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	04/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #6) reviewed for dignity, the facility failed to ensure that the resident was treated with dignity and respect after he/she requested to get out of bed prior to lunch. The findings include: Resident #6 was admitted to the facility on [DATE] with diagnoses that included quadriplegia, contracture of the left hand, and chronic pain syndrome. A physician's order dated 3/31/24 directed to transfer Resident #6 out of bed via a hoyer lift into the wheelchair daily for lunch and dinner. The care plan dated 3/31/24 identified Resident #6 needed assistance with all ADLs and mobility due to diagnosis and injuries following a motor vehicle accident. Interventions included to transfer the resident out of bed to wheelchair daily with assistance of 2 via a hoyer lift. The quarterly MDS dated [DATE] identified Resident #6 had intact cognition, was always incontinent of bowel, required an indwelling catheter for bladder and was fully dependent on staff to assist with eating, bathing, and transfers. Interview with Resident #6 on 4/21/25 at 9:35 AM identified that several months ago there was an incident with NA #1. Resident #6 identified he/she had orders to be out of bed daily by lunch and around 11:00 AM and he/she requested NA #1 for assistance to get out of bed, but NA #1 said she was busy and was unable to assist. Resident #6 identified after several minutes, he/she rang out and asked NA #1 again to get out of bed as it was almost 12:00 PM. Resident #6 identified that NA #1 again identified she had meal trays to deliver and instructed Resident #1 that if he/she wanted to get out of bed, he/she should get out of bed and get him/herself ready. Resident #1 identified he/she immediately reported NA #1 to RN #9 and NA #1 was suspended for several days as a result. Resident #6 identified he did not feel that NA #1 treated him/her with respect or respected his/her disability. Resident #6 identified that since that time, NA #1 has been assigned to provide care to him/her but NA #1 does not speak to the resident. Resident #6 reported he/she was fine with NA #1 still providing care but identified that what NA #1 did was not very disrespectful. Review of the clinical record failed to identify any incidents related to a negative interaction between NA #1 and Resident #6. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of NA #1's personnel file identified an Employee Conduct Corrective Action Record document dated 7/1/24. The document identified an incident that occurred on 6/16/24 during the 7:00 AM to 3:00 PM shift. The document further identified that at approximately 11:45 AM, NA #1 refused to help transfer a resident to his/her wheelchair for lunch as directed by the physician's order. The document identified that when the resident asked NA #1 for transfer assistance she responded in a rude and disrespectful manner and said (get yourself out of bed), even though the resident could not due to a diagnosis. Additionally, the document identified NA #1 was insubordinate to RN #9 (RN Supervisor) who explained to NA #1 that the resident needed to be transferred to a wheelchair per the physician's order for lunch. The document identified instead of assisting the resident to his/her wheelchair as directed, NA #1 provided care to another resident in direct violation of RN #9's instructions. The form further identified NA #1 was suspended from 7/8/24 to 7/10/24 as a result of violating multiple rules including respect and dignity for all people and providing quality care for residents. Further review of NA #1's personnel file identified multiple disciplinary actions and suspensions in 2024 related to issues providing care to facility residents. Interview with NA #1 on 4/23/25 at 3:07 PM identified she partially remembered the incident with Resident #6 on 6/16/24. NA #1 identified that she was assisting with lunch trays and Resident #6 requested to be out of bed for lunch. NA #1 identified that the facility was short staffed on nurse aides on that day and there was not a 2nd nurse aide available to assist her to transfer Resident #6. NA #1 identified that Resident #6 repeatedly asked to be brought out of bed and was rude and disrespectful. NA #1 identified that Resident #6 was rude and used profanities and due to this she did not assist Resident #6 out of bed and because she did not assist the resident she was suspended. NA #1 identified she never told Resident #6 to get out of bed or anything remotely like that. NA #1 identified that following the incident, she has provided care multiple times to Resident #6 and there have been no other issues. Interview with the Regional HR Director on 4/23/25 at 3:33 PM identified she was required to be included for any meetings related to disciplinary actions involving suspension or termination for all facility employees and had been involved with several meetings related to suspensions for NA #1, including the incident involving Resident #6. Interview with the DNS on 4/24/25 identified she was not employed with the facility at the time of the incident with Resident #6 and NA #1 but was aware of multiple issues related to NA #1. The DNS identified that all residents of the facility should be treated with dignity and respect and that she would speak to Resident #6 regarding the incident. Although attempted, an interview with RN #9 was not obtained. The facility policy on resident rights directed that residents' had the right to be treated with consideration, respect, and full recognition of their dignity and individuality.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Deficiency Text Not Available

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #33) reviewed for accidents, the facility failed to ensure the resident and/or resident representative were informed of their rights and of all rules and regulations governing resident conduct and responsibility upon admission to the facility. The findings include: Resident #33 was admitted to the facility on [DATE] with diagnoses that included alcohol dependence, repeated falls, and anxiety disorder. Review of the hospital W-10 dated 10/8/24 identified Resident #33 was hospitalized from [DATE] - 10/8/24 related to alcohol withdrawal. The hospital W-10 identified Resident #33's code status (the level of medical interventions a person wishes to have started if their heart or breathing stops) as full code (directs the medical team to take all possible measures to save the residents' life in the event of a medical emergency). Review of the clinical record failed to identify that admission paperwork was reviewed with the resident representative on admission, including the facility bed hold policy, contraband policy, consent for treatment, advance directive/code status consent, smoking policy, resident [NAME] of Rights, influenza vaccination consent and education form, and facility admission agreement. Review of the clinical record failed to identify documentation of a signed advance directives/code status consent form. A resident care conference note dated 10/15/24 by SW #1 identified Resident #33 had a Do Not Resuscitate (DNR) code status (DNR means the resident does not want any life saving measures in the event of cardiopulmonary arrest). The admission MDS dated [DATE] identified Resident #33 had severely impaired cognition, was frequently incontinent of bowel and bladder and required moderate assistance from staff with toileting, dressing, and transfers. The care plan dated 10/22/24 identified Resident #33 had an established advance directive of full code. Interventions included offering the resident an opportunity to complete advance directives. A physician's order dated 10/23/24 directed full code status for Resident #33. Review of the clinical record identified that Person #1, Resident #33's resident representative, was appointed Resident #33's conservator of person and estate effective 11/21/24. Interview with the Corporate COO on 4/24/25 at 9:01 AM identified that SW #1 was responsible to review all administrative paperwork, and the admitting RN supervisor was responsible to complete all clinical paperwork for all residents upon admission to the facility. Interview with SW #1 on 4/24/25 at 9:30 AM identified that she was responsible to review admission paperwork with newly admitted residents related to bed hold, resident rights, (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the admission agreement, and pay rates for the facility. SW #1 identified that while she reviewed the administrative portion of the admission packet, she did not review any clinical paperwork including advance directives, immunization status, or consent for treatment. SW #1 identified that due to Resident #33's cognition level at the time of admission, she reviewed admission paperwork with Person #1 following Resident #33's admission to the facility. SW #1 identified that the paperwork was stored in a tablet device and signed electronically. SW #1 identified that the facility did not print the paperwork out to place in a resident's paper chart, and did not upload or scan the documents into the electronic record. Subsequent to surveyor inquiry, SW #1 provided a copy of electronically signed admission paperwork including the resident admission agreement and bed hold policy. The paperwork was electronically signed by Person #1 on 11/5/24, approximately 1 month after Resident #33 was admitted to the facility. Interview with SW #1 on 4/24/25 at 11:51 AM identified that she reviewed the paperwork with Person #1 on 11/5/24 as that was the first available opportunity. SW #1 was unable to identify why the admission documents were not reviewed prior to 11/5/24. Subsequent to surveyor inquiry, a signed advance directive/code status consent form which identified Resident #33 requested full code status. The form was dated 4/24/25, 6 months after admission. Interview with the DNS on 4/24/25 at 12:00 PM identified that Resident #33 should have had advance directives reviewed upon admission to the facility and that it was the responsibility of the RN supervisor to ensure this was completed. The facility admission agreement directed that the resident acknowledged admission to the facility as a resident. The admission agreement also provided consent to the facility and all its employees and contractors to assess, diagnoses, and treat the resident during the stay in the facility and the resident agreed to such treatment. The facility policy on the Resident [NAME] of Rights directed that residents of the facility had the right to be fully informed, orally and in writing, of their conduct and responsibilities. The policy also directed that residents of the facility had the right to designate another person to represent the resident and exercise their rights and the facility must treat the decisions of such a designated person as the residents' decisions to the extent required by law. The policy also directed that residents of the facility had the right to be fully informed of services available in the facility including services not covered by Medicare or Medicaid and the charges for such services. The facility policy on the Resident's Right to Refuse Treatment and Formulate Advance Directives directed it was the policy of the facility to inform and provide written information to the resident and or their representative to accept or refuse medical or surgical treatment and, at the residence option, formulate an advance directive. The policy further directed that upon admission to the facility, a resident or their legally recognized representative would be provided with the residents' [NAME] of Rights which included a right to refuse treatment and the right to formulate an advance directive. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Code Status directed that it was the policy of the facility that upon admission to the facility and at all times thereafter the residence code status would be established to identify decisions regarding cardiopulmonary resuscitation. The policy further directed that upon admission to the facility, the resident and any known authorized decision maker would be provided with the code status policy, which contained information on cardiopulmonary resuscitation, do not resuscitate orders, And the advanced directive decision making policy which contained information about advanced directives.

