STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075436	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Chestnut	171 Main St East Windsor, CT 06088

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and review of facility documentation for 4 of 5 residents sampled, the facility failed to ensure comfortable and safe temperature levels.On 08/15/2025, observations at approximately 1:00 PM identified 3 resident rooms with a temperature that exceeded 81 degrees Fahrenheit. Room E4 was noted to be 83 degrees, Room E13 was noted to be 82 degrees, and Room S5 was noted to be 82 degrees.On 08/15/2025 at approximately 3:25 PM an interview with Resident # 2 identified complaints of the temperature in the building. Resident # 2 stated it is hot in the building and has been for approximately 2 to 3 weeks.On 08/15/2025 at approximately 3:28 PM an interview was conducted with Resident # 4 and Resident # 5. Both residents indicated it has been hot and has been that way for quite some time.On 08/15/2025 at approximately 3:34 PM an interview was conducted with Resident # 6. Resident # 6 stated his/her room is currently 83 degrees and it's been hot for the past 2 to 3 weeks. Resident #5 indicated he/she did ask the Maintenance Director for a portable air conditioner but has yet to receive one.On 08/15/2025 at approximately 3:45 PM an interview was conducted with the Director of Maintenance. The Director of Maintenance confirmed Resident # 6 did ask for a portable air conditioner a few days ago but they are prioritizing them. The Director of Maintenance indicated the air conditioning and the chiller has been an ongoing issue for some time.On 08/15/2025 The facility Administrator was unable to locate temperature logs from 08/11/2025 - 08/14/2025.A review of the outdoor high temperatures for East Windsor, Connecticut were as follows: August 11, 2025 - 90 degrees, August 12, 2025 - 91 degrees, August 13, 2025 - 88 degrees, August 14, 2025 - 88 degrees, and August 15, 2025 - 86 degrees.

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **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 two (2) residents (Resident #1) reviewed for total care, the facility failed to ensure the resident was provided incontinent care and turned/repositioned every two hours in accordance with the care plan. The findings include:Resident #1 was admitted to the facility with diagnoses that included stroke, hemiplegia (weakness) affecting the left side, dysphagia and epilepsy.The admission/annual/quarterly MDS dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition, had no speech (absence of spoken words), was always incontinent of bowel and bladder and required total dependence of two staff with activities of daily living (ADL's).The care plan dated 5/23/25 identified Resident #1 had a potential impairment of skin integrity, full urinary and bowel incontinence, diabetes, impaired mobility and splints. Interventions included to keep Resident #1's skin clean and dry, provide incontinence care every two hours and as needed and turn and reposition Resident #1 every two hours.The Braden scale assessment dated [DATE] identified Resident #1 was at a very high risk of pressure sores.The skin observation tool dated 7/22/25 identified Resident #1's skin was not intact due to stitches related to baclofen pump on Resident #1's sacrum (bone at the base of the spine that forms that back wall of the pelvis).The physician's order dated 7/30/25 directed to turn every two hours to help back wound to heal. The grievance report dated 7/24/25 identified Resident #1's family member arrived at 7:00 PM on 7/23/25 and Resident #1 was saturated with urine. The investigation identified that NA #1 did not go back into Resident #1's room after her first initial check on Resident #1 at 4:00 PM.The accident and incident form (A & I) dated 7/24/25 identified Resident #1's family member reported on 7/23/25 at 7:00 PM that Resident #1 was saturated with urine and Resident #1's feeding device was not hooked up (ordered to be on at 4:00 PM). Resident #1 had a skin check completed with no new skin impairments.NA #1's A&I statement dated 7/25/25 identified NA #1 started her shift at 3:30 PM and began her rounds. She was in Resident #1's room at 4:00 PM and Resident #1 was reported dry. At 4:45 PM - 5:00 PM NA #1 was passing out dinner trays. At 7:00 PM NA #1 heard Resident #1's family member yelling from Resident #1's room that Resident #1 was incontinent. NA #1 stated she checked Resident #1 at 4:00 PM and Resident #1's family member was upset Resident #1 did not checked again at 6:00 PM.Review of the bladder flowsheet dated 7/23/25 identified Resident #1 was incontinent at 12:21 PM and 10:19 PM. The flowsheet failed to identify documentation of incontinence care between 12:21 PM and 10:19 PM.Interview with RN #1 on 8/28/25 at 12:57 PM identified on 7/23/25 at 7:00 PM Resident #1's family member came to her with concerns that Resident #1 was saturated and did not have the tube feed being administered. She identified she went right to Resident #1 and identified he/she was wet. She identified Resident #1 was a heavy wetter but the NA had started cleaning Resident #1 up so she was not able to identify how saturated he/she was. She identified she assessed Resident #1's peri area and there were no injuries. She further identified incontinent residents should be checked/changed every two (2) hours.Interview with the DNS on 8/18/25 at 1:39 PM identified the facility standard for incontinent residents who do not have the capacity to call for staff for care is to check them for incontinence/provide care every two (2) hours.Multiple attempts were made to interview NA #1 with no success. Review of the continence management policy directed that the urinary evaluation will be completed if the resident is incontinent upon admission, readmission or change in urinary status. It directed to develop a plan of care based on information from the evaluations.

