STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Manchester, CT 06040

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 review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for medication administration, the facility failed to notify the Advanced Practice Registered Nurse (APRN) timely of medication omissions. The findings include Please cross reference F 684. Resident #2's diagnoses included cellulitis (bacterial skin infection) and spondylosis of the lumbar region (degeneration of the bones and disks in the lower spine). The Resident admission Profile dated 8/16/24 identified that Resident #2 was alert and oriented to person, place and time and was independent with eating and required assistance with transfers and mobility. Review of Resident #2's Face sheet identified that the resident was admitted to the facility on [DATE] at 6:30 PM. Review of Resident #2's admission orders dated 8/16/24 directed that the resident was to be administered: 1) Tylenol (pain reliever) 500 milligrams (mg), 2 tablets (1000 mg) by mouth three times daily at 6:00 AM, 2:00 PM and 10:00 PM. 2) Lipitor (used to lower blood cholesterol and fat) 10 milligrams (mg), 1 tablet daily in the evening at 5:00 PM. 3) Clonazepam (used to treat anxiety, prevent seizures and promote relaxation) 1 milligram (mg) tablet by mouth four times daily at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM. 4) Zanaflex (muscle relaxer) 2 milligram (mg) tablet by mouth every eight (8) hours around the clock at 6:00 AM, 2:00 PM and 10:00 PM. 5) Albuterol (relaxes and opens air passages to the lungs to make breathing easier) 108 micrograms (mcg) inhaler, inhale 1 puff every eight (8) hours around the clock at 6:00 AM, 2:00 PM and 10:00 PM. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Manchester, CT 06040

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	6) Keflex (antibiotic) 500 milligram (mg) capsule by mouth four times daily at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM. 7) Robaxin (muscle relaxer) 750 milligrams (mg) 1 tablet by mouth three times daily at 9:00 AM, 1:00 PM and 5:00 PM. 8) Lyrica (used to treat nerve and muscle pain and seizures) 75 milligram (mg) capsule by mouth twice daily at 9:00 AM and 5:00 PM. 9) Lyrica 150 milligram (mg) capsule, administer 2 capsules (300 mg) by mouth at bedtime (9:00 PM). 10) Metformin (used to treat high blood sugar levels) 500 milligrams (mg) tablet by mouth twice daily at 8:00 AM and 8:00 PM. 11) Remeron (used to treat depression) 15 milligram (mg) tablet by mouth at bedtime (9:00 PM). 12) Flonase (used to relieve allergic and non-allergic nasal symptoms) 50 microgram(mcg) nasal spray, administer 2 sprays each nostril every morning at 8:00 AM. 13) Breo Ellipta (used to treat asthma and chronic obstructive pulmonary disease) 100/25 micrograms (mcg) inhaler, inhale 1 puff daily at 9:00 AM. 14) Cozaar (used to treat high blood pressure) 25 mg tablet by mouth daily at 9:00 AM. Resident Grievance Report dated 8/19/24 identified, in part, that Resident #2 reported that his/her medications were not in from the pharmacy in a timely manner. The report identified that nursing responded (no staff name identified) stating the Medication Administration Record (MAR) was inspected and the resident received all medications on 8/17/24 and upon arrival on 8/16/24 at 6:30 PM, his/her medications were faxed to the pharmacy and arrived at 3:00 AM on 8/17/24. The report identified that the resident received pain medication and diabetic medication on admission. No supporting documentation was attached to the Grievance Report. Review of the Medication Administration Record (MAR) for August 2024 identified that Resident #2's Tylenol 1000 mg tablets were not administered on 8/16/24 at 10:00 PM or on 8/17/24 at 6:00 AM, Clonazepam 1 mg tablet was not administered on 8/16/24 at 9:00 PM or on 8/17/24 at 9:00 AM or 1:00 PM, Zanaflex 2 mg tablet was not administered on 8/16/24 at 10:00 PM, Albuterol 108 mcg inhaler was not administered on 8/16/24 at 10:00 PM, Keflex 500 mg capsule was not administered on 8/16/24 at 9:00 PM, , Lyrica 75 mg capsule was not administered on 8/17/24 at 9:00 AM, Lyrica 300 mg capsules were not administered on 8/16/24 at 9:00 PM, Metformin 500 mg tablet was not administered on 8/16/24 at 8:00 PM, Remeron 15 mg tablet was not administered on 8/16/24 at 9:00 PM, Flonase 50 mcg nasal spray was not administered on 8/17/24 at 8:00 AM, Breo Ellipta 100/25 mcg inhaler was not administered on 8/17/24 at 9:00 AM and the Cozaar 25 mg tablet was not administered on 8/17/24, 8/18/24 or 8/19/24 at 9:00 AM. Review of the hospital discharge paperwork dated 8/16/24 identified that all the above medications were to be taken upon transfer to the facility and that Resident #2 was last administered medications at 1:33 PM in the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Manchester, CT 06040