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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 1 of 5 residents (Resident #31) reviewed for unnecessary medications, the facility failed to notify the physician when blood sugars were outside the parameters and called for physician notification, and for 2 of 6 residents (Resident #23 and 33) reviewed for accidents, for Resident #23 the facility failed to notify the physician of the ongoing issue of the resident returning from Leave of Absences (LOA) smelling of marijuana, and for Resident #33 the facility failed to notify the physician and the resident representative when on multiple occasions, the resident was found smoking in the facility, and/or found with smoking paraphernalia, and/or when room searches were conducted. The findings include: 1. Resident #31 was admitted to the facility in September 2024 with diagnoses that included stroke and diabetes. The quarterly MDS dated [DATE] identified Resident #31 identified short term and long-term memory were okay and Resident #31 was independent with cognitive skills for daily decision making. Resident #31 had no hallucinations or delusions. Resident #31 exhibited rejection of care, and it occurred 1-3 days, but no other behaviors. Resident #31 required minimal assistance with personal hygiene and dressing and required touching assistance or supervision for toileting. The care plan dated 2/20/25 identified Resident #31 has diabetes. Interventions included receiving diabetes medication as ordered by the physician and educate Resident #31 regarding medications and importance of compliance. A physician's order dated 3/1/25 directed to provide Insulin teaching every shift and Metformin 1000 mg by mouth twice a day. Empagliflozin tab 10mg give 1 tablet by mouth one time a day. Lantus Insulin solution pen-injector 100 UNIT/ML Inject 44 units subcutaneously in the morning. Lantus Insulin solution pen-injector 100 UNIT/ML inject 50 units subcutaneously at bedtime. Admelog 100 units per milliliter solution pen-injector inject 5 units subcutaneously before meals and hold if finger stick is below 150. Additionally, Admelog 100 units per milliliter solution pen-injector per sliding scale if finger stick was: 0 - 130 = 0 units. 140 - 179 =1 unit. 180 - 219 = 2 units. 220 - 259 = 3 units. 260 - 299 = 4 units. 300 - 339 = 5 units. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Finger sticks 340 or higher give 6 units subcutaneously before meals and if greater than 340 call the physician. Review of MAR dated 3/1/25 to 3/31/25 identified Resident #31 had a fingerstick over 340 as follows: 3/2/25 at 7:30 AM fingerstick was 354. 3/12/25 at 6:00 PM fingerstick was 353. 3/16/25 at 7:30 AM fingerstick was 360. 3/22/25 at 6:00 PM fingerstick was 396. 3/24/25 at 6:00 PM fingerstick was 427. 3/25/25 at 11:00 AM fingerstick was 396. 3/31/25 at 7:30 AM fingerstick was 382. Review of the nurse's notes dated 3/1/25 to 3/31/25 did not reflect the APRN or physician were notified of the fingerstick greater than 340 per the physician order. Review of MAR dated 4/1/25 to 4/15/25 identified Resident #31 had a fingerstick over 340 as follows: 4/11/25 at 11:00 AM fingerstick was 372. 4/13/25 at 7:30 AM fingerstick was 578. Review of the nurse's notes dated 4/1/25 to 4/16/25 did not reflect the APRN or physician were notified of the finger stick greater than 340 per the physician order. The interview with LPN #4 on 4/23/25 at 11:16 AM indicated that she works per diem from 11:00 PM to 7:00 AM and if the day nurse is late, she will do the blood sugars for the day nurse and if a resident needed coverage, she would give the coverage and the scheduled Insulin and sign off on it. LPN #4 indicated that the day nurses that relieve her are usually agency and come late and then must give a through report because they don't know the residents. LPN #4 indicated that she signed off as doing Resident #31's fingerstick on 3/2/25 and 3/16/25 at 7:30 AM but she does not recall calling the APRN or physician regarding the elevated blood sugars, but if she had called, she would have written a progress note. Interview with LPN #2 on 4/23/25 at 11:26 AM indicated that she did work on 3/25/25 and did Resident #31's fingerstick at 11:00 AM and it was 396 and she gave Resident #31 six units of coverage and notified the supervisor but did not notify the APRN or physician. LPN #2 indicated she worked on 4/11/25 and did Resident #31's finger stick at 11:00 AM and it was 372 and she gave 6 units coverage and notified the supervisor, but did not notify the physician. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #5 on 4/23/25 at 12:07 PM indicated that she worked on 3:00 PM to 11:00 PM on 3/12/25 at 6:00 PM Resident #31's finger stick was 353 and she gave 6 units coverage, on 3/22/25 at 6:00 PM the finger stick was 398 and gave 6 units coverage, and 3/24/25 at 6:00 PM the finger stick was 427 and gave 6 units coverage. LPN #5 indicated that she does not recall if she had called the APRN or physician but if she did, she would have documented it in a progress note. The interview with the DNS on 4/23/25 at 12:54 PM indicated that her expectation was the nurses follow the physician's order. The DNS indicated that Resident #31 has a physician order if the finger stick was over 340 to give 6 units coverage and then call the physician to see if resident needs additional coverage. The DNS indicated that her expectation was that the nurses would have called the APRN or physician and write a nurse note indicating who they called and if there were any further directives. The interview with MD #1 on 4/24/25 at 11:23 AM indicated that his expectation was the nurses would follow the physician order and if the finger stick was over 340 that he would receive a telephone call. MD #1 indicated that his expectation was to be informed of the blood sugar because he would order for an extra dose of insulin coverage and how much would be determined based on how high the finger stick was and then it is up to Resident #31 if he/she accepts it. After review of the clinical record there were 9 times from 3/1/25 to 4/15/25 that the physician or APRN were not notified of elevated fingersticks greater than 340 per the physician's order and per MD #1 he would have given physician orders to receive additional Insulin coverage. Review of the Physician Notification - Change of Condition Policy identified it is the policy of this facility to notify the physician when the resident's' condition or status changes unexpectedly or substantially. This will ensure that the physician will be kept informed of changes in an appropriate and timely manner. The nurse will document in the nursing notes regarding assessment done, findings, changes, physician notification, and resident or resident representative notified. Although requested, a facility policy blood sugar monitoring policy was not provided. 2. Resident #23 was admitted to the facility in February 2023 with diagnoses that included chronic kidney disease, major depressive disorder, and anxiety disorder. The APRN note dated 1/30/25 at 7:07 AM identified Resident #23 was alert and oriented. Resident #23 has a diagnosis of chronic kidney disease and goes out to dialysis three times a week on Mondays, Wednesdays, and Fridays. Resident #23 goes out often with family on leave of absence. Resident #23 has a history of returning from leave of absence smelling of marijuana. Resident #23 was educated on the impacts of drug use on the kidney. The quarterly MDS dated [DATE] identified Resident #23 had intact cognition and was independent with motorized wheelchair. Additionally, the MDS indicated Resident #23 had no current tobacco use. The LCSW note dated 2/18/25 identified Resident #23 was oriented to person, place, time, and situation. Assessment screening for alcohol, and smoking was zero. Provided support and identification for coping strategies. Resident #23 will continue to be monitored. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social service note dated 2/25/25 at 3:50 PM identified Resident #23 had a room change, after it was reported by nursing staff in the safety committee meeting that Resident #23 smelled like marijuana and was smoking in the room. Resident #23 gave consent for a room search. A room search was performed, and no smoking material was found. Resident #23 was informed that he/she would be monitored for 72 hours, and social worker would be available as needed. The physician's order dated 1/1/25 - 2/28/25 directed to send Resident #23 to the dialysis center on Mondays, Wednesdays, and Fridays. Pick up at 7:00 AM charge nurse to complete pre dialysis form at 6:00 AM. Resident #23 may go on leave of absence with responsible party. Interview with the Administrator on 4/21/25 at 10:00 AM identified the facility has 3 residents that smoke. The Administrator indicated Resident #23 does not smoke cigarettes. Interview with LPN #3 on 4/22/25 at 2:43 PM identified she works on the South unit on the 7:00 AM - 3:00 PM shift. LPN #3 indicated when Resident #23 returns from dialysis she can smell marijuana (very strong) on the resident. LPN #3 indicated she has never smelled cigarettes or marijuana in Resident #23 room. LPN #3 indicated the staff on the 7:00 AM - 3:00 PM shift has not reported to her that Resident #23 was smoking in the room. Interview with RN #2 on 4/22/25 at 2:52 PM identified she has smelled marijuana in the hallway on the South unit but has never observed the resident smoking cigarettes or marijuana in the facility. RN #2 indicated the staff has reported to her that they smell marijuana in the hallway on the South unit. RN #2 indicated she investigated and was unable to find where the marijuana smell was coming from. RN #2 indicated she does not remember when the staff reported it or who the staff member was. Interview with NA #2 on 4/22/25 at 3:15 PM identified she works on the South unit on the 7:00 AM - 3:00 PM shift. NA #2 indicated when Resident #23 returns from dialysis and leaves of absence the resident smells of marijuana. NA #2 indicated the hallway and Resident #23 room would smell of marijuana. NA #2 indicated she does report it to the nurse or supervisor on duty at the time. NA #2 indicated she has not observed Resident #23 smoking in the room. NA #2 indicated the previous Administrator and DNS were aware of Resident #23 smelling of marijuana. NA #2 indicated that the staff at the facility (facility staff and agency staff) is aware that Resident #23 smell of marijuana, and that residents on the East unit have smoked marijuana in the facility and smell of marijuana and that is an ongoing issue at the facility. NA #2 indicated last year (2024) Resident #23 was observed smoking marijuana in the front of the facility. Interview with NA #3 on 4/22/25 at 3:35 PM identified she works on the South unit on the 3:00 PM - 11:00 PM shift. NA #3 indicated Resident #23 smells of marijuana when he/she comes back from dialysis and leave of absence. NA #3 indicated she does report it to the nurse on duty. NA #3 indicated the facility staff are aware Resident #23 smell of marijuana. Interview with NA #4 on 4/22/25 at 3:40 PM identified she works on the South unit on the 3:00 PM - 11:00 PM shift. NA #4 indicated Resident #23 smells of marijuana when he/she returns from dialysis. NA #4 indicated she reported it to the nurse or supervisor on duty. NA #4 indicated she has not observed Resident #23 smoking in the room. (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 Administrator on 4/22/25 at 4:40 PM identified she was aware of residents possibly smoking in the facility, but she has never observed a resident smoking in the facility. The Administrator indicated it had been brought to her attention that there was a smell of smoke in the bathroom, and she does not remember when the incident happened and there was no documentation of the incident. The Administrator indicated a search was done in the bathroom and no smoking materials were found. The Administrator indicated when the staff reported that they smell smoke in a resident room, with the resident permission a room search is immediately performed by the social worker. The Administrator indicated the facility does not fill out a facility reportable event form, and there is no documentation of the incident except for the social worker notes. The Administrator indicated the staff has reported that when Resident #23 returns from dialysis and leave of absence he/she smells of marijuana. The Administrator did not answer when asked if a room search is performed at the times that staff reported the smell of marijuana on Resident #23. The Administrator indicated she does not know why the nurses are not documenting when Resident #23 smells of marijuana or notifying the physician. The Administrator indicated the facility does not have any documents on every room search or smoking materials retrieved. Interview with the DNS on 4/22/25 at 5:43 PM identified she was not aware of residents smoking in the facility. The DNS indicated it has been reported to her that Resident #23 smells of marijuana. The DNS indicated she has asked Resident #23 did he/she smoke in the facility and Resident #23 has denied smoking in the facility. The DNS indicated she does not participate in the room searches, and she has not personally documented any smoking incidents or issues. The DNS indicated she was not aware that the nurses were not documenting when Resident #23 smells of marijuana or notification to the physician. The DNS indicated the facility does not fill out a reportable event when a resident is found with smoking materials. Interview with Resident #23 on 4/23/25 at 9:20 AM identified he/she does not smoke cigarettes. Resident #23 indicated he has never smoked inside the facility. Resident #23 indicated he/she does not remember when but one day in January or February 2025 the supervisor asked for his/her permission to search the room and his/her body because he/she smelled of marijuana. Resident #23 indicated the supervisor did not find any smoking materials in the room. But when he/she emptied out his/her coat pocket he/she had forgotten that there was a white lighter wrapped in a washcloth. Resident #23 indicated the white lighter was his/her and he/she gave the white lighter to the supervisor that day. Resident #23 declined to comment regarding smelling like marijuana when he/she comes back from dialysis or leave of absence. Resident #23 indicated what he/she does when he/she is out on leave of absence is nobody business. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MD #1 on 4/23/25 at 9:33 AM identified he was aware of a small group of residents last year that smoked marijuana within the facility or when they were on leave of absence. MD #1 indicated he thought the issue was resolved since the facility had not informed him of any further issues regarding marijuana smoking. MD #1 indicated he was aware of two different incidents last year (2024) when Resident #23 was found smoking marijuana in his/her room, and another incident when Resident #23 was found with marijuana gummies. MD #1 indicated he does not remember when exactly last year (2024) the incident took place, but it happened last year. MD #1 indicated the facility has not informed him that Resident #23 smelled of marijuana upon return from dialysis or leave of absences. MD #1 indicated he would have expected the facility to notify him, and the dialysis center every time Resident #23 smelled of marijuana due to the administration of prescription medications the resident receives at the facility. MD #1 indicated he would have expected the nurses to perform an assessment and document in Resident #23 clinical record every time Resident #23 smelled of marijuana upon return from dialysis or leave of absences. MD #1 indicated he would have liked to know when Resident #23 smelled of marijuana because the use of marijuana while taking prescription medications can be risky due to potential drug interactions. MD #1 indicated his dilemma is that the Ombudsman informed him that the residents at the facility has the right to go out on leave of absence. MD #1 indicated that when the resident goes out on leave of absence it is not a controlled environment. MD #1 indicated now that he is aware of Resident #23 smelling of marijuana upon return from dialysis or leave of absence, he will educate Resident #23 upon his next visit at the facility. Review of the clinical record failed to reflect a Smoking agreement form for the admission of February 2023 Review of the clinical record dated 1/1/25 - 4/21/25 failed to reflect documentation of a smoking assessment. Review of the nurse's note dated 1/1/25 - 4/21/25 failed to reflect documentation of assessments performed upon Resident #23's return from dialysis and leave of absences smelling of marijuana, or notification to the physician, or the dialysis center. The care plan dated 1/14/25 - 1/23/25 failed to reflect documentation Resident #23 smoked. Although requested, the facility failed to provide any documentation and education regarding smoking or the smells of marijuana upon returning from dialysis or leave of absence that were provided to Resident #23. Review of the facility smoking policy identified resident preference to smoke will be reasonably accommodated by staff assistance and supervision while maintaining the health and safety of the resident and other residents. Resident smoking is not allowed within the facility or in other areas on facility property that are not designated as smoking areas. Notification of Smoking Policy: Upon admission, a facility representative will orient the resident and/or conservator of person/responsible party to the smoking policy. Smoking Agreements: On admission, a facility representative will review the smoking agreement with a resident who is an active smoker or was smoking up to the time of hospitalization and obtain appropriate signatures. Smoking Evaluations: Smoking evaluations should be done upon admission/re-admission and after significant change in resident status. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents are not allowed to possess lighters, matches, cigarettes, e-cigarettes, tobacco, pipes, or any smoking material. All smoking materials will be kept with staff members. Failure to adhere to the smoking policy's safety standards related to smoking may result in the following: a. Residents may be placed on an increased level of supervision to ensure safety. b. Modifications to on-ground smoking as needed to ensure safety of the environment, residents, and staff. c. Issuance of an involuntary discharge/transfer notice if the resident's actions present a risk to the health, safety, and welfare of other residents of the facility and other interventions have not been successful. Review of the facility smoking agreement identified if it is suspected that a resident may have any hazardous smoking materials in their room or on their person (i.e., matches, or a lighter) a room search may be initiated at the discretion of the supervisor to assure resident's safety. Additionally, staff will emphasize the importance of safety with the residents and encourage and promote educational experience during the process. All restricted items will be removed from the resident's room/possession. The facility policy on Change of Condition directed that it was the policy of the facility to notify the physician when a resident had a change in condition or status that was unexpected or substantial. The policy identified that this would ensure the physician was kept informed of changes in an appropriate and timely manner. The policy further directed that a change of condition was a significant clinical development which required assessment and intervention. The policy also directed that the physician or alternate would be contacted to report findings and following physician notification the resident and/or resident representative would be notified. The policy also directed that the nurse would document in the nurse's notes regarding any assessment, findings, changes, physician notification, and resident and/or resident representative notification. 3. Resident #33 was admitted to the facility on [DATE] with diagnoses that included alcohol dependence, repeated falls, and anxiety disorder. Review of the hospital W-10 dated 10/8/24 identified Resident #33 was hospitalized from 10/4 -10/8/24 related to alcohol withdrawal. A clinical admission assessment dated [DATE] identified Resident #33's smoking status as not assessed upon admission to the facility. Review of the clinical record failed to identify any smoking assessments completed for Resident #33's after admission to the facility on [DATE]. Review of Resident #33's clinical record identified that admission paperwork including the contraband policy, and the smoking policy were blank. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 10/8/24 directed for Resident #33 to have supervised smoking per facility policy. The care plan dated 10/8/24 identified Resident #33 had documented safety concerns. Interventions included performing safety risk evaluations upon admission, as needed, and with changes in condition. The admission MDS dated [DATE] identified Resident #33 had severely impaired cognition, was frequently incontinent of bowel and bladder and required moderate assistance from staff with toileting, dressing, and transfers. The MDS also identified that Resident #33 did not have any current tobacco use. An APRN note dated 10/21/2024 identified Resident #33 had a history of alcohol dependency including drinking more than 6 nip bottles a day and smoking marijuana. The note also identified Resident #33 was treated for alcohol withdrawal during his/her hospitalization. A level 2 PASSAR dated 11/15/24 identified that Resident #33 had diagnoses that included anxiety disorder, alcohol use disorder, and adjustment disorder. The PASSAR identified that Resident #33 would need services and support to be provided, including a support group for recovery from substance abuse (Alcoholics Anonymous), group therapy with a therapist trained in group work, and a guardian conservator for decisions related to health and safety. A care plan dated 11/15/24 identified that Resident #33 had PASAR recommendations for specific services. Interventions included that Resident #33 would be provided with a support group for recovery from substance abuse and group therapy with the therapist trained in group work. Review of the clinical record identified that Person #1, Resident #33's resident representative, was appointed Resident #33's conservator of person and estate effective 11/21/2024. A nurse's note dated 12/11/2024 at 11:53 PM identified that nursing staff arrived to Resident #33's room at 11:20 PM due to the smell of wee'. The note further identified that upon arrival to Resident #33's room, he/she initially denied smoking. The note further identified upon the start of a room search; Resident #33 provided a black velvet drawstring bag which Resident #33 opened. The note identified that within the bag there was a lighter and a smoking apparatus. Review of the clinical record failed to identify any notification to Resident #33's physician or Person #1 related to the smoking incident on 12/11/24. A nurse's note dated 12/12/24 at 7:53 AM identified that Resident #33 was observed locked inside a facility bathroom smoking. The note further identified that the nursing supervisor was notified and went to speak with Resident #33. A resident room search form dated 12/12/2024 at 10:52 AM identified a room search conducted by SW #1 which was consented to by Resident # 33. The form further identified the room search findings included locating marijuana within Resident #33 bed and bedding, and small portions of marijuana located within a boot inside Resident #33's closet. The form failed to identify if Person #1 was notified or provided consent to the search. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/12/24 social work note by SW #1 identified Resident #33 had a room search conducted on that date and was found to have pocketknife, in addition to the marijuana noted on the 12/12/24 room search form. Review of the clinical record failed to identify any notification to Resident #33's physician or Person #1 related to the smoking incident on 12/12/24. A resident room search form dated 12/17/24 at 2:00 PM identified a room search conducted by SW #1 which was consented to by Resident #33. The room search form identified no dangerous or hazardous items were found in Resident #33's room. The form failed to identify a reason for the search, or that Person #1 was notified or provided with consent to the search. A social work note dated 1/16/2025 at 4:06 PM by SW #1 identified that Resident #33 had violated the facility smoking policy and the hazardous and precautionary policy. The note further identified that Person #1 was contacted to discuss discharge planning for Resident #33. Review of the clinical record failed to identify any notification to Resident #33's physician related to the incident on 1/16/25. Review of the clinical record and facility A&I reports failed to identify any additional documentation related to the incident referenced in the 1/16/2025 social work note. A social work note dated 2/25/25 at 3:48 PM by SW #1 identified Resident #33 had a room search and a smoking pipe was found within Resident #33's room. The note identified the pipe was confiscated and given to the Administrator. The note also identified that Resident #33's family was notified, and that Resident #33 would be placed on 15 minute checks. Review of the clinical record failed to identify any notification to Resident #33's physician or Person #1 related to the smoking incident on 2/25/25. A resident room search form dated 2/25/25 at 11:30 AM identified a room search was conducted on Resident #33's room due to the smell of marijuana in the residents' bathroom. The room searched further identified that a pipe was found beneath furniture located within Resident #33's room and no other materials were found in Resident #33's room or the bathroom. The note also identified Resident #33 provided consent for the room search. Review of the resident room search form failed to identify that Person #1 provided consent for the room search. (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 Person #1 on 4/22/25 at 3:20 PM identified he/she was notified regarding an incident related to marijuana and Resident #33 on 1/16/2025. Person #1 identified that she was contacted by SW #1 and notified the facility staff found Resident #33 smoking marijuana in a resident bathroom. Person #1 also identified that the only time the facility staff contacted him/her regarding any issue related to smoking, marijuana use, use of a lighter, or smoking in the facility building were on facility grounds was on 1/16/25. Person #1 also identified that when SW #1 called to notify him/her of the incident on 1/16 25, SW #1 identified that due to Resident #33 violating the facility policies related to smoking and hazardous materials, which Person #1 understood meant the use of a lighter, SW #1 identified that the facility would initiating Resident #33's transfer to another facility to ensure the safety of all residents. Person #1 also identified that he/she understood the reason for the transfer based on Resident #33 possession and use of a lighter. Person #1 identified that following the initial discussion with SW #1 on 1/16/25, no one from the facility had brought up any discussions regarding Resident #33 being transferred to another facility and he/she assumed the issue was resolved since it was a one time occurrence. Interview with the Administrator on 4/22/25 at 4:40 PM identified that she was aware there were issues related to possible smoking within the facility by residents. The Administrator identified that the facility did not allow smoking within the building, it had been brought to her attention that staff members reported smelling smoke. The Administrator identified that if she was notified of a smell of smoke, facility staff would obtain consent from the resident to conduct a room search. The Administrator identified she had not actually seen or had solid evidence that any smoking occurred within the building or in the residents' bathrooms. The Administrator identified that when a staff member reported to management or nursing supervisors that a resident was observed smoking, smelling of marijuana, or cigarettes, the protocol included the Administrator and facility staff observing for smoke, the smell of smoke, and or smoking material. The Administrator also identified that she would also ask the resident if they had been smoking, if they would consent to a room search, and if they would empty their pockets to determine if the resident had smoking materials on their person. The Administrator also identified that if smoking materials were found she would confiscate those materials and lock them in her office. The Administrator identified that in addition to room searches, the facility staff discussed the incident with the resident and provided education. The Administrator identified the facility did not complete any A&I documentation outside of what was documented on the room search forms including what was discovered during the room search, and notification to Person #1 which was all handled by SW #1. Interview with the DNS on 4/22/25 at 5:43 PM identified that she had received reports from facility staff that some residents of the facility smelled of smoke, including Resident #33. The DNS identified that when these issues were reported to her, she would speak to the resident and ask if they had been smoking within the building, which the DNS identified all residents had denied doing. The DNS also identified that while she did speak with the residents and had reports regarding the smell of smoke within the building, she did not document anything related to the reports or any part of her investigation. The DNS identified she had also been notified by a nursing supervisor of reports of the smell of marijuana from residents within the facility on the 3:00 PM to 11:00 PM shift. The DNS identified when she has received these reports, she directed the nursing supervisors to speak with the resident and on occasion also conduct a room search. The DNS identified the facility did not complete any A&I documentation related to these incidents. The DNS was unable to identify any additional information regarding these incidents. The DNS also identified that she was notif[TRUNCATED]

