

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/30/2026
NAME OF PROVIDER OR SUPPLIER Touchpoints at Manchester		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for competent nursing staff, the facility failed to ensure licensed nursing staff were competent to perform assigned duties of accurately reconciling and transcribing hospital discharge medication orders, recognizing and responding to electronic medication safety alerts, completing the required secondary review of readmission orders, and ensuring a newly assigned agency Registered Nurse Supervisor (RN #2) was oriented to the responsibilities of the 11:00 PM to 7:00 AM shift, including verification of readmission orders. As a result, Resident #1 received concurrent administration of Apixaban, Clopidogrel, and Aspirin for three (3) days after the hospital had discontinued Clopidogrel and Aspirin, resulting in a gastrointestinal (GI) bleed requiring hospital transfer. Resident #1's diagnoses included atherosclerotic heart disease, peripheral vascular disease and other disorders of the circulatory system. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had intact cognition, had a suprapubic catheter (a tube that goes directly into the bladder to drain urine), was incontinent of bowel and bladder and required substantial assistance with activities of daily living (bathing, transfers, bed mobility, and dressing). The Resident Care Plan dated [DATE] identified anemia related to low hemoglobin and hematocrit. Interventions directed to give medications as ordered and monitor for side effects and effectiveness. Physician's orders dated [DATE] directed to give Clopidogrel 75 milligrams (mg) (a medication to prevent the blood from clotting) once a day and to give Aspirin 81 mg once a day. The Interagency Patient Referral Report from the hospital dated [DATE] directed to discontinue Clopidogrel 75 mg and Aspirin 81 mg and to start Apixaban 5 mg (a medication to prevent the blood from clotting) once a day. The physician's orders dated [DATE] directed to give Apixaban 5 mg every 12 hours. The physician's orders failed to include orders directing to discontinue the Clopidogrel 75 mg and Aspirin 81 mg. Review of the Medication Administration Record (MAR) dated [DATE] identified Resident #1 received Aspirin 81 mg on [DATE], [DATE] and [DATE] for a total of 3 doses after the medication should have been discontinued. The MAR identified Resident #1 received Clopidogrel 75 mg on [DATE] and [DATE] for a total of 2 doses after the medication should have been discontinued. Additionally, the MAR identified Resident #1 received the physician ordered dose of Apixaban 5 mg twice a day on [DATE] and [DATE] for a total of 4 doses. The Order note dated [DATE] at 11:35 PM identified the addition of Apixaban 5 mg triggered the following drug protocol alerts/warnings: drug to drug interaction with Aspirin 81 mg, Aspirin may enhance the anticoagulant effect of direct oral anticoagulants (e.g., Apixaban 5 mg) as well as interaction of Clopidogrel 75 mg antiplatelet (part of the blood that assists in preventing the blood from clotting) inhibitors may enhance the anticoagulant effect of direct oral anticoagulants (e.g., Apixaban 5 mg). Interview with RN #1 on [DATE] at 12:09 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075314 If continuation sheet Page 1 of 6

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified on [DATE] when Resident #1 returned to the facility from the hospital RN #1 reviewed and entered the medication orders into the electronic medical record (EMR). RN #1 identified she was not aware the EMR system alerted there was a potential drug interaction between the Apixaban, Clopidogrel and Aspirin and therefore did not address the potential for the drug interaction. Interview with the Assistant Director of Nursing Services (ADNS) on [DATE] at 12:32 PM identified the facility policy for readmission medication orders directed the licensed staff member should perform medication reconciliation to ensure the medications were entered correctly, and the 11:00 PM to 7:00 AM shift supervisor was responsible for verifying readmission orders were entered correctly. The ADNS identified the policy was not followed on [DATE] by both the readmitting nurse (RN #1) and the 11:00 PM to 7:00 AM shift supervisor (RN #2). Interview and clinical record review with the Director of Nursing Services (DNS) on [DATE] at 1:01 PM identified that when Resident #1 was readmitted on [DATE], the electronic medical record (EMR) generated an Order Note alert identifying potential drug interactions between Apixaban, Clopidogrel, and Aspirin; however, RN #1 did not recognize or address the alert. The DNS identified the readmitting Registered Nurse Supervisor was responsible for reconciling the hospital discharge summary with the resident's current physician orders, ensuring discontinued medications were removed from the active medication profile, verifying new orders were entered accurately, and cross-referencing all readmission orders. The DNS further identified the 11:00 PM to 7:00 AM Registered Nurse Supervisor was responsible for independently performing a secondary verification of all readmission orders to ensure accuracy. The DNS identified RN #2 was working only her second shift at the facility and her first 11:00 PM to 7:00 AM shift on [DATE]. The DNS identified RN #1 was responsible for orienting RN #2 to the responsibilities of the night shift, including completion of the required secondary review of all readmission orders, but there was no formal checklist to ensure all shift-specific responsibilities were reviewed. The DNS confirmed the required secondary verification was not completed, resulting in Resident #1 continuing to receive Clopidogrel and Aspirin after the medications had been discontinued by the hospital. Interview with the medical director (MD) #1 on [DATE] at 10:04 AM identified the medication error was a significant medication error and Resident #1 should not have received the extra doses of Clopidogrel and Aspirin. Interview with RN #1 on [DATE] at 10:38 AM identified on [DATE], she was not aware that it was RN #2's first time working the 11:00 PM to 7:00 AM shift at the facility. RN #1 identified