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	Review of the nurse's notes dated 8/16/24, 8/17/24, 8/18/24 and 8/19/24 failed to identify that the above medications were unavailable, and that the provider was notified of the missed doses of medications. Interview with LPN #2 (Resident #2's charge nurse for 3:00 PM to 11:00 PM on 8/16/24) on 3/3/25 at 9:18 AM identified that in August 2024, she was new to the facility and stated she could not recall Resident #2. She reported that for new admissions, the Nursing Supervisor will obtain the physician's orders and then gather the medications available within the facility and give them to the charge nurse responsible for the new admission to administer. She identified that if any medications are unavailable, the Nursing Supervisor contacts the provider to notify them, reporting that she (LPN #2) will then sign off the medications that she administers in the MAR. Interview with RN #1 (3:00 PM to 11:00 PM Nursing Supervisor on 8/19/24) on 2/28/25 at 1:57 PM identified that after she finishes an admission and faxes the physician's orders, she will attempt to gather the resident's medications that are available within the facility and the Omnicell. She reported that if the medications are unavailable, she will communicate to the resident that they are awaiting the pharmacy delivery and that medications usually arrive on the overnight run, and they will administer the medication(s) when available. RN #1 identified that the Tylenol and the Clonazepam should have been available but was unsure if she had attempted to obtain the Clonazepam from the Omnicell. She reported that if the medications are more than one hour past their administration time, she should have contacted the APRN or the Medical Director to get a new order or an order to administer the medication once it was available but stated she was unsure if she had done that, stating she should have documented the notification in the clinical record if she had. Interview with APRN #1 on 2/28/25 at 2:05 PM identified that if medications are ever not available for a resident, nursing should be contacting the facility provider or on-call provider to report that the medication(s) is/are unavailable. She reported that although she was unsure if she had been contacted regarding Resident #2, she stated that if she was, she would have adjusted or given new orders for alternative medications or given an order to administer the medication when it arrived from the pharmacy. Additionally, she identified that with all the medications that were omitted for Resident #2, she did not attribute any of them as significant medication errors and was unaware of any change in condition that occurred due to the medication omissions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Manchester, CT 06040

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	Interview and review of the August 2024 MAR for Resident #2 with the DNS on 2/28/25 at 1:39 PM identified that the facility utilizes an Omnicell (an automatic medication dispensing system) for overflow prescription and emergency medications, stating that the Nursing Supervisors are responsible for notifying the provider of any medications that are not available as either house stock or in the Omnicell on admission, as nursing has one hour after the administration is due to administer the medication before the provider must be notified. She reported that in August of 2024, the 3:00 PM to 11:00 PM Nursing Supervisors would have faxed the admission physician's orders to the pharmacy and if the medications were unavailable within the facility, their night delivery would usually arrive between 10:00 PM and 1:00 AM from the pharmacy. The DNS identified that although the resident should have received his/her medications on admission, if nursing didn't sign off on the Medication Administration Record (MAR) that the medications were given and there were no nursing notes indicating that the provider was notified of the missed doses, she would have classified that as a medication error, stating she was unaware that the Resident did not receive his/her medications and had medication omissions on the MAR. Additionally, she stated she was unsure why the 8/19/24 Grievance Report identified that Resident #2 received all of their medications on 8/17/24 and did not validate that he/she was not administered all of his/her medications on 8/16/24, when according to the documentation he/she did not. She identified that she was unable to pull reports from the Omnicell back to August 2024 but stated she would contact the pharmacy to see if any of Resident #2's medications were pulled from the Omnicell on 8/16/24 or 8/17/24. .Documentation provided by the DNS on 3/3/25 at 10:20 AM via email failed to identify that any of Resident #2's omitted medications were pulled/obtained through the Omnicell by staff on 8/16/24 or 8/17/24. Although requested, facility policies for Medication Errors and Provider Notification was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Manchester, CT 06040