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	075436	A. Building B. Wing	04/24/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for residents 1 of 5 (Resident #17) reviewed for abuse, the facility failed to protect Resident #17 from physical abuse by Resident #23, who had a history of resident to resident altercations. The findings include: 1a. Resident #17 was admitted to the facility in August 2024 with diagnoses that included dementia with behavioral disturbance, epilepsy, anxiety disorder, and depressive disorder. The quarterly MDS dated [DATE] identified Resident #17 had intact cognition and was independent with the wheelchair. Additionally, Resident #17 had no physical or verbal behaviors directed at others. The care plan dated 9/26/24 identified Resident #17 had the potential to be verbally aggressive related to dementia, poor impulse control, and low tolerance for peers with dementia and behaviors. Interventions included monitor behaviors such as engaging in verbal confrontation with peers. Document observed behavior and attempted interventions. The physician's order dated 10/1/24 directed to monitor behavior for isolation, and irritability every shift related to anxiety disorder, monitor behavior for yelling every shift related to anxiety disorder, and monitor for any signs of seizure activity every shift related to epilepsy. The care plan dated 10/19/24 identified Resident #17 was involved in a resident to resident altercation. Resident #17 exchanged derogatory words with another resident, and this triggered a resident to resident physical altercation. Interventions included assisting the resident to develop more appropriate methods of coping and interacting. b. Resident #23 was admitted to the facility in February 2023 with diagnoses that included chronic kidney disease, adjustment disorder, major depressive disorder, and anxiety disorder. The care plan dated 8/9/24 identified Resident #23 had a behavior problem related to being inconsiderate to roommates encroaching on their space and being rude to them and intentionally playing television loud throughout the night to disturb them. Intervention included to intervene as necessary to protect the rights and safety of others. The quarterly MDS dated [DATE] identified Resident #23 had intact cognition and was independent with motorized wheelchair. Additionally, Resident #23 had no physical or verbal behaviors directed at others. The care plan dated 10/19/24 identified Resident #23 was involved in a resident to resident altercation. Resident #23 was triggered by the another resident who has behavioral issues also (including name calling and poor impulse, and dementia). Intervention included to analyze times of day, places, circumstances, triggers, and what de-escalate behavior and document. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The reportable event dated 10/19/24 at 6:45 PM identified Resident #17 was in the hallway at the nurse's medication cart waiting for his/her medication. Resident #23 was attempting to get by in his/her wheelchair. Resident #17 accidentally touched Resident #23, and Resident #23 punched Resident #17 in the nose. Staff immediately intervened and separated the residents. Both residents were assessed by an RN and there were no injuries. Both residents were placed on every 15 minutes monitoring. Resident #17 was placed on neurological assessment times 72 hours. The DNS, Administrator, physician, and the police were notified. The nurse's note by RN #9 dated 10/19/24 at 7:47 PM identified an RN assessment was performed. Resident #17 was alert and oriented times three. Resident #17 complained of pain, discomfort to his/her nose, and reported being struck in the nose. No visible signs of trauma, mild discomfort upon palpation. The physician and DNS were notified. Resident #17 was placed on neurological checks and every 15 minutes monitoring. The nurse's note by RN #9 dated 10/19/24 at 7:53 PM identified that an RN assessment was performed. Resident #23 was involved in a resident to resident. No complaint of injury. Resident #23 was placed on every 15 minutes monitoring. A written statement by RN #8 dated 10/19/24 at 10:00 PM identified she was the nurse on the South unit on the 3:00 PM - 11:00 PM shift. RN #8 indicated she witnessed the entire incident. RN #8 indicated Resident #17 was in the hallway at the medication cart waiting for his/her medication. Resident #23 wanted to pass through, and Resident #17 tried to make a way for Resident #23, but Resident #23 could not pass through. Resident #23 shouted to Resident #17 to move out of the way and quickly hit Resident #17's wheelchair with his/her fist. RN #8 indicated she tried to stop Resident #23's wheelchair from hitting Resident #17's wheelchair but failed. RN #8 indicated Resident #23 hit Resident #17 in the face with his/her fist. RN #8 indicated she placed her body in between both residents to stop Resident #23 and separated both residents. RN #8 indicated she was injured in the process. The summary dated 10/24/24 at 4:24 PM identified Resident #17 was in the hallway, and Resident #23 was attempting to get by. Resident #17 accidentally touched Resident #23, and Resident #23 punched Resident #17 in the nose. Both residents were immediately separated and placed on every 15 minutes monitoring until cleared by psychiatrist. Both residents were evaluated by the psychiatrist. Both residents were assessed by an RN and there were no injuries. Resident #17 was placed on neurological checks for 72 hours. Both residents will be followed by psychiatrist, and social service as needed. Interview with Resident #17 on 4/22/25 at 3:48 PM identified he/she was not expecting to get punched in the nose by Resident #23. Resident #17 indicated he/she was embarrassed and afraid after Resident #23 punched him/her in the nose. Resident #17 indicated he/she was trying to make a path for Resident #23 to get by. Resident #17 indicated he/she does not speak to Resident #23, and he/she stays out of Resident #23's way. Interview with RN #8 on 4/24/25 at 11:40 AM identified she does remember the resident-to-resident physical altercation but does not remember every details due to it was so long ago. RN #8 indicated she recalled Resident #23 was yelling at Resident #17 to get out of the way before he punched Resident #17 in the nose. RN #8 indicated to read her written statement on 10/19/24. RN #8 indicated she got hurt during the resident to resident altercation. Although attempted an interview with NA #1, NA #9, and RN #9 were not obtained. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility abuse policy identified abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property is prohibited. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 5 residents (Resident #31 and 199) reviewed for abuse, the facility failed to report an allegation of verbal abuse. The findings include: 1. Resident #31 was admitted to the facility on [DATE] with diagnoses that included hemiplegia, hemiparesis, and depression. The quarterly MDS dated [DATE] identified Resident #31 had moderately impaired cognition and was currently using tobacco. The care plan dated 4/8/25 identified Resident #31used tobacco. Interventions included educating Resident #31 on the facility's tobacco smoking policy. The care plan further identified Resident #31 had a mood problem related to depression with adjustment disorder. Interventions included monitoring/recording/reporting to the physician risk for harming others: increased anger, labile mood or agitation, feeling threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons, and observing for signs and symptoms of mania or hypomania racing thoughts or euphoria, increased irritability, frequent mood changes pressured speech, flight of ideas, marked change and need for sleep, agitation or hyperactivity. The care plan identified that Resident #31 had the potential to be verbally aggressive related to ineffective coping skills, poor impulse control, and makes threatening statements against others. Interventions included intervening before Resident #31's agitation escalates, guiding away from the source of distress, engaging calmly in conversation, and if his/her response was aggressive walk away calmly and approach later. Interview with Resident #31 on 4/23/25 at 9:11 AM identified that on 4/22/25 during the 4:30 PM smoking break, NA #14 was the staff member responsible for supervising the resident smoking break which included Residents #21, 28, and 31. Resident #31 indicated that NA #14 offered Resident #21 a second cigarette because his/her cigarette burnt out quickly and also offered a second cigarette to Resident #28 and him/herself. Resident #31 indicated that he/she told NA #14 that the Administrator and the state only allow one cigarette during the smoking time. Resident #31 alleged that NA #14 then replied, (I don't give a *** about what the state said, they could kiss my *** and the union can kiss my ***). Resident #31 further identified that NA #14 called the resident a racial slur. Resident #31 identified he/she reported the incident to the Administrator. Interview with Resident #28 on 4/23/25 at 9:25 AM indicated that it was the Administrator who supervised the 4:30 PM smoking break on 4/22/25 but then clarified that it was NA #14, and during the smoking break Resident #21 had dropped his/her cigarette but could not recall if anything else was out of the ordinary. When asked if NA #14 treated everyone respectfully during the break, Resident #28 indicated that something took place between NA #14 and Resident #31, but he/she could not remember what was said and no profanity was used by either party. (continued on next page)

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	04/24/2025

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 4/23/25 at 10:00 AM identified that she had returned to the facility on 4/22/24 around 9:50 PM to assist with a room search, and while she was completing the room search Resident #31 began loudly talking at her and said that NA #14 was speaking in a rude manner and loudly, and that he/she did not like NA #14. The Administrator indicated that she was unable to give Resident #31 her full attention, at that time, because she was dealing with another matter and told him/her that she would talk to him/her in a little while. The Administrator identified that Resident #31 escalates quickly and had gotten angry with her and was using foul language to describe NA #14, but that she did not hear Resident #31 allege that NA #14 used profanity towards him/her during the smoking break. The Administrator indicated that when she later spoke with NA #14 around 10:45 PM about the incident, she identified that Resident #31 became very upset during the 4:30 PM smoke break and called her foul language, and that NA #14 denied calling him or talking to him using inappropriate language. The Administrator indicated that she asked NA #14 to avoid contacting Resident #31 for the remainder of the shift and to punch out as scheduled (11:00 PM). The Administrator identified that she arranged to have another nurse aide provide care to Resident #31. Interview with NA #14 on 4/23/25 at 11:56 AM identified that on 4/22/25 around 4:30 PM she had brought Residents # 21, 28, and 31 out for the smoke break, and Resident #31 began speaking to Resident #21 in manner that was rude and putting him/her down; Resident #31 began swearing in front of the group and was making fun of Resident #21 for having a Band-Aid on his/her finger. NA #14 indicated that Resident #31 was giving her an attitude so she was attempting to redirect him/her, but Resident #31 started escalating and began banging on his/her own chest and told NA #14 that he/she would report her to the state, and she would lose her job. NA #14 indicated that at that point, she ended the smoking break and notified the charge nurse about the incident, sometime shortly after 4:30 PM. NA #14 identified that Resident #31 had been arguing with everyone lately, but at no point did she use profanity or racial slur. Interview with LPN #2 on 4/23/25 at 12:10 PM identified that she was not the 3-11 PM Charge Nurse on 4/22/25, at the time of the allegation, and was unaware of the incident, but she works with Resident #31 frequently and that he/she frequently directs both the f-word and n-word toward staff, and that he/she can escalate quickly. LPN #2 indicated that Resident #31's behaviors have been reported to the psychiatric provider, and that the DNS and Administrator were also aware. Interview with the 3-11 PM Nursing Supervisor (RN #7) on 4/23/25 at 12:29 PM identified that no concerns related to the 4:30 PM smoking break on 4/22/25 were brought to her attention by any staff members or residents. RN #7 indicated that while she was completing a room search with the Administrator, behind closed doors, she could hear Resident #31 screaming profanities in the hallway and threatening the staff that if anyone searches his/her room he/she will report it to the state, and they will all be ***. RN #7 further indicated that since the door was closed it was unclear what else Resident #31 had said. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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Touchpoints at Chestnut	171 Main St East Windsor, CT 06088

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 4/23/25 at 12:35 PM identified that she was the 3-11 PM Charge Nurse on 4/22/25, and around dinner time NA #14 had reported to her that Resident #31 had been rude and disrespectful towards her. LPN #3 indicated that when Resident #31 returned from the 4:30 PM smoking break, he/she had reported to her that NA #14 called him/her a racial slur, or something like that, but Resident #31 refused to answer any additional questions and that she could tell he/she needed time to cool down. LPN #3 indicated that she was aware that she should have reported that allegation to the RN Supervisor but she did not because she wanted to give Resident #31 time to cool down so she could reapproach him/her and get additional details about the allegation. LPN #3 indicated that she did attempt to reapproach Resident #31 again during the evening medication pass and then again between 8-9:00 PM, but he/she didn't want anything to do with her. LPN #3 indicated that Resident #31 had also refused his/her medications during that shift, and he/she refused to talk to the RN Supervisor, when she was sent in to assess his/her medication refusals. LPN #3 indicated that Resident #31's behaviors were escalated because a room search was being conducted in the facility, and Resident #31 was accusing the staff of being cops/detectives, and that he/she was going to record them and show it to the state, in the morning. Interview with Resident #21 on 4/23/25 at 2:42 PM identified that there was nothing out of the ordinary that took place during the 4:30 PM smoking break on 4/22/25, and that he could not recall anyone using profanity or speaking disrespectfully to him/her or anyone else. Interview with the Administrator on 4/23/25 at 3:59 PM identified that it wasn't until that morning that she was made aware that Resident #31 had alleged that NA #14 used profanity towards him/her, and that is when she removed NA #14 from the schedule, notified the state agency of the allegation, and began her investigation. The facility's Abuse policy directs any abuse, neglect, exploitation, and/or mistreatment of residents or misappropriation of resident property is prohibited. Allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property are due to be reported to the state agency immediately but not later than two hours after the allegation is made, if the allegations involve abuse or result in serious bodily injury or if there is a reasonable suspicion of a crime. The definition of verbal abuse includes any use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or their families or within their hearing distance, to describe residents regardless of their age, ability to comprehend, or disability. 2. Resident #199 had diagnoses that included chronic osteomyelitis and diaphragmatic hernia without obstruction. The baseline care plan dated 2/26/25 identified Resident #199 had an ADL self-care performance deficit related to activity intolerance and was incontinent of urine. Interventions included assist of one with transfers and assist with perineal care as needed. Physician orders dated 2/26/25 directed transfer with assist of two using a mechanical lift. The admission MDS dated [DATE] identified Resident #199 was cognitively intact and required one person assist with bed mobility and toileting, two person assist with transfers. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Resident Grievance Report dated 3/4/24 identified that on 3/2/25 Resident #199 reported calling for assistance at 2:00 PM after having a bowel movement in their brief which was reported to the nurse. The report further noted Resident #199 called for assistance on three occasions between 2:00 PM and 7:00 PM. However, the aides were reportedly too busy to respond until 7:00 PM. Staff education regarding the timely response to call lights was conducted on 3/6/25. The date of decision was noted on 3/18/25 with documentation indicating Resident #199 was satisfied with the resolution. However, there was no completed summary of findings documented on the grievance form, which was signed by the administrator on 3/20/25. Social services progress note dated 3/4/25 at 11:18 AM identified Resident #199 filed a grievance about care. The social worker would inform the appropriate department about the grievance and remain available as needed for assistance and support. An interview with the DNS on 4/22/25 at 9:50 AM identified the administrator, social services and herself were responsible for investigating any resident care concerns or allegation of neglect. The DNS further identified she was unaware of the resident reported concern of neglect dated 3/2/25 and would have to look further into the matter for any documented investigation. An interview with SW #1 on 4/22/25 at 9:57 AM identified she was responsible for providing support and gathering details for any resident reported care concern or allegation of neglect. All allegations of neglect were immediately referred to nursing and administration for investigation. SW #1 identified she met with Resident #199 on 3/4/25 to provide support after receiving the grievance, and reported the allegation to the DNS for follow up and investigation. An interview with the Administrator on 4/22/25 at 1:43 PM and 4/22/25 at 3:12 PM identified all allegations of neglect should be reported immediately and then investigated. Upon learning of the allegation, the administrator spoke with Resident #199 who reported not being changed for several hours after an incontinent episode. The Administrator then spoke with the assigned aide who reported incontinent care was provided during that time frame. This information was received within the first two hours after learning of the allegation, therefore did not require reporting. A review of the facility policy for abuse directs all allegations of mistreatment be reported to the state agency no later than two hours for allegations after the allegation was made.

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	075436	A. Building B. Wing	04/24/2025

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Touchpoints at Chestnut	171 Main St East Windsor, CT 06088

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #199) reviewed for abuse, the facility failed to thoroughly investigation an allegation of neglect. The findings include: Resident #199 had diagnoses that included chronic osteomyelitis and diaphragmatic hernia without obstruction. The baseline care plan dated 2/26/25 identified Resident #199 had an ADL self-care performance deficit related to activity intolerance and was incontinent of urine. Interventions included assist of one with transfers and assist with perineal care as needed. Physician's order dated 2/26/25 directed transfer with assist of two using a mechanical lift. The admission MDS dated [DATE] identified Resident #199 was cognitively intact and required one person assist with bed mobility, two person assist with transfers. A Resident Grievance Report dated 3/4/24 identified that on 3/2/25 Resident #199 reported calling for assistance at 2:00 PM after having a bowel movement in their brief which was reported to the nurse. The report further noted Resident #199 called for assistance on three occasions between 2:00 PM and 7:00 PM, however, the aides were reportedly too busy to respond until 7:00 PM. Staff education regarding the timely response to call lights was conducted on 3/6/25. The date of decision was noted on 3/18/25 with documentation indicating Resident #199 was satisfied with the resolution. However, there was no completed summary of findings documented on the grievance form, which was signed by the administrator on 3/20/25. Social services progress note dated 3/4/25 at 11:18 AM identified Resident #199 filed a grievance about care. The social worker would inform the appropriate department about the grievance and remain available as needed for assistance and support. An interview with the DNS on 4/22/25 at 9:50 AM identified the administrator, social services and herself were responsible for investigating any resident care concerns or allegation of neglect. The DNS further identified she was unaware of the resident reported concern of neglect which occurred on 3/2/25 and would have to look further into the matter for any documented investigation. An interview with SW #1 on 4/22/25 at 9:57 AM identified she was responsible for providing support and gathering details for any resident reported care concern or allegation of neglect. All allegations of neglect were immediately referred to nursing and administration for investigation. SW #1 identified she met with Resident #199 on 3/4/25 to provide support after receiving the grievance. SW #1 did not obtain any further details regarding the matter and reported the allegation to the DNS for follow-up and investigation. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 4/22/25 at 1:43 PM and 4/22/25 at 3:12 PM identified any resident reported concern or allegation of mistreatment would be immediately investigated. Documentation would be collected including staff and resident statements along with the outcome. The Administrator identified that any resident reported concern of not receiving incontinent care for five hours would be investigated as neglect. Allegations of mistreatment were primarily overseen by the DNS who was responsible for reporting and investigating the claim. Social services would offer support, while she completed an administrative review and signed off once the investigation was concluded. In this instance, Resident #199 reported the allegation a couple of days following the reported incident. Upon learning of the allegation, the administrator spoke with Resident #199 who reported not being changed for several hours. The Administrator spoke with the assigned nurse aide who reported incontinent care was provided during that time frame. Although the Administrator identified that an investigation was completed, she was unable to identify the nurse aide involved or provide any documentation of the investigation, including residents and staff statements or a summary of findings. The Administrator could not ascertain why the DNS was not involved in the investigation or why she was unaware of the allegation. Further, the Administrator indicated no staff member was removed from the schedule pending the outcome of the investigation as Resident #199 was unable to identify the specific staff member(s) responsible. An interview with NA #2 on 4/23/25 at 8:25 AM identified she was the assigned nurse aide for Resident #199 on 3/2/25 during the 7:00 AM to 3:00 PM shift. NA #2 identified there were no care concerns reported to her by Resident #199 during the shift. NA #2 was not removed from the schedule, had not spoken to the DNS or Administrator about any details regarding the event and had not received any education following the event. An interview with LPN #6 on 4/23/25 at 12:22 PM identified he was the assigned agency nurse during the 7:00 AM to 3:00 PM shift on 3/2/25. LPN #6 identified he could not recall the resident or any reported incidents regarding untimely incontinent care, he was not contacted to provide any information about the incident, and he was not provided any education following the incident. An interview with LPN #2 on 4/23/25 at 12:50 PM identified she was working from 7:00 AM to 3:00 PM shift on 3/2/25 but was unaware of any reported care concerns regarding Resident #199. LPN #2 identified administrative staff did not ask her if she had any details regarding the incident. However, LPN #2 did recall signing a staff education form related to answering call bells timely, but was not made aware of any specific resident or care concern. Subsequent interview with the DNS on 4/24/25 at 9:46 AM identified any care concern related to incontinent care not being provided for 5 hours was considered neglect and should have been reported to the state agency and thoroughly investigated according to policy. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for abuse directs that all residents will not be subjected to abuse, neglect or mistreatment. Neglect defined as failure of the facility, it's employees or service providers to provide services necessary to prevent harm, mental anguish, or emotional distress. All allegations of abuse will be reported to the state agency no later than two hours after the allegation was made. An investigation will be initiated within 24 hours of the discovery and is the responsibility of the administrator to initiate. Residents are to be removed from the alleged abuser. If an employee, he/she will be removed from resident care and schedule pending the outcome of the investigation. The investigation should include statements from witnesses and staff, consultation with family, physician, Department of Public Health (DPH) and other state agencies as required. The investigation and findings will be documented and submitted to the facility's medical staff meetings. Attempts to interview NA #3, the assigned aide on 3/2/25 during the 3:00 PM - 11:00 PM shift was unsuccessful. Attempts to interview NA #6, a scheduled aide on 3/2/25 during the 7:00 AM to 3:00 PM shift was unsuccessful. Attempts to interview LPN #7, the assigned nurse on 3/2/25 during the 3:00 PM-11:00 PM was unsuccessful.

