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	06/20/2025

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 clinical record reviews, facility documentation, facility policies and interviews for one (1) of four (4) sampled residents (Resident #2) who had a witnessed fall with no initial injuries noted, the facility failed to notify the physician after a change in condition was identified. The findings include: Resident #2's diagnoses included malignant neoplasm of the oropharynx, anxiety, and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had poor short- and long-term memory recall. The nurse's note dated 1/9/25 at 3:08 PM identified Resident #2 had a witnessed fall at 2:45 PM in the hallway. Resident #2 was ambulating in the hallway, lost his/her balance and fell. Resident #2 complained of right hip and knee pain, there were no bruises or discoloration seen at that time and Resident #2 had positive range of motion (ROM) to all extremities. The note identified the Advanced Practice Registered Nurse (APRN) #1 was updated and directed a stat x-ray order for the right knee and hip along with neurological checks for seventy-two (72) hours. The nurse's note dated 1/9/25 at 10:16 PM identified the x-ray was done. The physician's progress noted dated 1/10/25 at 2:45 PM identified APRN #1 evaluated Resident #2 for follow-up after the fall on 1/9/25 and reviewed the x-ray results. APRN #1 identified Resident #2 continued to report right hip pain at ten (10) out of ten (10), Resident #2 had full ROM in all joints, there was no bruising, upper extremity deformity, normal muscle bulk and tone, edema, joint swelling, or deformity, Resident #2 moved all extremities equally, and had tenderness on exam. The right hip x-ray dated 1/9/25 identified mild osteoarthritis and right knee x-ray identified modest osteoarthritis and no acute fracture was identified on the x-ray. APRN #1 directed to continue the pain medication Resident #2 was currently on for palliative care, monitor pain levels and mobility, and encourage use of the walker and assist with ambulation as needed. APRN #1 directed to monitor for any delayed symptoms or complications from the fall. The 7AM-3PM nurse's note dated 1/11/25 at 3:09 PM identified Resident #2 continued to complain of right hip pain and was unable to fully extend his/her leg, Morphine was given with good effect and the Nursing Supervisor was made aware. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 1/12/25 at 4:15 PM identified Resident #2 complained of right hip pain at 10 out of 10 not relieved by pain management. The physician on call was notified and the physician directed to increase the Morphine dose for two (2) days and have APRN #1 follow-up the next day. The physician's progress note dated 1/12/25 at 4:40 PM from the on-call physician identified Resident #2 continued to complain of right hip and knee pain and given the limitation of ambulation at baseline, questionable to repeat or escalate the imaging to a CT or MRI. Plan to increase analgesia coverage and have primary team reassesses. Review of the clinical record from 1/11/25 through 1/13/25 failed to reflect documentation the provider was notified when Resident #2 was unable to fully extend his/her leg. The physician's progress note dated 1/13/25 at 4:45 PM identified APRN #1 evaluated Resident #2 for increased right hip pain with swelling. Previously on 1/10/25 Resident #2 had pain 10 out of 10 and full ROM. The note indicated Resident #2 was now identified with swelling and tenderness to the proximal right femur, decreased ROM in the right leg, unable to lift the right leg or bear weight on leg, and due to worsening symptoms APRN #1 directed to send Resident #2 to the Emergency Department (ED) for further evaluation and treatment. The nurse's note dated 1/17/25 at 7:33 PM identified Resident #2 returned to the facility after being diagnosed with a right hip proximal femoral fracture. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1, on 6/20/25 at 11:45 AM identified on 1/11/25 Resident #2 complained of pain and was unable to extend his/her right leg and after administering Morphine, Resident #2 was more comfortable but was still unable to extend his/her leg. LPN #1 identified that she notified the Nursing Supervisor but could not recall the response. Interview with the Assistant Director of Nursing (ADON) on 6/20/25 at 11:55 AM identified she was called to the unit on 1/9/25 when Resident #2 fell. The ADON indicated although Resident #2 complained of right hip pain but had no noted abnormalities and she along with the nurse aide and charge nurse assisted Resident #2 up and walk back to his/her room with no difficulty. Interview with APRN #1 on 6/20/25 at 12:40 PM identified she evaluated Resident #2 on 1/10/25 and although Resident #2 had a high pain level which was not uncommon for Resident #2 to have due to her chronic co-morbidities. APRN #1 indicated although Resident #2's x-rays were negative, Resident #2 should be monitored and staff needed to notify her if there was any change in status or symptoms so that further testing could be ordered. APRN #1 identified the staff should have notified her on 1/11/25 when Resident #2 was unable to extend his/her leg and if she had been notified, she would have sent Resident #2 out for further evaluation at that time. Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #2, on 6/20/25 at 1:45 PM identified she was the Supervisor working on 1/11/25. RN #2 explained she could not recall being notified Resident #2 was unable to extend his/her leg and if she had been notified, she would have assessed Resident #2, documented the assessment, and called the physician for further direction. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 6/20/25 at 2:12 PM identified if a nurse noted a change in condition, they need to inform the Nursing Supervisor who would assess then update the physician to get direction. The DON indicated that on 1/11/25 when Resident #2 no longer had full range of motion in his/her right leg, that would have been classified as a change in condition. Review of the facility policy Change of Condition identified it was the facility's policy to notify the physician when the residents' condition or status changed. The policy further identified if the resident is evaluated by a charge nurse to have a changed in condition, the charge nurse would notify the RN supervisor on duty who would do a follow-up assessment. The follow-up assessment would be documented and reported to the physician. Although attempted, an interview with the 3-11PM Nursing Supervisor was not obtained.