that she was aware of the facility process that directed to orient new agency staff nurses to the facility policies and procedures for third shift. RN #1 identified she attempted to orient RN #2 to the facility policies and procedures, but RN #2 informed RN #1 that she was aware of the policies and procedures so did not pursue further orientation. Although attempted, an interview with RN #2 was unable to be obtained. Review of the facility policy titled admission Nursing Process, last reviewed [DATE], directed, in part, prior to beginning the admission assessment, quickly review the discharge summary and the W-10 (an interagency discharge form) and when a resident is a readmission, upon the resident return, the admission documentation must be redone in its entirety. Review of the facility policy titled Physician Orders-Twenty-four Hour Check, last revised [DATE], directed, in part, a double check of all medical records is to be completed daily by the night supervisor to ensure that all new orders are confirmed/transcribed accurately. The facility policy titled Physician Review of Medical Orders, effective date [DATE], directed, in part, all medical orders for residents of the facility are timely, accurate, clinically appropriate and reviewed by a licensed physician in accordance with all applicable regulations and requirements. The policy further directed, in part, discontinued or expired orders shall be clearly identified and removed from active treatment records. The facility policy titled Physician Orders-Transcription, last revised [DATE], directed, in part, physician orders will be transcribed or (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directly entered into the EMR by a licensed nurse and followed through in a manner consistent with quality standard of care practices. The policy further directed, in part, enter and/or review the orders in the EMR and confirm accuracy.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation/policies, and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for medication administration, the facility failed to ensure Resident #1's hospital discharge medication orders were accurately reconciled, transcribed, and verified upon readmission to the facility on [DATE]. Specifically, the facility failed to discontinue Clopidogrel 75 mg and Aspirin 81 mg as directed by the hospital, failed to recognize and address an electronic medical record alert identifying potential drug interactions between Clopidogrel, Aspirin, and newly ordered Apixaban, and failed to complete the required secondary verification of the readmission medication orders. As a result, Resident #1 received Clopidogrel, Aspirin, and Apixaban concurrently for three (3) days, resulting in a gastrointestinal (GI) bleed requiring transfer to the emergency department. The findings include:Resident #1's diagnoses included atherosclerotic heart disease, peripheral vascular disease and other disorders of the circulatory system.The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had intact cognition, had a suprapubic catheter (a tube that goes directly into the bladder to drain urine), was incontinent of bowel and bladder and required substantial assistance with activities of daily living (bathing, transfers, bed mobility, and dressing).The Resident Care Plan dated [DATE] identified anemia related to low hemoglobin and hematocrit. Interventions directed to give medications as ordered and monitor for side effects and effectiveness.The physician's orders dated [DATE] directed to give Clopidogrel 75 milligrams (mg) (a medication to prevent the blood from clotting) once a day and to give Aspirin 81 mg once a day.The Interagency Patient Referral Report from the hospital dated [DATE] directed to discontinue Clopidogrel 75 mg and Aspirin 81 mg and to start Apixaban 5 mg (a medication to prevent the blood from clotting) twice a day.The physician's orders dated [DATE] directed to give Apixaban 5 mg every 12 hours. The physician's orders failed to include orders directing to discontinue the Clopidogrel 75 mg and Aspirin 81 mg.Review of the Medication Administration Record (MAR) dated [DATE] identified Resident #1 received Aspirin 81 mg on [DATE], [DATE] and [DATE] for a total of 3 doses after the medication should have been discontinued. The MAR identified Resident #1 received Clopidogrel 75 mg on [DATE] & [DATE] for a total of 2 doses after the medication should have been discontinued. Additionally, the MAR identified Resident #1 received the physician ordered dose of Apixaban 5 mg twice a day on [DATE] and [DATE] for a total of 4 doses.The order note dated [DATE] at 11: 35 PM identified the addition of Apixaban 5 mg had triggered the following drug protocol alerts/warnings: drug to drug interaction with Aspirin 81 mg, Aspirin may enhance the anticoagulant effect of direct oral anticoagulants (e.g., Apixaban 5 mg) as well as interaction of Clopidogrel 75 mg antiplatelet (part of the blood that assists in preventing the blood from clotting) inhibitors may enhance the anticoagulant effect of direct oral anticoagulants (e.g., Apixaban 5 mg).The nurse's note dated [DATE] at 12:30 PM identified that Resident #1 vomited dark brown vomitus and there was active rectal bleeding. The note further identified Resident #1 was assessed by the Advanced Practice Registered Nurse (APRN #1) and was found to have small to moderate amount of rectal bleeding, dark brown in color with small clots present and the resident reported feeling sleepier than usual with intermittent nausea and a blood pressure reading of 96/54 (normal blood pressure range is 91-120 for the top number and 61-80 for the lower number). The note further identified due to the concern for GI bleeding Resident #1 was sent to the ED for evaluation.Interview with RN #1 on [DATE] at 12:09 PM identified on [DATE] when Resident #1 returned to the facility from the hospital, she entered the orders from the hospital into the electronic medical record system (EMR). RN #1 identified she sent (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed through in a manner consistent with quality standard of care practices. The policy further directed, in part, enter and/or review the orders in the EMR and confirm accuracy.		