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	075436	A. Building B. Wing	04/24/2025

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #3) reviewed for Pre-admission Screening and Record Review (PASARR), the facility failed to ensure a PASARR rescreen was completed following a new mental health diagnosis. The findings include: A PASARR dated 10/29/01 identified that based on a Level 2 evaluation, Resident #3 met the criteria for nursing home level-of-care and did not require specialized mental services to treat an acute episode of serious mental illness. The client may choose admission to, or continued stay in the nursing facility. However long-term nursing home placement was not appropriate for the client. He/she should receive rehabilitative services enabling him/her to live in a more normal, less restrictive environment. No further evaluations were required unless the client experienced a change of condition related to his/her mental illness. Report a change of condition promptly to the change of condition coordinator. Resident #3 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and major depressive disorder. Review of Resident #3's clinical record identified schizoaffective disorder as his/her primary diagnosis, with an onset date of 9/5/19. The annual MDS dated [DATE] identified Resident #3 had intact cognition and failed to identify a serious mental illness or intellectual disability as a Level II PASARR condition. The care plan dated 3/18/25 identified Resident #3 was using psychotropic medications related to schizoaffective disorder, autistic disorder, major depression with anxiety, and mixed obsessional thoughts. Interventions included administering psychotropic medications as ordered by the physician and monitoring for side effects/effectiveness, monitoring target behavior symptoms, and documenting per facility protocol. The care plan further identified Resident #3 had a psychosocial well-being problem related to depression with anxiety, autism, schizoaffective disorder, and disturbing intrusive thoughts. Interventions included consulting with social services, psychiatric services, and the care plan team. Interview with the Director of Social Services (SW #1) and the Corporate Director of Behavior Programs on 4/23/25 identified that the PASARR dated 10/29/01 was the only PASARR that the facility had on file for Resident #3. SW #1 indicated that she was not aware that Resident #3 had a diagnosis of schizoaffective disorder, and she was not the facility's social worker, in 2019, at the time the diagnosis was made. SW #1 and the Corporate Director further indicated that another Level 1 and then Level 2 PASARR should have been completed upon the new schizoaffective diagnosis. The Corporate Director identified that any new recommendations that would have been made on the Level 2 rescreen would have required a care plan revision in collaboration with the interdisciplinary team. SW #1 identified that she would submit a new Level 1 PASARR for Resident #3 and begin audits of the facility's PASARR documents, to ensure all are up to date. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PASARR for Connecticut policy directs facility staff to follow procedures for screening, authorization verification, change reporting, and recommendation follow up as required. Upon a change in the resident's condition or evidence of a need for extension of an authorization, the facility will provide as needed information to the appropriate agency, in accordance with state and federal PASARR procedures.

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	075436	A. Building B. Wing	04/24/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #199) reviewed for abuse, the facility failed to conduct an RN assessment after the resident reported having waited for 5 hours for incontinent care. The findings include: Resident #199 had diagnoses that included chronic osteomyelitis and diaphragmatic hernia without obstruction. The baseline care plan dated 2/26/25 identified Resident #199 had an ADL self-care performance deficit related to activity intolerance and was incontinent of urine. Interventions included assist of one with transfers with controlled, ankle, motion (CAM) boot used for stabilization and assist with perineal care as needed. Physician's order dated 2/26/25 directed transfer with assist of two using a mechanical lift. The admission MDS dated [DATE] identified Resident #199 was cognitively intact and required one person assist with bed mobility and toileting, two person assist with transfers. A Resident Grievance Report dated 3/4/24 identified that on 3/2/25 Resident #199 reported calling for assistance at 2:00 PM after having a bowel movement in their brief. The concern was reported to the nurse at that time. Resident #199 called for assistance on three occasions between 2:00 PM and 7:00 PM and the aides were reportedly too busy to respond until 7:00 PM. A nurse's note dated 3/4/25 at 11:46 AM by LPN #3 identified Resident #199 was alert and oriented, no pain skin was warm and dry and within normal limits. Social services progress note dated 3/4/25 at 11:18 AM identified Resident #199 filed a grievance about care. The social worker would inform the appropriate department about the grievance and remain available as needed for assistance and support. An interview with SW #1 on 4/22/25 at 9:57 AM identified she was responsible for providing support and gathering details for any resident reported care concern or allegation of neglect. All allegations of neglect were immediately referred to nursing and administration for investigation. SW #1 identified she met with Resident #199 on 3/4/25 to provide support after receiving the grievance, and reported the allegation to the DNS for follow up and investigation. An interview with the DNS on 4/24/25 at 9:46 AM identified she was unaware of the resident reported allegation of neglect on 3/4/25. The DNS identified any care concern related to incontinent care not being provided for hours was considered neglect and that an RN assessment should have been completed to determine if there were injuries. An interview with LPN #3 on 4/24/25 at 9:49 AM identified she was not made aware of any untimely care concern reported from the weekend and that any progress note written would have been regarding routine care. Although requested, a policy for assessment following a change of condition was not provided.

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	075436	A. Building B. Wing	04/24/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Deficiency Text Not Available

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	075436	A. Building B. Wing	04/24/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 4 resident (Resident #1 and 32) reviewed for nutrition, the facility failed to ensure that an RN assessment was completed and documented following the dislodgment of a feeding tube, failed to ensure that weights were obtained and documented per the physician's order and failed to provide education to the resident when weights were refused, and for 1 of 6 residents (Resident #23) reviewed for accidents, the facility failed to provide treatment and care in accordance with professional standards of practice when the resident continued to return to the facility from LOA smelling of marijuana. The findings include: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses that included epilepsy, gastrostomy, and dysphagia. The admission nursing assessment dated [DATE] identified Resident #1 had an admission weight of 173.6 lbs. The physician's order dated 12/30/24 directed to administer Enteral Nutrition 1.2% at 47 ml per hour for 24 hours via pump per gastrotomy tube (G-tube) around the clock. The admission MDS dated [DATE] identified Resident #1 had intact cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with bathing, toileting, and transfers. The care plan dated 1/6/25 identified Resident #1 had a nutritional problem related to GI issues and refusal of tube feedings. Interventions included to obtain weights as ordered and monitor/record/report to the physician as needed signs/symptoms of malnutrition including muscle wasting. emaciation, and significant weight loss (3lbs. in one week, >5% in one month, >7.5% in 3 months, >10 % in 6 months). A physician's note by MD #1 on 1/28/25 identified that Resident #1 had an admission weight of 173 lbs. and a re-weight on 1/9/25 was 164 lbs. MD #1 identified that the weight may not be accurate as it did clinically not appear to correlate. MD #1 identified that Resident #1 was tolerating oral intake, but he would still like to continue tube feeding for the next 2 - 3 months to ensure that Resident #1 continued to gain weight. Review of the clinical record failed to identify any additional weights for Resident #1 documented for January 2025. A nurse's note dated 2/13/25 at 3:13 PM by LPN #2 identified that Resident #1 had a dislodged G-tube. LPN #2 identified that Resident #1 was able to make his/her needs known and that the site had no irritation or bleeding after dislodgement. LPN #2 identified she would continue to monitor. Review of the clinical record failed to identify an RN assessment or documentation that the provider was notified on 2/13/25 related to Resident #1's G-tube dislodgement. (continued on next page)