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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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of two (2) residents (Resident #1 and Resident #2) reviewed for skin integrity, the facility failed to ensure the residents had documented weekly skin assessments. The findings include:1. Resident #1 was admitted to the facility with diagnoses that included stroke, hemiplegia (weakness) affecting the left side, dysphagia and epilepsy. The Braden scale assessment dated [DATE] identified Resident #2 was at a very high risk of pressure sores. The weekly skin observation tool dated 2/11/25 identified Resident #1's skin was intact. The care plan dated 5/23/25 identified Resident #1 had a potential impairment of skin integrity, full urinary and bowel incontinence, diabetes, impaired mobility and splints. Interventions included to keep Resident #1's skin clean and dry, weekly skin check per protocol, provide incontinence care every two hours and as needed and turn and reposition Resident #1 every two hours.The quarterly MDS dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of zero (0) indicative of severely impaired cognition, was always incontinent of bowel and bladder, required total dependence of two staff with activities of daily living (ADL's) and did not have any pressure ulcers. The weekly skin observation tool dated 6/27/25 identified Resident #1's skin was intact. Review of the medical record failed to identify any documentation skin observation tool assessments from 2/11/25 - 6/27/25. The Braden scale assessment dated [DATE] identified Resident #1 was at a very high risk of pressure sores. 2. Resident #2 was admitted to the facility with diagnoses that included non-pressure chronic ulcer of the left foot, chronic osteomyelitis and stroke.The admission/annual/quarterly MDS dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, was always continent of bowel and bladder, required supervision of one staff with activities of daily living (ADL's) and did not have any pressure ulcers. The weekly skin observation tool dated 4/27/25 identified Resident #2's skin was intact. The care plan dated 5/15/25 identified Resident #2 had a potential risk for skin breakdown related to fragile skin. Interventions included Braden/Norton Assessment per policy. The Braden scale assessment dated [DATE] identified Resident #2 was at risk of pressure sores. The weekly skin observation tool dated 7/12/25 identified Resident #2's skin was intact. Review of the medical record failed to identify any documentation skin observation tool assessments from 5/23/25 - 7/12/25. Interview and review of the clinical record with the DNS on 8/18/25 at 1:39 PM identified she was unable to provide documentation of skin assessments between the dates of 2/11/25 - 6/27/25 for Resident #1 and unable to provide documentation of skin assessments between the dates of 4/27/25 - 7/12/25 for Resident #2. She identified the expectation is for skin assessments to be completed and documented weekly. Review of the pressure ulcer prevention policy directed that upon admission and weekly thereafter, the nurse will complete a head-to-toe skin check to identify any new or pre-existing skin issues.