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	09/02/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, interviews, and review of facility documentation and policies for one of three residents (Resident #1) reviewed for change of condition, the facility failed to ensure the clinical record was complete and accurate to include timely notification of a change in condition. The findings included: Based on review of clinical records, interviews, and review of facility documentation and policies for one of three residents (Resident #1) reviewed for change of condition, the facility failed to ensure the clinical record was complete and accurate to include timely notification of a change in condition. The findings included: Resident #1 had diagnoses that included anxiety disorder, and chronic systolic heart failure. Review of the medical record on 9/2/2025 identified Person #1 was the court appointed Conservator of Person (COP). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) score of zero (0), indicating severe cognitive impairment and was dependent for personal hygiene. Review of the Resident Care Plan dated 7/23/2025 identified a self-care deficit. Interventions directed to provide assistance as indicated, and to discuss with resident/family/power of attorney any concerns. Respiratory Therapist's note dated 7/30/2025 identified Resident #1 was scratching his/her eyes and they were red. Physician order dated 7/30/2025 directed to instill one (1) drop of Artificial Tears Ophthalmic Solution (Artificial Tear Solution) in both eyes every four (4) hours as needed for reddened sclera (white area of the eye) to both eyes. Review of the nursing notes dated 7/30 and 7/31/2025 failed to identify the COP was notified Resident #1's eyes were noted to be red and failed to identify the COP was notified of the new order for Artificial Tear eye drops. Nursing note dated 7/31/2025 at 7:43 PM identified the COP requested Resident #1 be transferred to the hospital for evaluation of his/her eyes. Resident #1 was transferred to the hospital at 8:07 PM. Review of a hospital Discharge summary dated [DATE] identified Resident #1 was seen for eye swelling and was diagnosed with conjunctivitis (infection of the eye). The hospital administered Ofloxacin (an antibiotic used to treat eye infections) eye drops and was discharged with an order for Ofloxacin 0.3% eyedrops, one drop to both eyes four (4) times daily. Nursing note dated 8/1/2025 at 7:16 PM identified Resident #1 returned to the facility with a new order for Ofloxacin 0.3% eyedrops. Record review failed to identify Resident #1's COP was notified of the conjunctivitis diagnosed at the hospital, and failed to identify he/she was notified of the new orders for Ofloxacin eye drops. Interview with APRN #1 on 9/2/2025 at 9:11 AM identified on 7/30/2025 he/she was notified that Resident #1's eyes were red and irritated. APRN #1 stated she gave a new order to administer Artificial Tears, and informed staff that he/she would see Resident #1 on 8/1/2025. Interview with RN #1 on 9/2/25 at 10:40 AM identified Resident #1 was readmitted from the hospital on Ofloxacin eye drops. Further, the interview failed to identify the COP was notified of the diagnosis of conjunctivitis and the new orders for eye drops. Although RN #1 stated the facility practice was to inform the family/resident of new orders, and she may have called the COP to inform him/her, she stated she did not document any call was made. Interview failed to identify why the COP was not notified. Interview with the ADNS on 9/2/25 at 11:02 AM identified the facility should have contacted the COP regarding the new diagnosis and new eye drop orders, and it should have been documented in the resident's chart. Interview failed to identify why the COP was not notified. Interview with the Director of Nursing Services (DNS) on 9/2/2025 at 4:16 PM identified the COP had contacted the facility prior to Resident #1's return from the hospital and informed him/her of Resident #1's conjunctivitis diagnosis and treatment, however the DNS stated she did not write a nursing note to indicate she had notified the COP. The DNS indicated a note should have been written in the resident's medical record. Review of the undated Change of Condition Policy directed in part, the resident and/or responsible party will be notified of a resident change of condition, and document in the nurse's notes regarding changes, physician notification, and resident and/or responsible party notification.