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	04/24/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An APRN note by APRN #2 on 2/18/25 (approximately 5 days after Resident #1's G-tube dislodgement) identified she was asked to see Resident #1 due to Resident #1 self-discontinuing his/her G-tube, which was initially placed due to paralysis of vocal cords and larynx, that those symptoms had slowly resolved, and Resident #1 was tolerating food, fluids, and medications by mouth per nursing staff. APRN #2 identified that the plan included covering the G-tube site with wet-to-dry dressing and that the opening would close and resolve on its own. Review of the clinical record failed to identify any documentation related to Resident #1 removing or self-discontinuing his/her G-tube. Review of the clinical record failed to identify any documentation related to nutritional assessments or additional weight monitoring of Resident #1 from 2/1/25 - 2/21/25. Review of the clinical record identified Resident #1 was hospitalized from [DATE] - 2/26/25 for stroke symptoms and pulmonary edema. Review of the clinical record failed to identify any admission weight obtained for Resident #1 upon readmission to the facility on 2/26/25. A physician's order dated 2/28/25 directed to obtain Resident #1's weight on admission and then weekly for 4 weeks. Review of the clinical record identified Resident #1 weighed 152.6 lbs. on 3/1/25, a 21 lb. or 12.1% loss since admission on [DATE], and a 11.6 lb. or 7.06% loss since 1/9/25. Review of the 3/2025 TAR identified Resident #1 weighed 152.6 on 3/8/25 and 3/15/25. Review of the clinical record failed to identify any additional weights for Resident #1 for 3/2025. Review of the clinical record identified Resident #1 had a weight of 162 lbs. on 4/4/25. Review of the clinical record identified Resident #1 had a weight of 162.4 lbs. on 4/12/25. Interview with Resident #1 on 4/21/25 at 10:44 AM identified he/she had multiple issues with weight monitoring. Resident #1 identified he/she did not feel that the facility was monitoring his/her weight appropriately, and that during a PT session the week prior, he/she requested the PT #1 assist him/her onto a scale to check his/her weight. Resident #1 identified that the weight was 156 lbs. which would have been a 6 lb. loss from his/her previous weight a week prior. Resident #1 identified he/she had a G-tube previously in place that dislodged during a transfer from his/her bed to a wheelchair for a shower in February. Resident #1 identified that since he/she had previously requested the G-tube be removed and since Resident #1 had been eating by mouth, the G-tube was not replaced. Resident #1 reported that while he/she was able to eat by mouth, he/she had issues with nausea and at times was unable to eat at all. Interview with PT #1 on 4/22/25 at 11:05 AM identified she was present when Resident #1 requested to use the facility scale to check his/her weight the week prior and that Resident #1 had a weight of 158.4 lbs. PT #1 identified she wrote the weight on a slip of paper and gave it to LPN #2. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #2 on 4/22/25 at 11:54 AM identified that she was present at the time Resident #1 was discovered to have a dislodged G-tube on 2/13/25. LPN #2 identified that Resident #1 was being transferred from the bed to either a wheelchair or a shower chair on 2/13/25. LPN #2 identified that two nurse aides were assisting with the transfer and that she was called to the room due to the dislodgement and, upon entering the room, the G-tube was on the floor. LPN #2 identified she covered the G-tube site with gauze and notified RN #2. LPN #2 identified she had asked Resident #1 what happened to the G-tube and Resident #1 identified that he/she did not know. LPN #2 also identified that the nurse aides assisting Resident #1 were also unsure how the G-tube became dislodged. LPN #2 identified that since she had seen Resident #1 touching the G-tube earlier in the shift and complained that it was painful, LPN #2 identified she assumed that Resident #1 had removed the G-tube on his/her own. LPN #2 also identified that she notified APRN #2 on 2/18 25 that Resident #1 had self-discontinued the G-tube. LPN #2 identified staff had not reported that Resident #1 was observed attempting to remove the G-tube. LPN #2 also identified that the 2 nurse aides assisting with the transfer on 2/13/25 did not report Resident #1 removed the G-tube, and LPN #2 identified that while she observed Resident #1 touching the G-tube, she did not witness Resident #1 ever attempting to remove the G-tube. LPN #2 also identified that PT #1 did hand her a slip of paper that had a weight for the week prior. LPN #2 identified that she placed the slip of paper in the unit weight book but did not enter it into Resident #1 clinical record and identified she could not remember the weight. Review of the weight book for Resident #1's unit on 4/22/25 failed to identify any documentation or paper notes for any recent weights for Resident #1. Interview with RN #2 on 4/22/25 at 1:25 PM identified she was notified by LPN #2 on 2/13/25 that Resident #1 had a G-tube dislodgement during a transfer. RN #2 identified that Resident #1 was in the process of scheduling an appointment for the G-tube to be removed. RN # 2 identified that she did see the resident, observed the G-tube was out, and notified MD #1 via phone. RN #2 identified MD #1 instructed her to cover the site with gauze and that it would naturally close on its own. RN #2 identified she had no knowledge of Resident #1 removing the G-tube on his/her own. RN #2 identified she did not complete an assessment for Resident #1 and did not document a note related to the G-tube dislodgment or notification to MD #1. Interview with LPN #2 on 4/23/24 at 3PM identified that, subsequent to surveyor inquiry, she entered a weight of 158.4 lbs. for Resident #1 on 4/17/25, a 4 lb. or 2.46% loss from 5 days prior. Interview with the DNS on 4/24/25 at 12:00 PM identified that all residents were to be weighed upon admission and monthly. The DNS also identified any residence that required additional weight monitoring typically had an order placed by the physician or APRN. The DNS also identified that any residents who have been identified with significant weight loss should be followed by the dietitian and have an RN assessment along with the physician being notified. The DNS identified that at the minimum, resident #1 should have had admission weights and monthly weights per the facility policy. The facility policy on weight directed that weights would be obtained for all residents on admission to the facility. The policy further directed that the frequency of weights would be determined by the interdisciplinary team post admission based on the resident's individual needs. The policy also directed that all residents would be weighed at least monthly, which would be done before the last day of each month. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on nursing progress notes identified that the residents' progress would be documented in the medical record by licensed staff as required. The policy further directed that nursing staff would document resident progress in the progress note section of the electronic medical record. The facility policy on general information directed that it was the policy of the facility that each resident admitted had a medical record maintained by the resident's physician and nursing department. The policy also directed that the medical record would be kept current, dated, and signed by the appropriate individual. 2. Resident #32 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF) and severe protein calorie malnutrition. A physician's order dated 8/1/24 directed to follow the heart failure protocol: daily weights at 6:00 AM prior to breakfast: notify MD/APRN with weight gain greater than 2 pounds in one day or 5 pounds in one week. A physician's order dated 11/28/24 directed to administer Milrinone Lactate (Primacor) (a vasodilator medication used as a short-term treatment for heart failure) in Dextrose 5% IV solution 40mg/200ml, use 11ml/hr. intravenously every shift related to systolic heart failure. The quarterly MDS dated [DATE] identified Resident #32 had intact cognition and was taking medications from the following high-risk drug classes: antipsychotic, antidepressant, anticoagulant, diuretic, and antiplatelet and was on an IV (intravenous) medication, while a resident. The care plan dated 2/19/25 identified Resident #32 had altered cardiopulmonary status related to congestive heart failure, hypertension, hyperlipidemia, low ejection fraction with impaired cardiac output and a history of pulmonary embolism. Interventions included monitoring vital signs and weights as ordered and as needed for symptoms or complaints and monitoring, documenting, and reporting any changes in lung sounds on auscultation, edema, and changes in weight. The care plan further identified Resident #32 had a PICC (peripherally inserted central catheter) line for Primacor Infusion due to coronary artery disease with insufficient cardiac output. Interventions included maintaining infusion device per current physician's order. Resident #32 has congestive heart failure. Interventions included weight monitoring as ordered. Resident #32 has liver disease related to Cirrhosis. Interventions included fluid restriction and weight monitoring as ordered. The care plan failed to identify a focus, goal, or interventions for refusals of care. Review of the February 2025 Medication Administration Record (MAR) and Weights and Vital Signs Summary failed to identify Resident #32's weights were obtained on the following days: 2/2, 2/3, 2/13, 2/14, 2/19, 2/21, 2/23, 2/24, and 2/27/25 (9 of 28 days). Review of the March 2025 Medication Administration Record (MAR) and Weights and Vital Signs Summary failed to identify Resident #32's weights were obtained on the following days: 3/1, 3/2, 3/3, 3/5, 3/6, 3/9, 3/10, 3/11, 3/13, 3/15, 3/16, 3/18, 3/19, 3/20, 3/23, 3/25, 3/27, 3/28, 3/29, and 3/30/25 (19 of 31 days). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the April 2025 Medication Administration Record (MAR) and Weights and Vital Signs Summary failed to identify Resident #32's weights were obtained on the following days: 4/1, 4/5, 4/6, 4/7, 4/8, 4/12, 4/13, 4/14, 4/17, 4/19, 4/21, and 4/22 (12 of 23 days). The nurse's notes dated 2/1/25 through 4/23/25 failed to identify follow-up documentation for Resident #32's weight refusals, following 40 instances of refusal; 5 nurse's notes dated 3/3/25 at 1:30 PM, 3/5/25 at 8:37 AM, 3/10/25 at 3:21 PM, 4/8/25 at 3:19 PM, and 4/15/25 at 6:27 AM indicated Resident #32 had refused the daily weight, but failed to identify that he/she was educated, reapproached, and that the physician/APRN was notified of the refusals. Interview with LPN #8 on 4/23/25 at 2:17 PM identified that she had worked on 4/19/25 and provided care for Resident #32. LPN #8 indicated that the nurse aide attempted to weigh Resident #32, and he/she refused to be weighed; the nurse aide notified her of the refusal and she reapproached Resident #32 and he/she said, (I don't want to be weighed). LPN #8 identified that she documented the refusal in the MAR and notified that night supervisor but did not write a progress note. Interview with Resident #32 on 4/23/25 at 4:00 PM identified that he/she was supposed to be weighed on Monday, Wednesday, and Friday, and that he/she had not refused weights, recently. Interview and clinical record review with the Regional Clinical Director (RN #13) on 4/23/25 at 4:18 PM identified that since Resident #32 was on an Inotrope (a medication that affects the strength or force of the heart muscle contraction) he/she would need to be weighed per the physician's order, which was daily. RN #13 indicated that the facility nurses had documented some of Resident #32's weight refusals but not consistently. Interview with the DNS on 4/23/25 at 5:06 PM indicated that she was aware that Resident #32 had at times, refused his/her daily weight order. The DNS identified that when Resident #32's weight refusals had been brought up during morning report, his/her nurse was directed to reapproach the resident. The DNS further identified that moving forward all residents requiring a daily weight will be reviewed daily during morning report and a follow-up plan will be put in place, for any resident refusing their daily weight. The DNS indicated that she would expect there to be documentation in the nursing progress notes following Resident #32's weight refusals, as well as a notification to the medical provider of the refusal. Interview with the Medical Director (MD #1) on 4/24/25 at 11:29 AM identified that, while he could not recall the date or time that was notified, he was aware of Resident #32's weight refusals. MD #1 indicated that he was aware of a handful of residents that were non-compliant or refused daily weights. MD #1 indicated that despite Resident #32's CHF diagnosis and being on an Inotrope, there was no impact of his/her weight refusals because he/she was stable. MD #1 further indicated he may discontinue the daily weight order because Resident #32 has been stable. The Guidelines for Inotrope Therapies directed daily weights are incredibly important during this therapy and should be conducted daily at the same time, using the same scale, and wearing similar clothing, after voiding. 3. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 was admitted to the facility in February 2023 with diagnoses that included chronic kidney disease, major depressive disorder, and anxiety disorder. The APRN note dated 1/30/25 at 7:07 AM identified Resident #23 was alert and oriented. Resident #23 has a diagnosis of chronic kidney disease and goes out to dialysis three times a week on Mondays, Wednesdays, and Fridays. Resident #23 goes out often with family on leave of absence. Resident #23 has a history of returning from leave of absence smelling of marijuana. Resident #23 was educated on the impacts of drug use on the kidney. The quarterly MDS dated [DATE] identified Resident #23 had intact cognition and was independent with motorized wheelchair. Additionally, the MDS indicated Resident #23 had no current tobacco use. The LCSW note dated 2/18/25 identified Resident #23 was oriented to person, place, time, and situation. Assessment screening for alcohol, and smoking was zero. Provided support and identification for coping strategies. Resident #23 will continue to be monitored. The social service note dated 2/25/25 at 3:50 PM identified Resident #23 had a room change, after it was reported by nursing staff in the safety committee meeting that Resident #23 smelled like marijuana and was smoking in the room. Resident #23 gave consent for a room search. A room search was performed, and no smoking material was found. Resident #23 was informed that he/she would be monitored for 72 hours, and social worker would be available as needed. The physician's order dated 1/1/25 - 2/28/25 directed to send Resident #23 to the dialysis center on Mondays, Wednesdays, and Fridays. Pick up at 7:00 AM charge nurse to complete pre dialysis form at 6:00 AM. Resident #23 may go on leave of absence with responsible party. Interview with the Administrator on 4/21/25 at 10:00 AM identified the facility has 3 residents that smoke. The Administrator indicated Resident #23 does not smoke cigarettes. Interview with LPN #3 on 4/22/25 at 2:43 PM identified she works on the South unit on the 7:00 AM - 3:00 PM shift. LPN #3 indicated when Resident #23 returns from dialysis she can smell marijuana (very strong) on the resident. LPN #3 indicated she has never smelled cigarettes or marijuana in Resident #23 room. LPN #3 indicated the staff on the 7:00 AM - 3:00 PM shift has not reported to her that Resident #23 was smoking in the room. Interview with RN #2 on 4/22/25 at 2:52 PM identified she has smelled marijuana in the hallway on the South unit but has never observed the resident smoking cigarettes or marijuana in the facility. RN #2 indicated the staff has reported to her that they smell marijuana in the hallway on the South unit. RN #2 indicated she investigated and was unable to find where the marijuana smell was coming from. RN #2 indicated she does not remember when the staff reported it or who the staff member was. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #2 on 4/22/25 at 3:15 PM identified she works on the South unit on the 7:00 AM - 3:00 PM shift. NA #2 indicated when Resident #23 returns from dialysis and leaves of absence the resident smells of marijuana. NA #2 indicated the hallway and Resident #23 room would smell of marijuana. NA #2 indicated she does report it to the nurse or supervisor on duty at the time. NA #2 indicated she has not observed Resident #23 smoking in the room. NA #2 indicated the previous Administrator and DNS were aware of Resident #23 smelling of marijuana. NA #2 indicated that the staff at the facility (facility staff and agency staff) is aware that Resident #23 smell of marijuana, and that residents on the East unit have smoked marijuana in the facility and smell of marijuana and that is an ongoing issue at the facility. NA #2 indicated last year (2024) Resident #23 was observed smoking marijuana in the front of the facility. Interview with NA #3 on 4/22/25 at 3:35 PM identified she works on the South unit on the 3:00 PM - 11:00 PM shift. NA #3 indicated Resident #23 smells of marijuana when he/she comes back from dialysis and leave of absence. NA #3 indicated she does report it to the nurse on duty. NA #3 indicated the facility staff are aware Resident #23 smell of marijuana. Interview with NA #4 on 4/22/25 at 3:40 PM identified she works on the South unit on the 3:00 PM - 11:00 PM shift. NA #4 indicated Resident #23 smells of marijuana when he/she returns from dialysis. NA #4 indicated she reported it to the nurse or supervisor on duty. NA #4 indicated she has not observed Resident #23 smoking in the room. Interview with the Administrator on 4/22/25 at 4:40 PM identified she was aware of residents possibly smoking in the facility, but she has never observed a resident smoking in the facility. The Administrator indicated it had been brought to her attention that there was a smell of smoke in the bathroom, and she does not remember when the incident happened and there was no documentation of the incident. The Administrator indicated a search was done in the bathroom and no smoking materials were found. The Administrator indicated when the staff reported that they smell smoke in a resident room, with the resident permission a room search is immediately performed by the social worker. The Administrator indicated the facility does not fill out a facility reportable event form, and there is no documentation of the incident except for the social worker notes. The Administrator indicated the staff has reported that when Resident #23 returns from dialysis and leave of absence he/she smells of marijuana. The Administrator did not answer when asked if a room search is performed at the times that staff reported the smell of marijuana on Resident #23. The Administrator indicated she does not know why the nurses are not documenting when Resident #23 smells of marijuana or notifying the physician. The Administrator indicated the facility does not have any documents on every room search or smoking materials retrieved. Interview with the DNS on 4/22/25 at 5:43 PM identified she was not aware of residents smoking in the facility. The DNS indicated it has been reported to her that Resident #23 smells of marijuana. The DNS indicated she has asked Resident #23 did he/she smoke in the facility and Resident #23 has denied smoking in the facility. The DNS indicated she does not participate in the room searches, and she has not personally documented any smoking incidents or issues. The DNS indicated she was not aware that the nurses were not documenting when Resident #23 smells of marijuana or notification to the physician. The DNS indicated the facility does not fill out a reportable event when a resident is found with smoking materials. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #23 on 4/23/25 at 9:20 AM identified he/she does not smoke cigarettes. Resident #23 indicated he has never smoked inside the facility. Resident #23 indicated he/she does not remember when but one day in January or February 2025 the supervisor asked for his/her permission to search the room and his/her body because he/she smelled of marijuana. Resident #23 indicated the supervisor did not find any smoking materials in the room. But when he/she emptied out his/her coat pocket he/she had forgotten that there was a white lighter wrapped in a washcloth. Resident #23 indicated the white lighter was his/her and he/she gave the white lighter to the supervisor that day. Resident #23 declined to comment regarding smelling like marijuana when he/she comes back from dialysis or leave of absence. Resident #23 indicated what he/she does when he/she is out on leave of absence is nobody business. Interview with MD #1 on 4/23/25 at 9:33 AM identified he was aware of a small group of residents last year that smoked marijuana within the facility or when they were on leave of absence. MD #1 indicated he thought the issue was resolved since the facility had not informed him of any further issues regarding marijuana smoking. MD #1 indicated he was aware of two different incidents last year (2024) when Resident #23 was found smoking marijuana in his/her room, and another incident when Resident #23 was found with marijuana gummies. MD #1 indicated he does not remember when exactly last year (2024) the incident took place, but it happened last year. MD #1 indicated the facility has not informed him that Resident #23 smelled of marijuana upon return from dialysis or leave of absences. MD #1 indicated he would have expected the facility to notify him, and the dialysis center every time Resident #23 smelled of marijuana due to the administration of prescription medications the resident receives at the facility. MD #1 indicated he would have expected the nurses to perform an assessment and document in Resident #23 clinical record every time Resident #23 smelled of marijuana upon return from dialysis or leave of absences. MD #1 indicated he would have liked to know when Resident #23 smelled of marijuana because the use of marijuana while taking prescription medications can be risky due to potential drug interactions. MD #1 indicated his dilemma is that the Ombudsman informed him that the residents at the facility has the right to go out on leave of absence. MD #1 indicated that when the resident goes out on leave of absence it is not a controlled environment. MD #1 indicated now that he is aware of Resident #23 smelling of marijuana upon return from dialysis or leave of absence, he will educate Resident #23 upon his next visit at the facility. Review of the clinical record failed to reflect a Smoking agreement form for the admission of February 2023 Review of the clinical record dated 1/1/25 - 4/21/25 failed to reflect documentation of a smoking assessment. Review of the nurse's note dated 1/1/25 - 4/21/25 failed to reflect documentation of assessments performed upon Resident #23's return from dialysis and leave of absences smelling of marijuana, or notification to the physician, or the dialysis center. The care plan dated 1/14/25 - 1/23/25 failed to reflect documentation Resident #23 smoked. Although requested, the facility failed to provide any documentation and education regarding smoking or the smells of marijuana upon returning from dialysis or leave of absence that were provided to Resident #23. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility smoking policy identified resident preference to smoke will be reasonably accommodated by staff assistance and supervision while maintaining the health and safety of the resident and other residents. Resident smoking is not allowed within the facility or in other areas on facility property that are not designated as smoking areas. Notification of Smoking Policy: Upon admission, a facility representative will orient the resident and/or conservator of person/responsible party to the smoking policy. Smoking Agreements: On admission, a facility representative will review the smoking agreement with a resident who is an active smoker or was smoking up to the time of hospitalization and obtain appropriate signatures. Smoking Evaluations: Smoking evaluations should be done upon admission/re-admission and after significant change in resident status. Residents are not allowed to possess lighters, matches, cigarettes, e-cigarettes, tobacco, pipes, or any smoking material. All smoking materials will be kept with staff members. Failure to adhere to the smoking policy's safety standards related to smoking may result in the following: a. Residents may be placed on an increased level of supervision to ensure safety. b. Modifications to on-ground smoking as needed to ensure safety of the environment, residents, and staff. c. Issuance of an involuntary discharge/transfer notice if the resident's actions present a risk to the health, safety, and welfare of other residents of the facility and other interventions have not been successful. Review of the facility smoking agreement identified if it is suspected that a resident may have any hazardous smoking materials in their room or on their person (i.e., matches, or a lighter) a room search may be initiated at the discretion of the supervisor to assure resident's safety. Additionally, staff will emphasize the importance of safety with the residents and encourage and promote educational experience during the process. All restricted items will be removed from the resident's room/possession.