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 review of the clinical record, facility policy, and interviews for the one (1) of three (3) residents (Resident #1) reviewed for diabetes management, the facility failed to revise the care plan to include the resident's diagnosis and concerns related to his/her diabetic plan of care. The findings include: Resident #1's diagnoses included Congestive Heart Failure (CHF) and Chronic Kidney Disease (CKD). The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and required moderate assistance with showering/bathing self, bed mobility and transfers. Review of Resident #1's hospital Discharge summary dated [DATE] identified that Resident #1 had a diagnosis of diabetes mellitus, type II and was discharged to the facility on insulin glargine (lantus) 100 units per milliliter (mL) directing to inject 12 units under the skin at bedtime. A physician's order dated 1/25/25 directed to continue Lantus 12 units daily at bedtime and implement blood glucose monitoring before meals and notify provider if blood glucose is <70 or >400. Advanced Practice Registered Nurse (APRN) note dated 1/27/25 at 8:00 AM identified that Resident #1 was on 36 units of Lantus at home, but it was decreased due to some hypoglycemia (low blood sugar) in the hospital. He/she has a monitor in place for the blood sugar. He/she does not use short acting insulin at home. A Resident Care Conference note dated 2/7/25 at 1:15 PM identified that diabetic education as well as teaching was discussed. Interview with the DNS on 2/28/25 at 2:30 PM identified that per the policy, a Comprehensive Care Plan for Resident #1 should have been developed by the Interdisciplinary Team (IDT) within seven (7) days of the completion of the MDS dated [DATE]. She identified that although a Resident Care Conference for Resident #1 was held on 2/7/25 and diabetic teaching and education was discussed, she was unsure why a Care Plan was not developed for the resident's diabetic care. Review of the Care Plan policy dated 4/17/24 directed, in part, that within seven (7) days of completing the MDS, the Interdisciplinary Team (IDT) develops, reviews and revises the plan of care to ensure 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
	075314	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Manchester, CT 06040

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for medication administration, the facility failed to ensure that a newly admitted resident was provided with medications in accordance with hospital discharge summary directions and physician's orders. The findings includePlease cross reference F 580Resident #2's diagnoses included cellulitis (bacterial skin infection) and spondylosis of the lumbar region (degeneration of the bones and disks in the lower spine).The Resident admission Profile dated 8/16/24 identified that Resident #2 was alert and oriented to person, place and time and was independent with eating and required assistance with transfers and mobility.Further Review of the Resident admission Profile identified that RN #1 completed Resident #2's admission assessment on 8/16/24 at 6:16 PM.Review of Resident #2's admission orders dated 8/16/24 directed that the resident was to be administered:1) Tylenol (pain reliever) 500 milligrams (mg), 2 tablets (1000 mg) by mouth three times daily at 6:00 AM, 2:00 PM and 10:00 PM.2) Lipitor (used to lower blood cholesterol and fat) 10 milligrams (mg), 1 tablet daily in the evening at 5:00 PM.3) Clonazepam (used to treat anxiety, prevent seizures and promote relaxation) 1 milligram (mg) tablet by mouth four times daily at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM.4) Robaxin (muscle relaxer) 750 milligrams (mg) 1 tablet by mouth three times daily at 9:00 AM, 1:00 PM and 5:00 PM.5) Lyrica (used to treat nerve and muscle pain and seizures) 75 milligram (mg) capsule by mouth twice daily at 9:00 AM and 5:00 PM.6) Lyrica 150 milligram (mg) capsule, administer 2 capsules (300 mg) by mouth at bedtime (9:00 PM).7) Flonase (used to relieve allergic and non-allergic nasal symptoms) 50 microgram(mcg) nasal spray, administer 2 sprays each nostril every morning at 8:00 AM.9) Breo Ellipta (used to treat asthma and chronic obstructive pulmonary disease) 100/25 micrograms (mcg) inhaler, inhale 1 puff daily at 9:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Manchester, CT 06040

