities for residents who required EBP. Physician #2 entered Resident #90's room without a gown and failed to follow EBP precautions when she performed direct care by removing a dirty dressing and measuring his/her wound without wearing appropriate PPE. Physician #2 indicated that she was aware Resident #90 was on EBP, she did not wear a gown when removing his/her dirty dressing or while assessing his/her wound, but she should have. Review of the facility's Dressing Change: Dry Clean Policy identified in part, that after a soiled dressing is removed and disposed, gloves should be removed and disposed, hands should be washed, and clean gloves should be put on. 3. Resident #140's diagnoses included streptococcal (bacteria) infection, osteomyelitis (bone infection) of both feet and ankles, and Type 2 Diabetes. The admission Minimum Data Set assessment (MDS) dated [DATE] identified Resident #140 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition and was independent with eating, toileting and personal hygiene. Additionally, the MDS identified Resident #140 was receiving intravenous medications. The Resident Care Plan dated 11/12/25 identified Resident #140 was on Enhanced Barrier Precautions (EBP) in addition to the facility's standard precautions because of a higher risk for infection. Interventions included an orange sticker next to the name tag identifying EBP and ensuring appropriate PPE was readily available/accessible. (continued on next page)

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	11/21/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 11/19/25 at 1:57 PM identified Licensed Practical Nurse (LPN) #3 entered Resident #140's room to administer an Intravenous (IV) medication through a central IV catheter (catheter placed in a vein ending near the heart). Although LPN #3 was aware Resident #140 required EBP, as evidenced by the orange dot next to his/her name, she failed to place a gown prior to entry. Additionally, LPN #3 indicated that PPE was required for EPB during high contact activities but was unable to identify if the EBP pertained to central catheters, or if PPE should be applied prior to administering IV medication via a central catheter. Interview with the Infection Prevention Registered Nurse (RN) #4 identified the facility policy on EBP was to place PPE (gloves and gown) prior to performing high contact activities such as wound care, personal care or device care. Further, PPE should be worn per the EBP policy when administering IV medications, and LPN #3 should have worn a gown and gloves when administering Resident #140s IV medication. Review of the facility's Enhanced Barrier Precautions policy effective 3/28/24 directed, in part, that activities requiring a gown and glove use for EBP include care of chronic wounds: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. A resident that has been identified as requiring EBP will receive a color-coded sticker next to their name tag outside their room, indicating to staff that the resident is on EBP. Actual EBP signage will be placed on or around strategically placed PPE carts as a reminder to staff the type of PPE that is required and during which activities. The resident's care card will also be updated to notify staff that a resident is on EBP.