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	04/24/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 6 residents (Resident #31 and 33) reviewed for accidents, for Resident #31, the facility failed to address repeat ongoing observations by staff of the resident vaping in the facility and for Resident #33 the facility failed to provide adequate supervision to the resident and implement interventions to ensure safety after Resident #33 was observed smoking in the facility on multiple occasions and had been found with smoking paraphernalia. The findings include: 1. Resident #31 was admitted to the facility on [DATE] with diagnoses that included hemiplegia, hemiparesis, and depression. The signed Smoking Agreement dated 9/15/24 identified that Resident #31 acknowledged that- residents were not allowed to possess lighters, matches, cigarettes, e-cigarettes, tobacco, pipes, of any other smoking material, all smoking materials were to be kept with staff members at all times, and if a resident was suspected of having any restricted items in their room or on their person a room search would be initiated at the discretion of the supervisor to assure residents' safety. The quarterly MDS dated [DATE] identified Resident #31 had moderately impaired cognition, was currently using tobacco, and had a functional limitation in range of motion on one side of the upper and lower extremities that interfered with daily functions or placed the resident at risk for injury, in the last 7 days. The care plan dated 4/8/25 identified Resident #31 used tobacco. Interventions included educating Resident #31 on the facility's tobacco smoking policy. The care plan further identified Resident #31 had a mood problem related to depression with adjustment disorder. Interventions included monitoring/recording/reporting to the physician risk for harming others: increased anger, labile mood or agitation, feeling threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons, and observing for signs and symptoms of mania or hypomania racing thoughts or euphoria, increased irritability, frequent mood changes pressured speech, flight of ideas, marked change and need for sleep, agitation or hyperactivity. Interview with NA #13 on 4/22/25 at 11:17 AM identified that nursing staff has witnessed Resident #31 vaping in his/her room and the bathroom on multiple occasions, and it had been happening more frequently as of late. NA #13 indicated that, approximately, 3 weeks ago he/she observed a vape cloud in Resident #31's room, when he/she was walking by. NA #13 further indicated that when he/she went into Resident #31's room, the resident hid the vape under the covers. NA #13 indicated that he/she reminded Resident #31 that vaping in the facility was not allowed and notified the Nursing Supervisor. NA #13 indicated that he/she could not recall the name of the Nursing Supervisor that was notified because it was an agency nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #15 on 4/22/25 at 12:10 PM identified that on multiple occasions he/she had observed Resident #31 vaping away in his/her room. NA #15 indicated that he/she had not reported the recent observations because management was aware and didn't do anything about it; it was the norm. Interview with Resident #31 on 4/23/25 at 3:36 PM identified that he/she had denied ever vaping in his/her room or bathroom and denied ever having smoking materials in his/her possession. Interview with the DNS on 4/23/25 at 5:17 PM identified that it has never been brought to her attention that Resident #31 had been observed vaping or had smoking contraband in his/her room. The DNS further indicated that she would have expected any nursing staff members that observed smoking/vaping in the building or smoking contraband to have notified her or the facility Administrator, including agency staff. The care plan dated 4/23/25 identified Resident #31 was at risk for putting the facility at risk due to unauthorized use of smoking materials and devices. Interventions dated 4/23/25 included education in regard to smoking policy and hazardous material policy, ensuring medical provider was aware of his/her choices, and to conduct an individualized meeting with the resident, responsible party, and interdisciplinary team. The facility's Smoking-Resident policy directs that resident smoking is not allowed within the facility or in other areas on the facility property that are not designated as smoking areas. All resident smoking at the facility is supervised by staff. Residents may smoke only in designated areas and at designated times under the supervision of a staff member, and residents are not allowed to possess lighters, matches, cigarettes, E-cigarettes, tobacco, pipes or any smoking material. All smoking materials will be kept with staff members. The policy further directs that in the event of a policy infringement, each resident's individual needs/capabilities will be considered to determine the most appropriate revision to the resident's plan of care. Failure to adhere to the Smoking Policy's safety standards related to smoking may result in the following: resident may be placed on increased level of supervision to ensure safety, modifications to on-ground smoking as needed to ensure safety of the environment, residents, and staff, and issuance of an involuntary discharge/transfer notice if the resident's actions present a risk to the health, safety, and welfare of other residents of the facility and other interventions have not been successful. 2. Resident #33 was admitted to the facility on [DATE] with diagnoses that included alcohol dependence, repeated falls, and anxiety disorder. Review of the hospital W-10 dated 10/8/24 identified Resident #33 was hospitalized from [DATE] -10/8/24 related to alcohol withdrawal. A clinical admission assessment dated [DATE] identified Resident #33's smoking status as not assessed upon admission to the facility. A physician's order dated 10/8/24 directed Resident #33 to have supervised smoking per facility policy. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 10/8/24 identified Resident #33 had documented safety concerns. Interventions included performing safety risk evaluations upon admission, as needed, and with changes in condition. The admission care plan failed to identify any interventions related to smoking. The admission MDS dated [DATE] identified Resident #33 had severely impaired cognition, was frequently incontinent of bowel and bladder and required moderate assistance from staff with toileting, dressing, and transfers. The MDS also identified that Resident #33 did not have any current tobacco use. An APRN note dated 10/21/2024 identified Resident #33 had a history of alcohol dependency including drinking more than 6 nip bottles a day and smoking marijuana. The note also identified Resident #33 was treated for alcohol withdrawal during his/her hospitalization. A level 2 PASARR dated 11/15/24 identified that Resident #33 had diagnoses that included anxiety disorder, alcohol use disorder, and adjustment disorder. The PASARR identified that Resident #33 would need services and support to be provided, including a support group for recovery from substance abuse (Alcoholics Anonymous), group therapy with a therapist trained in group work, and a guardian conservator for decisions related to health and safety. A care plan dated 11/15/24 identified that Resident #33 had PASARR recommendations for specific services. Interventions included that Resident #33 would be provided with a support group for recovery from substance abuse and group therapy with the therapist trained in group work. Review of the clinical record identified that Person #1, Resident #33's resident representative, was appointed Resident #33's conservator of person and estate effective 11/21/2024. A nurse's note dated 12/11/2024 at 11:53 PM identified that nursing staff arrived to the residents room at 11:20 PM due to the smell of weed. The note further identified that upon arrival to Resident #33's room, he/she initially denied smoking. The note further identified upon the start of a room search, Resident #33 provided a black velvet drawstring bag which Resident #33 opened and contained a lighter and a smoking apparatus, which was subsequently locked in the DNS office. Review of the clinical record failed to identify any notification to Resident #33's physician or Person #1 related to the smoking incident on 12/11/24. A nurse's note dated 12/12/24 at 7:53 AM identified that Resident #33 was observed locked inside a facility bathroom smoking. The note further identified that the nursing supervisor was notified and went to speak with Resident #33. Review of the clinical record and facility Accident and Incident (A&I) reports failed to identify any additional documentation or information related to the smoking incidents for Resident #33 on 12/11/24 and 12/12/24. A resident room search form dated 12/12/2024 at 10:52 AM identified a room search conducted by SW #1 which was consented to by Resident #33. The form further identified the room search findings included locating marijuana within Resident #33 bed and bedding, and small portions of marijuana located within a boot inside Resident #33's closet. The form failed to identify if Person #1 was notified or provided consent to the search. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/12/24 social work note by SW #1 identified Resident #33 had a room search conducted on that date and was found to have pocketknife, in addition to the marijuana noted on the 12/12/24 room search form. Review of the clinical record failed to identify any notification to Resident #33's physician or Person #1 related to the smoking incident on 12/12/24. Review of the clinical record failed to identify any documentation related to a smoking assessment or revisions to Resident #33's care plan to reflect the smoking incidents on 12/11/24 - 12/12/24. A resident room search form dated 12/17/2024 at 2 PM identified a room search conducted by SW #1 which was consented to by Resident #33. The room search form identified no dangerous or hazardous items were found in Resident #33's room. The form failed to identify a reason for the search, or that Person #1 was notified or provided with consent to the search. Review of the clinical record failed to identify any incidents or rationale related to the 12/17/2024 room search. A social work note dated 1/16/2025 at 4:06 PM by Social Worker #1 identified that Resident #33 had violated the facility smoking policy and the hazardous and precautionary policy. The note further identified that Person #1 was contacted to discuss discharge planning for Resident #33. Review of the clinical record and facility A&I reports failed to identify any additional documentation related to the incident referenced in the 1/16/2025 social work note. Review of the clinical record failed to identify any notification to Resident #33's physician related to the incident on 1/16/25. Review of the clinical record failed to identify any documentation related to a smoking assessment or revisions to Resident #33's care plan related to the incident referenced in the 1/16/2025 social work note. A resident room search form dated 2/25/25 at 11:30 AM identified a room search was conducted in Resident #33's room due to the smell of marijuana in the residents' bathroom. The room searched further identified that a pipe was found beneath furniture located within Resident #33's room and no other materials were found in Resident #33's room or the bathroom. The note also identified Resident #33 provided consent for the room search. Review of the clinical record and the resident room search form failed to identify that Person #1 provided consent for the room search. A social work note dated 2/25/2025 at 3:48 PM by SW #1 identified Resident #33 had a room search and a smoking pipe was found within Resident #33's room. The note identified the pipe was confiscated and given to the Administrator. Then note also identified that Resident #33's family was notified, and that Resident #33 would be placed on 15 minute checks. Review of the clinical record failed to identify any notification to Resident #33's physician or Person #1 related to the smoking incident on 2/25/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to identify any documentation that 15-minute checks were initiated or conducted for Resident #33 following the incident on 2/25/25. Further review of the clinical record also failed to identify any documentation related to a smoking assessment or revisions to Resident #33's care plan following the incident on 2/25/25. Interview with Person #1 on 4/22/25 at 3:20 PM identified he/she was notified regarding an incident related to marijuana and Resident #33 on 1/16/2025. Person #1 identified that he/she was contacted by SW #1 and notified the facility staff found Resident #33 smoking marijuana in a resident bathroom. Person #1 identified when he/she spoke to Resident #33 about the incident, Resident #33 identified he/she was smoking marijuana but outside of the facility. Person #1 identified that he/she instructed Resident #33 that under no circumstances was there to be any smoking inside of the facility building and that Resident #33 agreed. Person #1 also identified that the only time the facility staff contacted him/her regarding any issue related to smoking, marijuana use, use of a lighter, or smoking in the facility building were on facility grounds was on 1/16/25. Person #1 also identified that when SW #1 called to notify him/her of the incident on 1/16 25, SW #1 identified that due to Resident #33 violating the facility policies related to smoking and hazardous materials, which Person #1 understood meant the use of a lighter, SW #1 identified that the facility would initiating Resident #33's transfer to another facility to ensure the safety of all residents. Person #1 also identified that he/she understood the reason for the transfer based on Resident #33 possession and use of a lighter. Person #1 identified that following the initial discussion with SW #1 on 1/16/25, no one from the facility had not brought up any discussions regarding Resident #33 being transferred to another facility and he/she assumed the issue was resolved since it was a one-time occurrence. Interview with the Administrator on 4/22/25 at 4:40 PM identified that she was aware there were issues related to possible smoking within the facility by residents. The Administrator identified that the facility did not allow smoking within the building, it had been brought to her attention that staff members reported smelling smoke. The Administrator identified that if she was notified of a smell of smoke, facility staff would obtain consent from the resident to conduct a room search. The Administrator identified she had not actually seen or had solid evidence that any smoking occurred within the building or in the residents' bathrooms. The Administrator identified that when a staff member reported to management or nursing supervisors that a resident was observed smoking, smelling of marijuana, or cigarettes, the protocol included the Administrator and facility staff observing for smoke, the smell of smoke, and or smoking material. The Administrator also identified that she would also ask the resident in question if they had been smoking, if they would consent to a room search, and if they would empty their pockets to determine if the resident had smoking materials on their person. The Administrator also identified that if smoking materials were found she would confiscate those materials and lock them in her office. The Administrator identified that in addition to room searches, the facility staff discuss the incident with the resident and provided education. The Administrator identified the facility did not complete any A&I documentation outside of what was documented on the room search forms including what was discovered during the room search. The Administrator identified she did not believe there were any other documents related to Resident #33 and the incidents related to smoking and/or smoking materials on 12/11/24, 12/12/24, 1/16/25, or 2/25/25. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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Touchpoints at Chestnut	171 Main St East Windsor, CT 06088

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/22/25 at 5:43 PM identified that she had received reports from facility staff that some residents of the facility smelled of smoke, including Resident #33. The DNS identified that when these issues were reported to her, she would speak to the resident in question and ask if they had been smoking within the building, which the DNS identified all residents had denied doing. The DNS also identified that while she did speak with the residents and had reports regarding the smell of smoke within the building, she did not document anything related to the reports or any part of her investigation. The DNS identified she had also been notified by a nursing supervisor to report the smell of marijuana from residents within the facility on the 3:00 PM to 11:00 PM shift. The DNS identified when she has received these reports, she directed the nursing supervisors to speak with the resident and on occasion also conduct a room search. The DNS identified the facility did not complete any A&I documentation related to these incidents. The DNS was unable to identify any additional information regarding these incidents. The DNS also identified that she was notified of an incident with Resident #33 on 12/11/24 related to the smell of smoke and subsequently found a smoking pipe. The DNS identified that the pipe was placed in her office, but she was out of the country at the time of the incident. The DNS identified that she was only notified of the smell of smoke but was not notified that Resident #33 was found smoking anywhere in the facility. The DNS identified there was no A&I reports or investigation completed for this incident. The DNS failed to provide any investigation into the incidents to ensure that all residents in the facility were safe. The DNS also identified that the interdisciplinary team discussed the issue related to marijuana use, and smoking by residents within the facility but identified that no determination was found and also identified she had not done as much as she could have. The DNS identified for Resident #33 she recalled placing him/her under 15 minute checks at one point however the DNS was unable to identify the incident that prompted the checks including the date or the duration that Resident #33 remained on 15 minute checks. Interview with MD #1 on 4/23/25 at 9:36 AM identified he was not aware of any incidents involving Resident #33 and use of marijuana within or outside of the facility until 4/23/25. MD #1 identified he was not notified of any other incidents involving Resident #33 on 12/11/24, 12/12/25, 1/16/25, or 2/25/25. MD #1 identified he would have expected to be notified regarding each incident related to Resident #33 if the facility suspected Resident #33 was smoking or using marijuana, as this would have impacted Resident #33's treatment including the administration of medications. MD#1 also identified that he would have expected a nursing assessment for each incident which the nurse or facility staff suspected Resident #33 of using marijuana, and he would also have assessed the resident himself if he had been notified of the incidents. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 4/23/25 at 4:20 PM identified that she conducted the room searches of Resident #33's room [ROOM NUMBER]/12/24, 12/17/24, and 2/25/25. SW #1 identified that she contacted Person #1 regarding each incident including the room searches however identified the facility policy was always to obtain consent from the resident, and that the facility would notify the resident representative, even if the resident representative was a conservator of person, after the room search was completed if the facility deemed there was a safety risk. SW #1 identified that following two smoking incidents on 12/11 and 12/12/24, she and a nurse at the facility conducted a room search on 12/12/24 and located marijuana and a small pocketknife in Resident #33's room. Following this initial search, SW #1 identified a second search was done on 12/17/24 however she was unable to identify what incident prompted the room search as the clinical record did not identify any event or incident. SW #1 identified she was unable to recall why a room search was conducted on 12/17/24 and identified it may have been due to a smoke odor. SW #1 identified that no room search was conducted related to the 1/16/25 incident and was unable to recall the specific events of the incident on that date, however, SW #1 identified that Resident #33 was asked to empty his/her pockets on that date and was found to have a lighter and possibly cigarettes however SW #1 could not recall exactly. SW #1 identified that due to Resident #33 possessing a lighter and cigarettes on that date, she reached out to Person #1 to notify him/her of the need to transfer Resident #33 to a more appropriate facility. SW #1 identified that due to an outbreak at the receiving facility, Resident #33 was not transferred as discussed with person number one in January of 2025. SW #1 identified a room search was conducted on 2/25/25 due to a smell of marijuana from a resident bathroom on that date. SW #1 also identified in morning report it was also discussed that Resident #33 may have had a pocketknife however no pocketknife was found during this room search. Subsequent to surveyor inquiry, Resident #33's care plan was revised on 4/23/25. The care plan identified that Resident #33 was at risk, as well as putting the facility at risk due to unauthorized use of smoking materials and devices. Interventions included constant observation, ensuring the medical provider was aware of the resident's choices, and review with the resident and resident representative regarding the facility smoking policy. Although requested, the facility failed to provide any documentation related to education provided to Resident #33 and/or Person #1 for the incidents on 12/11/24, 12/12/24, 1/16/25, or 2/25/25. The facility resident smoking policy directed that smoking evaluations would be done upon admission/readmission to the facility and after a significant change in resident status. The policy directed that smoking care plans with appropriate interventions would then be developed, reviewed quarterly as part of the care plan review process, and updated to reflect the resent current status. The policy also directed that smoking was not allowed within the facility or in other areas on the facility property that are not designated as smoking areas. The policy further directed that residents may smoke only in designated areas and at designated times under the supervision of a staff member, and residents were not allowed to possess lighters, matches, cigarettes, pipes or any smoking material. The policy further directed that in the event of a policy infringement, each resident's individual needs/capabilities would be considered to determine the most appropriate revision to the resident's plan of care, and failure to adhere to safety standards related to smoking may result in the resident being placed on increased level of supervision to ensure safety and issuance of an involuntary discharge/transfer notice if the resident's actions present a risk to the health, safety, and welfare of other residents of the facility and other interventions were not successful. 3. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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Touchpoints at Chestnut	171 Main St East Windsor, CT 06088

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33 was admitted to the facility on [DATE] with diagnoses that included disorders of the lung, repeated falls, and difficulty in walking. The admission MDS dated [DATE] identified Resident #33 had no current tobacco use. The quarterly MDS dated [DATE] identified Resident #33 had moderately impaired cognition, was independent with sitting to standing, required assistance prior or following ambulating 150 feet, and required a wheelchair for a mobility device. The care plan dated 1/14/25 identified Resident #33 had documented safety concerns. Interventions included initiating safety measures including strategies to reduce the risk of infection, falls, and injury, as appropriate. The care plan failed to identify revisions reflecting Resident #33 having smoking contraband in his/her possession. The Resident Room Search document dated 2/25/25 at 11:30 AM identified that there was a smell of marijuana in Resident #33's bathroom, and a pipe was identified underside/beneath furniture. Although requested an A&I for the 2/25/25 room search was not available. Interview with LPN #15 on 4/22/25 at 12:09 PM identified that there has been an on-going problem with residents smoking marijuana inside the facility. LPN #15 indicated that last week she entered Resident #33's room and observed him/her smoking weed in his/her room; LPN #15 asked Resident #33 if anyone had spoken to him/her about not smoking marijuana in the facility, Resident #33 replied, everyone is smoking here. LPN #15 indicated that she did not report this incident because the problem had been happening for so long and multiple staff members, including herself, have reported it and nothing had been done. LPN #15 further indicated that while she could not recall the exact date, recently, she observed Residents #23 and 28 smoking weed in the dining room and she reported the incident to the RN Supervisor (RN #9). LPN #15 further indicated that when RN #9 walked through the dining room, he didn't see anything, but LPN #15 was sure of what she saw. LPN #15 identified that she had concerns over resident safety, if there was ever a fire. Interview with RN #9 on 4/22/25 at 1:07 PM identified that while reports of the smell of marijuana have been brought to his attention, each time he would try to identify which room it was coming from, but he had never been able to identify which resident(s) were smoking because he could not identify where the smell was coming from or observed anyone smoking marijuana or cigarettes in the facility. RN #9 further indicated that it was not reported to him that Residents #23 and 28 were observed smoking in the dining room. RN #9 further indicated that if it was brought to his attention that a resident was smoking in the facility, he would report it to the DNS and begin an investigation. RN #9 identified that to the best of his recall there have been no reports of active cigarette or marijuana smoking in the facility brought to his attention, with the exception of a reported incident that happened over a year ago, and the product was removed from the resident's possession and management was aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 4/22/25 at 4:40 PM identified that smoking inside of the facility is prohibited, and while it has been brought to her attention that there have been smells of smoking in the bathroom, there has been no solid evidence of resident's smoking in the facility, nor has she physically seen anyone smoking in the facility, with the exception of the an allegation of smelling marijuana back in 2024, which resulted in room searches. The Administrator indicated that she would expect any staff members that have observed smoking in the facility to report the incident to a supervisor, the DNS, or Administrator immediately. Interview with the DNS on 4/22/25 at 5:43 PM identified that it has been reported to her that individuals, including Resident #33, have smelled like marijuana smoke; when she has spoken to the individuals, they have all denied it, and it has not been brought to her attention that individual residents were observed smoking inside of the facility. On 4/23/25 at 6:30 AM the Administrator notified the survey team leader and survey team that she needed to have a meeting with the team leader about an incident that occurred on 4/22/25. Interview with the Administrator, DNS, the Chief Nursing Officer (RN #4), Regional Nurse (RN #6), and survey team leader on 4/23/25 at 6:31 AM, the Administrator identified that on 4/22/25, the management team conducted a meeting with the 3-11 PM staff, in the dining room around 8:00 PM, and at the completion of the meeting she and the DNS closed and locked the dining room windows and the front door had been secured around 6:00 PM. The Administrator indicated that she received a call from the RN Supervisor (RN #7), around 9:45 PM that she had observed Resident #33 smoking marijuana on the front porch of the facility. Resident #33 indicated that he/she went out the dining room window. Resident #33 denied having any other smoking contraband. The Administrator further indicated that RN #7 escorted Resident #33 back to his/her room, notified the Administrator of the incident, and a staff member remained with him/her until the Administrator arrived (around 9:50 PM - 10:00 PM). The Administrator identified that when she arrived in Resident #33's room, the RN Supervisor and Charge Nurse were in the room, and asked Resident #33 to give her any smoking materials; Resident #33 replied with profanity, but did verbally agree to a room search. The Administrator indicated that she and RN #7 looked through the room, and a lighter was located in the closet inside of a dirty sock. Resident #33 stood up to empty his/her pockets and there was nothing in the pockets, but when he/she stood up 3 plastic tubes (1 containing brown rolled paper, burnt on one end, containing a leafy substance with the odor of marijuana, and 2 containing brown rolled papers, not burned, containing a leafy substance with the odor of marijuana) and a white lighter were identified and removed from inside the wheelchair cushion. The Administrator indicated that Resident #33 laughed and stated, go ahead, I don't know how it got there. The Administrator indicated that no other smoking contraband was identified during the room search, Resident #33's responsible party and the Medical Director were notified, and Resident #33 was placed on a 1:1 observation. The DNS further indicated that Resident #33 would remain a 1:1 observation until the facility could develop a care plan, in collaboration with his/her responsible party; additionally, the facility would notify the Consultant Pharmacist to review any potential medication reactions with marijuana and reach out to the state agency and Long-Term Care Ombudsman for directives. (continued on next page)