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10) Cozaar (used to treat high blood pressure) 25 mg tablet by mouth daily at 9:00 AM.A Resident Grievance Report dated 8/19/24 identified, in part identified that Resident #2 reported that his/her medications were not in from the pharmacy in a timely manner. The report identified that nursing responded (no staff name identified) stating the Medication Administration Record (MAR) was inspected and the resident received all medications on 8/17/24 and upon arrival on 8/16/24 at 6:30 PM, his/her medications were faxed to the pharmacy and arrived at 3:00 AM on 8/17/24. The report identified that the resident received pain medication and diabetic medication on admission. No supporting documentation was attached to the Grievance Report. Review of the Medication Administration Record (MAR) for August 2024 identified that Resident #2's Tylenol 1000 mg tablets were not administered on 8/16/24 at 10:00 PM or on 8/17/24 at 6:00 AM (which was available as a house stock medication), Clonazepam 1 mg tablet was not administered on 8/16/24 at 9:00 PM (which was stocked in the Omnicell and available) or on 8/17/24 at 9:00 AM or 1:00 PM, Lyrica 75 mg capsule was not administered on 8/17/24 at 9:00 AM, Flonase 50 mcg nasal spray was not administered on 8/17/24 at 8:00 AM, Breo Ellipta 100/25 mcg inhaler was not administered on 8/17/24 at 9:00 AM and the Cozaar 25 mg tablet was not administered on 8/17/24, 8/18/24 or 8/19/24 at 9:00 AM.Review of the hospital discharge paperwork dated 8/16/24 identified that all the above medications were to be taken upon transfer to the facility and that Resident #2 was last administered medications at 1:33 PM at the hospital.Review of the nurse's notes dated 8/16/24, 8/17/24, 8/18/24 and 8/19/24 failed to identify that the above medications were unavailable, and that the provider was notified of the missed doses of medications.Interview with LPN #2 on 3/3/25 at 9:18 AM (nurse who was working on 8/16/24 when the resident was admitted) identified that in August 2024, she was new to the facility and stated she could not recall Resident #2. She reported that for new admissions, the Nursing Supervisor will obtain the physician's orders and then gather the medications available within the facility and give them to the charge nurse responsible for the new admission to administer. She identified that if any medications are unavailable, the Nursing Supervisor contacts the provider to notify them, reporting that she (LPN #2) will then sign off the medications that she administers in the MAR.Interview with RN #1 (the 3:00 PM to 11:00 PM Nursing Supervisor on 8/16/24) on 2/28/25 at 1:57 PM identified that after she finishes an admission and faxes the physician's orders, she will attempt to gather the resident's medications that are available within the facility and the Omnicell. She reported that if the medications are unavailable, she would communicate to the resident that they are awaiting the pharmacy delivery and that medications usually arrive on the overnight run, and they will administer the medication(s) when available. RN #1 identified that the Tylenol and the Clonazepam should have been available on the medication cart and in the omnicell, however, she was unsure if she had attempted to obtain the Clonazepam from the Omnicell. She reported that if the medications are more than one hour past their administration time, she should have contacted the APRN or the Medical Director to get a new order or an order to administer the medication once it was available but stated she was unsure if she had done that, stating she should have documented the notification in the clinical record if she had.Interview with APRN #1 on 2/28/25 at 2:05 PM identified that the medication omissions would not be considered significant medication errors and was unaware of any change in condition that occurred due to the medication omissions.Interview and review of the August 2024 MAR for Resident #2 with the DNS on 2/28/25 at 1:39 PM identified that the facility utilizes an Omnicell (an automatic medication dispensing system) for overflow prescription and emergency medications, stating that the Nursing Supervisors are responsible for notifying the provider of any medications that are not available as either house stock or in the Omnicell on admission, as nursing has one hour after the administration is due to administer the medication before the provider must be notified. She reported that in August of 2024, the 3:00 PM to 11:00 PM Nursing Supervisors would have faxed the admission physician's orders to the pharmacy and if the medications were unavailable within the facility, their night delivery would usually arrive between 10:00 PM and 1:00 AM from the pharmacy. The DNS identified that although the resident should have received his/her medications on admission, if nursing didn't sign off on the Medication Administration Record (MAR) that the medications were given and there were no nursing notes indicating that the provider was notified of the missed doses, she would have classified that as a medication error, stating she was unaware that the Resident did not receive his/her medications and had medication omissions on the MAR. Additionally, she stated she was unsure why the 8/19/24 Grievance Report identified that Resident #2 received all of their medications on 8/17/24 and did not