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	04/24/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's video footage on 4/23/25 at 9:51 AM with RN #4 and the Team Leader identified Resident #33 standing in front of the window with his/her back to the window facing the parking lot and then sat down on a chair on the front porch of the building at 8:48 PM, with a smoking substance. At 8:50 PM a facility staff member (NA #3) entered the facility through the front door, and Resident #33 then re-entered the facility through the dining room window (the window was set approximately 3-4 inches off the ground and was opened from the bottom up), closed and locked the window, and seated him/herself into a wheelchair. Interview with the DNS on 4/23/25 at 4:57 PM identified that she was shocked to learn that Resident #33 had been smoking marijuana on the front porch of the facility and was not aware of any other incidents like this prior. The DNS indicated that Resident #33 should not have been in possession of marijuana or any smoking contraband, while in the facility, and now that management has been made aware an improvement plan was being developed. Interview with the 3-11 PM RN Supervisor (RN #7) on 4/23/25 at 7:36 PM identified that she was notified by NA #3, at approximately 9:00 PM, that Resident #33 had been observed smoking marijuana on the front porch. RN #7 indicated that by the time she got to the front porch, Resident #33 had already come back inside through the dining room window, but she could still see smoke in the air and a heavy-heavy odor of marijuana was in the

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	075436	A. Building B. Wing	04/24/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #1) reviewed for nutrition, the facility failed to ensure that the resident's nutritional status and weights were monitored after a significant weight loss was identified. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included epilepsy, gastrostomy, and dysphagia. The admission nursing assessment dated [DATE] identified Resident #1 had an admission weight of 173.6 lbs. The physician's order dated 12/30/24 directed to administer Enteral Nutrition 1.2% at 47 ml per hour for 24 hours via pump per gastrotomy tube (G-tube) around the clock. The admission MDS dated [DATE] identified Resident #1 had intact cognition, was always incontinent of bowel and bladder and was dependent on staff to assist with bathing, toileting, and transfers. The care plan dated 1/6/25 identified Resident #1 had a nutritional problem related to GI issues and refusal of tube feedings. Interventions included to obtain weights as ordered and monitor/record/report to the physician as needed signs/symptoms of malnutrition including muscle wasting. emaciation, and significant weight loss (3lbs. in one week, >5% in one month, >7.5% in 3 months, >10 % in 6 months). A nutrition note dated 1/9/25 at 1:48 PM by Dietitian #2 identified that Resident #1 weighed 164.2 lbs., which was a significant weight loss of 9.4 lbs. or 5.4% over one 1 week. Dietitian #1 identified that Resident #1 had a poor oral intake between 0 - 25% with most meals and that Resident #1 had refused tube feeding since admission. Dietitian #2 identified she would start Ensure 240cc three times daily and request a consult for an appetite stimulant. (Review of the clinical record failed to reflect the appetite stimulant had been started). A physician's note by MD #1 on 1/28/25 identified that Resident #1 had an admission weight of 173 lbs. and a re-weight on 1/9/25 was 164 lbs. MD #1 identified that the weight may not be accurate as it did clinically not appear to correlate. MD #1 identified that Resident #1 was tolerating oral intake, but he would still like to continue tube feeding for the next 2-3 months to ensure that Resident #1 continued to gain weight. Review of the clinical record failed to identify any additional nutritional assessments or weight monitoring of Resident #1 in January 2025 following the identified significant weight loss on 1/9/25. Review of the clinical record identified Resident #1 was hospitalized from [DATE] - 2/26/25 for stroke symptoms and pulmonary edema. Review of the clinical record failed to identify any readmission weight obtained for Resident #1 upon re-admission to the facility on 2/26/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record identified there were no weights obtained or additional nutritional assessments in February 2025. A physician's order dated 2/28/25 directed to obtain Resident #1's weight on admission and then weekly for 4 weeks beginning on 3/1/25. Review of the clinical record identified Resident #1 weighed 152.6 lbs. on 3/1/25, a 21 lb. or 12.1% loss since admission on [DATE], and a 11.6 lb. or 7.06% loss since 1/9/25. A quarterly nutritional assessment note dated 3/3/25 by Dietitian #3 identified Resident #1 was recently hospitalized and was noted to have a 20 lb. weight loss over 2 months, with a current weight of 153 lbs. The note further identified that Resident #1 was previously on tube feedings and was changed to a carb controlled therapeutic diet. The note identified the nutritional plan included continue Ensure 3 times a day for an additional 660 calories, continue to monitor weights, monitor intake, encourage supplement intake, and encourage fluid intake at and between meals. Review of the clinical record failed to identify any additional nutritional interventions or changes to Resident #1's treatment plan following the 2nd identified significant weight loss on 3/1/25. Review of Resident #1 care plan failed to identify revisions or any additional interventions following the significant weight loss on 3/1/25. Review of the clinical record failed to identify any additional weights for Resident #1 for 3/2025. Interview with the Dietary Director on 4/21/25 at 7:29 AM identified she did not believe the facility had a current dietitian on staff. The Dietary Director identified that there were two dietitians covering the facility at the beginning of the year, however she is unsure when the last dietitian left and did not believe a new dietitian had been hired. Interview with Resident #1 on 4/21/25 at 10:44 AM identified he/she had multiple issues with weight monitoring. Resident #1 identified he/she did not feel that the facility was monitoring his/her weight appropriately, and that during a PT session the week prior, he/she requested the PT #1 assist him/her onto a scale to check his/her weight. Resident #1 identified that the weight was 156 lbs. which would have been a 6 lb. loss from his/her previous weight a week prior. Resident #1 identified he/she had a G-tube previously in place that dislodged during a transfer from his/her bed to a wheelchair for a shower in February. Resident #1 identified that since he/she had previously requested the G-tube be removed and since Resident #1 had been eating by mouth, the G-tube was not replaced. Resident #1 reported that while he/she was able to eat by mouth, he/she had issues with nausea and at times was unable to eat at all. Interview and review of the unit weight worksheets with LPN #2 on 4/23/24 at 3PM identified that, subsequent to surveyor inquiry, she entered a weight of 158.4 lbs. for Resident #1 on 4/17/25, a 4 lb. or 2. 46% loss from 5 days prior. LPN #2 identified that she did not believe that the facility currently had a dietitian to address any weight issues. LPN #2 identified that the facility administration had not notified the nursing staff regarding if there was a dietitian in place, however, LPN #2 identified that for the last two months, diet slips for newly admitted residents and diet change forms were not being signed off by the dietitian. LPN #2 also identified she is not sure of the exact date when the last dietitian was in the building. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following interviews and clinical record review, a request was made to the Administrator on 4/24/25 to provide the names along with dates of coverage and hours of coverage per week for all facility dietitians beginning 1/2025. Review of the facility documentation of dietitian coverage identified the following: Dietitian #2 provided coverage to the facility from 1/1/25 - 1/31/2025 and was in the building 8 hours per week. Dietitian #3 provided coverage to the facility from 2/1/25 - 4/20/2025 and was in the building 8 hours per week. Dietitian #1 provided coverage to the facility beginning 4/20/2025 and in the building 8 hours per week. Interview with Dietitian #1 on 4/24/25 at 10:04 AM identified she was notified on 4/20/25 she was going to be assigned to cover the facility starting on that date. Dietitian #1 identified that 4/24/25 was her first day physically in the building and reviewing nutritional information for the facility residents. Dietitian #1 identified that she was aware Resident #1 had an identified weight loss on 1/9/25 and again on 3/3/25. Dietitian #1 identified that while the facility did not have set criteria on weight monitoring, she would have expected a reweight within a month of the interventions put in place on 1/9/25 to evaluate for efficacy. Dietitian #1 also identified she would have expected Resident #1 to have weekly weights following the 2nd identified weight loss on 3/1/25 as well as additional interventions including increasing supplementation. Dietitian #1 identified she was not aware of which dieticians were covering the building or when they covered prior to her being assigned. Interview with Dietitian #2 on 4/24/25 at 10:36 AM identified that she covered the facility from 1/1/25 - 1/23/25 and for one day on 1/30/25. Dietitian #2 identified that during this time frame she was covering 3 facilities. Dietitian #2 identified that she did work on 1/23/25 but was covering all three facilities on that date and was physically in the facility one last day on 1/30/25 to try to catch up previous work. Dietitian #2 identified she remembered Resident #1 and initiating supplements but did not cover the facility long enough to follow up to ensure the nutritional supplements were working. Dietitian #2 identified Resident #1 should have had weekly weights following the identified weight loss on 1/9/25 and should have had nutritional follow up in February 2025 to determine if the supplements were working. Dietitian #2 identified she was not aware who provided coverage to the facility after she left. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Dietitian #3 on 4/24/25 at 10:46 AM identified she provided coverage to the facility beginning on 2/17/25 and ending on 4/10/25. Dietitian #3 identified that she was located out of state and provided full time coverage for another facility within the same corporation. Dietitian #3 identified she was notified on 2/17/25 that 2 facilities located in a different state required temporary dietitian coverage while those facilities attempted to hire permanent staff. Dietitian #3 identified that the coverage she provided was remote due to the distance and she worked roughly 8 to 10 hours per week in remote coverage. Dietitian #3 identified she was only physically in the facility twice, on 2/18/25 and on 4/10/25. Dietitian #3 identified she never met or spoke to Resident #1 and all recommendations were based on record review only. Dietitian #3 identified she did remember Resident #1 had a history of noncompliance but could not recall if it was related to supplementation or meals. Dietitian #3 also identified she did not add any additional interventions following the identified weight loss on 3/1/25 based on previous multiple interventions being tried based on her recollection of the clinical record. Dietitian #3 also identified due to working remotely she was unable to conduct a comprehensive nutritional assessment on Resident #1, and if she had been able to physically be in the facility and conduct in person nutritional assessments, she would have been able to track down weights for Resident #1 and develop a more comprehensive nutritional plan. Dietitian #3 identified interventions that she may have tried including fortified foods, alternate nutrition, and updating meal preferences. Dietitian #3 identified due to providing nutritional services remotely, none of these interventions were initiated or implemented. Dietitian #3 identified that she was notified on 4/10/25 that she would no longer be covering the facility effective that date. Dietitian #3 identified she was unaware of who provided coverage after she left. Interview with the Corporate Chief Operations Officer (COO) on 4/24 25 at 11:04 AM identified that the information provided by the Administrator related to dietitian coverage was correct and accurate. The corporate COO identified coverage provided by Dietitian #2 and Dietitian #3 were supposed to be in person but identified there were issues. The Corporate COO failed to elaborate any further related to physical coverage by a dietitian in the facility. Interview with MD #1 on 4/24/25 at 11:44 AM identified Resident #1 should have had weight monitoring and nutritional assessments by the facility dietitian to determine the resident's nutritional needs. MD #1 identified he was not aware of the issues with the dietitian coverage for the facility and he was also not aware that Resident #1 did not have a reweight done following the identified weight loss on 1/9/25 until 3/1/25, when Resident #1 had an additional identified weight loss. MD #1 identified that Resident #1 weights should have been monitored at least every other week based on his/her history of weight loss on 1/9/25. MD #1 also identified any resident with issues related to intake and weight loss should have weights obtained at least every one to two weeks. Interview with the DNS on 4/24/25 at 12:00 PM identified that all residents were to be weighed upon admission and monthly. The DNS also identified that any resident that required additional weight monitoring typically had an order placed by the physician or APRN. The DNS also identified that any residents who have been identified with the significant weight loss should be followed by the Dietitian and have an RN assessment along with the physician being notified. The DNS identified that at the minimum, Resident #1 should have had admission weights and monthly weights per the facility policy. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on weight directed that weights would be obtained for all residents on admission and at least monthly, which would be done before the last day of each month. The policy further directed that the frequency of weights would be determined by the interdisciplinary team post admission based on the resident's individual needs. The policy also directed that residents with a weight variance of 5% or more than the previous month would be reweighed, and the charge nurse would notify the dietitian when a 5% or more or less variance was noted in a resident's weight. The policy identified that the facilities registered dietitian would review the resident weight and make recommendations accordingly and with a significant weight fluctuation of 5% or more or less, the resident would be weighed based on the determination of the interdisciplinary team. The policy also directed that the physician and responsible party would be notified with a significant weight fluctuation of 5% more or less and the resident's plan of care would be updated.

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	075436	A. Building B. Wing	04/24/2025

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #33) reviewed for accidents, the facility failed to ensure that Level II Preadmission Screening and Resident Review (PASARR) recommendations were implemented for a resident with an identified substance abuse disorder. The findings include: Resident #33 was admitted to the facility on [DATE] with diagnoses that included alcohol dependence, repeated falls, and anxiety disorder. Review of the hospital W-10 dated 10/8/24 identified Resident #33 was hospitalized from [DATE] - 10/8/24 related to alcohol withdrawal. A clinical admission assessment dated [DATE] identified Resident #33's smoking status as not assessed upon admission to the facility. Review of the clinical record failed to identify any smoking assessments completed for Resident #33's after admission to the facility on [DATE]. A physician's order dated 10/8/24 directed supervised smoking per facility policy. The care plan dated 10/8/24 identified Resident #33 had documented safety concerns. Interventions included performing safety risk evaluations upon admission, as needed, and with changes in condition. The admission MDS dated [DATE] identified Resident #33 had severely impaired cognition, was frequently incontinent of bowel and bladder and required moderate assistance from staff with toileting, dressing, and transfers. The MDS also identified that Resident #33 did not have any current tobacco use. An APRN note dated 10/21/2024 identified Resident #33 had a history of alcohol dependency including drinking more than 6 nip bottles a day and smoking marijuana. The note also identified Resident #33 was treated for alcohol withdrawal during his/her hospitalization. A Level II PASARR dated 11/15/24 identified that Resident #33 had diagnoses that included anxiety disorder, alcohol use disorder, and adjustment disorder. The PASARR identified that Resident #33 would need services and support to be provided, including a support group for recovery from substance abuse (Alcoholics Anonymous), group therapy with a therapist trained in group work, and a guardian conservator for decisions related to health and safety. A care plan dated 11/15/24 identified that Resident #33 had PASARR recommendations for specific services. Interventions included that Resident #33 would be provided with a support group for recovery from substance abuse and group therapy with the therapist trained in group work. Review of the clinical record identified that Person #1, Resident #33's resident representative, was appointed Resident #33's conservator of person/estate effective 11/21/2024. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 12/11/2024 at 11:53 PM identified that nursing staff arrive to the residents room at 11:20 PM due to the smell of weed. The note further identified that upon arrival to Resident #33's room, he/she initially denied smoking. The note further identified upon the start of a room search; Resident #33 provided a black velvet drawstring bag which Resident #33 opened. The note identified that within the bag there was a lighter and a smoking apparatus, which was locked in the DNS office. A nurse's note dated 12/12/24 at 7:53 AM identified that Resident #33 was observed locked inside a facility bathroom smoking. The note further identified that the nursing supervisor was notified and went to speak with Resident #33. A resident room search form dated 12/12/2024 at 10:52 AM identified a room search conducted by SW #1. The form further identified the room search findings included locating marijuana within Resident #33 bed and bedding, and small portions of marijuana located within a boot inside Resident #33's closet. A 12/12/24 social work note by SW#1 identified Resident #33 had a room search conducted on that date and was found to have pocketknife, in addition to the marijuana noted on the 12/12/24 room search form. A social work note dated 1/16/2025 at 4:06 PM by SW #1 identified that Resident #33 had violated the facility smoking policy and the hazardous and precautionary policy. The note further identified that Person #1 was contacted to discuss discharge planning for Resident #33. A social work note dated 2/25/2025 at 3:48 PM by SW #1 identified Resident #33 had a room search and a smoking pipe was found within Resident #33's room. The note identified the pipe was confiscated and given to the Administrator. The note also identified that Resident #33's family was notified and that Resident #33 would be placed on 15 minute checks. A resident room search form dated 2/25/25 at 11:30 AM identified a room search was conducted on Resident #33's room due to the smell of marijuana in the residents bathroom. The room searched further identified that a pipe was found beneath furniture located within Resident #33's room and no other materials were found in Resident #33's room or the bathroom. Interview with SW #1 and the Corporate Director of Behavior Programs on 4/24/25 at 9:30 AM identified that SW#1 was not aware Resident #33 had actively abused alcohol or used marijuana prior to admission to the facility on [DATE]. SW #1 identified that while she was aware Resident #33 had a Level II PASARR which identified Resident #33 required support services including a group for recovery from substance abuse and group therapy with the therapist trained in group work, however the facility did not offer any kind of group counseling or substance abuse support programs. SW #1 identified that there was a discussion of bringing these kinds of programs to the facility at one point in the past, but she was unable to identify when and why the programs were not put into place. The Corporate Director of Behavior Programs identified that Resident #33 would benefit from the supportive services identified in the Level II PASARR that specifically addressed substance abuse. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on the pre-admission screening and resident review for Connecticut directed that facility staff would follow procedures for the screening, authorization verification, change reporting, and recommendation follow up as required of the Ascend Maximus assessment pro PASARR screening and report system. The policy further directed for any level II outcome that included recommendations for services to be provided to the resident, the social work staff would have the responsibility to ensure that recommendations were made available to the resident's interdisciplinary team.

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	075436	A. Building B. Wing	04/24/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 3 of 5 residents (Resident #1, 31, and 32) reviewed for unnecessary medications, the facility failed to ensure the physician acted upon pharmacy recommendations in a timely manner. The findings include: 1. Resident #1 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included diabetes, systemic lupus, stroke, epilepsy, gastrostomy, and dysphasia. A physician order dated 12/30/24 identified Resident #1 was NPO (nothing by mouth) and required tube feeding 1.2 at 47 ml per hour for 24 hours and 45 ml of water per hour using a dual system device. A physician order dated 12/30/24 directed for Lovenox 40 MG per 0.4 ML inject 1 syringe subcutaneously daily for DVT prophylaxis, Gabapentin 100 MG give 1 capsule via G-Tube 3 times a day for neuropathy, and fingerstick blood sugar's 3 times a day for diabetes. The admission MDS dated [DATE] identified Resident #1 had intact cognition and required total assistance oral hygiene, toileting, dressing, personal hygiene, rolling side to side and sitting up. Additionally, Resident #1 had no behaviors. Resident #1 was admitted with a feeding tube and while a resident with no therapeutic or mechanically altered diet. Resident #1 was receiving antipsychotic, antianxiety, antidepressant, anticoagulant, diuretic, antiplatelet, and hypoglycemic, and anticonvulsant medications. The care plan dated 2/4/25 identified Resident #1 was at risk for impaired swallowing related to a stroke. Interventions included to provide an NDD2 (chopped, soft, and moist foods) consistency diet as ordered with moist bakery and resident is to sit upright position in/out of bed when swallowing food or drink. a. The pharmacy consultant admission medication regimen review dated 1/2/24 at 9:57 AM identified the following recommendations. Resident #1 was currently receiving Lovenox for a DVT prophylaxis without an intended stop date. Please evaluate and add a stop date now, if appropriate. Resident #1 is receiving Gabapentin 100 mg capsule via g tube 3 times a day. Consider switching to Gabapentin oral solution 50mg per ml for greater easy with administration. Resident #1 currently gets routine fingerstick blood sugars checks. Please consider adding an order to notify physician if the results are less than 70 and greater than 300. (continued on next page)

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	04/24/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted on Seroquel with no clear diagnosis to support use. Please consider a psychosocial workup along with performing a medical workup as soon as possible to assess for underlying causes of behaviors or identification of a chronic psychiatric condition, please consider implementing a tapering schedule and/or discontinue. Resident #1 admitted on Seroquel please consider adding orthostatic blood pressure monitoring once weekly for 4 weeks, lying, standing, and sitting and notify the physician if systolic changes greater than 20 mm Hg or diastolic changes greater than 10 mm Hg. b. The pharmacy consultant medication regimen review dated 2/13/24 at 10:31 AM identified all the same recommendations made on 1/2/25. Further, recommendations included Resident #1 was currently receiving Carbamazepine and unable to locate recent serum level in chart. Recommend a carbamazepine level at initiation of therapy and every 6 months to ensure continuous monitoring. c. The pharmacy consultant medication regimen review dated 2/27/24 at 10:31 AM identified the following recommendations. Resident #1 currently has an order for both Hydromorphone 2 mg as needed for severe pain and Tramadol 50 mg as needed for severe pain. Please reevaluate the need for 2 medications in the same drug class. Consider discontinue one order to avoid adverse effects. The resident is currently receiving Lovenox for DVT prophylaxis without an intended stop date. Please evaluate and add a stop date. (recommended on 1/2/25 and 2/13/25) The resident currently has an active order for Aspirin with a listed allergy to Aspirin. Please reevaluate accuracy of allergy list. Consider discontinuing the Aspirin or updating the allergy list. d. The pharmacy consultant admission medication regimen review dated 4/11/25 at 9:45 AM identified the following recommendations. Resident #1 was receiving Lipitor for dyslipidemia. Unable to locate recent serum lipid profile in the chart. Recommend 3 months after starting and then annually thereafter. Review of the pharmacy recommendations dated 1/2/25, 2/13/25 and the 2/27/25 failed to indicate that the physician/APRN had responded to or acted upon them. The interview with Pharmacist #1 on 4/23/25 at 8:20 AM indicated that the pharmacy recommendations are expected to be followed up by the APRN or physician per the policy within 7 - 14 days but no later than a month from the date on the form. Pharmacist #1 indicated that the APRN or physician is expected to identify if they agree or disagree with each recommendation by checking the appropriate box and then sign and date the form. Pharmacy #1 indicated that if the APRN or physician disagrees with a recommendation the provider needs to write a note explaining why they do not agree with the recommendation. Pharmacist #1 indicated the pharmacy recommended to change the Gabapentin from a capsule to a liquid for the use in a g-tube for administration and change Omeprazole from a capsule to a dissolvable tablet for easier administration and since there is a dissolvable form it would help to prevent clogging of the tube; it is less risky. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DNS on 4/23/25 at 9:00 AM indicated that the pharmacy consultant comes and reviews the residents' charts and makes recommendations on admission and monthly. The DNS indicated that she and the ADNS receive the recommendations via email from the pharmacist, and she prints out one copy. The DNS indicated that if it is a nursing recommendation that she or the ADNS will make corrections to the EMR but if it is for the physician, APRN's, or psychiatric group she will place the printed recommendation in their folder at the nurse's stations for them to review, agree or disagree, and sign and date. The DNS indicated the APRN or physician will give it to the ADNS to put in the changes for new orders. The DNS indicated once the physician or APRN address the pharmacy recommendations it would go to medical records to scan into the resident's EMR. The DNS indicated that she does not make a second copy to follow up and make sure all recommendations were followed up on. After reviewing the pharmacy recommendation forms dated 1/2/25, 2/13/25 and the 2/27/25 the DNS recommendations were not responded to by the physician or APRN. Interview with the ADNS on 4/23/25 at 9:10 AM indicated that sometimes the APRN or physician will give her the pharmacy recommendation forms once completed but she knows she does not receive them all back. The ADNS indicated that the Optum APRN sometimes will change their own orders. Interview with APRN #2 on 4/23/25 at 9:24 AM indicated she only started here in February 2025. APRN #2 indicated she receives the pharmacy recommendations in her folder and sometimes are handed to her for review. APRN #2 indicated that she must check off as agreeing or disagreeing with the recommendation, sign and date the form. APRN #2 indicated that if she disagrees with a recommendation, she must write a note as to why she does not agree and will not make the changes. APRN #2 indicated that sometimes she will change the order herself in the EMR if it is a simple order and sometimes gives the form to the ADNS or DNS if changing the order is complicated. Interview with MD #1 on 4/23/25 at 9:28 AM indicated that pharmacy recommendations are put in his binder at the nurse's station, and he checks it every other day and he signs them. MD #1 indicated when he receives a pharmacy recommendation for a resident, he must check off if he agrees or disagrees with the recommendation. MD #1 indicated that if he disagrees, he must write a note explaining why he disagrees and he writes it directly on the pharmacy recommendation form not necessarily in his progress note. MD #1 indicates that he would agree to change to the liquid form of a medication for a resident with a feeding tube if that was pharmacy's recommendation. MD #1 indicated that Resident #1 was on tube feeding for nutrition. MD #1 indicated he would agree with having parameters for fingersticks less than 70 greater than 300 to call the physician. MD #1 indicated the labs are usually done and the pharmacist doesn't see them so he will write on the form to notify the alert the pharmacist when the labs were done. 2. Resident #31 was admitted to the facility in September 2024 with diagnoses that included stroke, diabetes, and heart failure, hypertension, atrial flutter, cardiomyopathy, congestive heart failure, venous insufficiency, COPD, chronic embolism and thrombosis. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS dated [DATE] identified Resident #31 identified short term and long-term memory were okay and Resident #31 was independent with cognitive skills for daily decision making. Resident #31 had no hallucinations or delusions. Resident #31 exhibited rejection of care, and it occurred 1-3 days, but no other behaviors. Resident #31 required minimal assistance with personal hygiene and dressing and required touching assistance or supervision for toileting. The care plan dated 2/20/25 identified Resident #31 has diabetes. Interventions included receiving diabetes medication as ordered by the physician and educate Resident #31 regarding medications and importance of compliance. Review of the clinical record from 3/1/25 to 4/24/25 did not reflect the AIMS or lipid profile lab were completed. A physician's order dated 3/7/25 directed to administer Risperidone 1 mg once in the evening for behavioral disturbances related to depression. The pharmacy note dated 3/12/25 at 10:29 AM indicated that the medication regimen review was completed, and recommendations were made to the physician. a. Pharmacy recommendation dated 3/12/25 indicated Resident #31 was recently started on Risperidone. Please add an order for orthostatic blood pressures monitoring once a week for 4 weeks, lying, standing, and sitting and notify the physician for systolic changes greater than 20mm Hg and/or diastolic changes greater than 10mm Hg. Resident #31 was recently started on antipsychotic drug therapy, Baseline AIMS (Abnormal Involuntary Motion Scale) test recommended after initiation of therapy and every six months thereafter to assess the potential development and progression of side effects. b. Pharmacy recommendation dated 4/11/25 indicated Resident #31 is receiving Lipitor for dyslipidemia. Unable to locate a recent serum lipid profile in the chart. Recommend 3 months after starting then annually thereafter. Interview with RN #10 (Regional MDS nurse) on 4/24/25 at 6:28 AM indicated that she had reviewed all of Resident #31's medical record and there were no AIMS completed between 3/7/25 to today and she could not find a lipid profile lab in the clinical record since admission. Additionally, RN #10 indicated that the pharmacy recommendations dated 3/12/25 were not reviewed, signed, or dated by the APRN or physician. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Pharmacist #1 on 4/23/25 at 8:20 AM indicated that she is a supervisor, and she reviews all admission and readmission residents to facility's medications and another pharmacist goes to the facility monthly to do the monthly reviews. Pharmacist #1 indicated that the pharmacy recommendations are expected to be followed up by the APRN or physician per the policy within 7 - 14 days but no later than a month from the date on the form from the review. Pharmacist #1 indicated that the APRN or physician is expected to check that they agree or disagree in the box with each recommendation and then sign and date the form. Pharmacy #1 indicated that if the APRN or physician disagrees with a recommendation the provider needs to write a note explaining why they do not agree with the recommendation. The interview with the DNS on 4/23/25 at 12:54 PM indicated that her expectation was the physician or APRN would review the pharmacy recommendation and check off the box to agree or disagree with the recommendation then give the forms to the ADNS to input the orders into the resident's EMR. After clinical record review, the DNS indicated that she did not see that the pharmacy recommendation dated 3/12/25 was completed and the form was not signed off by the provider. An interview with RN #10 on 4/24/25 at 10:20 AM indicated that she did not find the lab for Depakote level in the last year and did not find the AIMS completed when resident was started on Risperidone or the lipid profile per the pharmacy recommendations. Interview with the APRN #3 (psychiatric APRN) on 4/24/25 at 10:24 AM indicated that when a resident is started on an antipsychotic like Risperidone the expectation was that an AIMS would be done initially than every 6 months. After clinical record review, APRN #3 indicated that there wasn't an AIMS completed in Resident #31's medical record. APRN #3 indicated that she receives the pharmacy recommendations directly by the staff or she will get it from her communication book on the nursing units. APRN #3 indicated after she reviews the recommendations, she gives to the charge nurse on the unit to make changes in the medical record and about a month ago she started to make orders in the computer. APRN #3 indicated that she was responsible for Resident #31's pharmacy recommendation dated 3/12/25 but she did not see it before and she did not sign or date the form as required, nor has she seen the pharmacy recommendation dated 4/11/25 for her to order a Depakote level. APRN #3 indicated if she had seen the recommendations dated 3/12/25 and 4/11/25 she would have agreed with the recommendations and put the orders in place. Review of the Drug Regimen Review Monthly identified in accordance with federal regulations, the Consultant Pharmacist must review the medical record of each resident and perform a Drug Regimen Review at least once each calendar month. The Consultant Pharmacist shall identify, document and report possible medication irregularities for review and action by the attending physician, where appropriate. The attending physician or licensed designee shall respond to the Drug Regimen Review within 7-14 days or more promptly, whenever possible. Any identified irregularities of an urgent nature shall be communicated to the Director of Nursing and/or Nursing Supervisor for immediate notification and action of the attending physician or licensed designee. The facility Administrator, Director of Nursing, and Medical Director shall be notified of all findings. The Consultant Pharmacist will provide written documentation of all recommendations and submit monthly to the physician to review and respond. The written documentation and physicians' response shall be considered a permanent part of each resident's medical record. The physician shall act upon the Drug Regimen Review recommendations in a timely manner of 7-14 days or less. The physician shall document on the drug regimen review form whether he/she agrees or disagrees with the recommendations and provide a brief clinical rationale if no change is to be made. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #32 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, hyperlipidemia, and alcohol use. A physician's order dated 5/16/24 directed to administer Lurasidone HCL (Latuda) 40mg, give 1 tablet by mouth, once daily related to bipolar disorder. The quarterly MDS dated [DATE] identified Resident #32 had intact cognition and was taking medications from the following high-risk drug classes: antipsychotic, antidepressant, anticoagulant, diuretic, and antiplatelet. The care plan dated 2/19/25 identified Resident #32 used psychotropic medications related to bipolar and schizoaffective disorder. Interventions included administering psychotropic medications as ordered by the physician, monitoring side effects and effectiveness every shift, consulting with pharmacy, and educating the resident and family about risks, benefits, and side effects and/or toxic symptoms of psychotropic medications. The Consultant Pharmacist's Medication Regimen Review Psychoactive Medication Use Recommendations dated 2/13/25 identified Resident #32 was receiving Lurasidone HCL (Latuda) and was unable to locate a recent lipid profile (blood test that measures the amount of cholesterol and triglycerides in the blood) and HbA1C (blood test that measures the average blood glucose levels in the blood) in chart; recommended at start and then annually due to risk of diabetes and dyslipidemia with use. Please consider ordering. The recommendations were reviewed and agreed upon by the licensed prescriber on 2/17/25. Interview and clinical record review with Regional Clinical Director (RN #13) on 4/22/25 at 9:17 AM failed to identify documentation that a lipid profile had been completed for Resident #32; a HbA1C was completed on 3/11/25 (26 days after the Consultant Pharmacist's recommendation was made). Interview and clinical record review with the DNS on 4/23/25 at 5:10 AM identified that she would have expected Resident #32's lipid profile order to have been placed by the provider and the order to be completed by now. The DNS indicated that the Consultant Pharmacist's recommendation(s) are received by the DNS via email, and she gives the recommendation to the medical provider for review, once the recommendation is signed and returned it is up to the ADNS to ensure the order has been completed. The facility's Drug Regimen Review-Monthly policy directs the Consultant Pharmacist shall identify, document, and report possible medication irregularities for review and action by the attending physician where appropriate. The attending physician or licensed designee shall act upon the drug regimen review findings/recommendations in a timely manner of 7 to 14 days or less. The prescriber shall document on the drug regimen review form whether he/she agrees or disagrees with the recommendation and provide a brief clinical rationale if no change is to be made.

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	075436	A. Building B. Wing	04/24/2025

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each 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 2 residents (Resident #26 and 11) reviewed for dental services, the facility failed follow recommendations for an outside dental consultation. The findings include: 1. Resident #26 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, paraplegia, and cardiomegaly. A physician's order dated 7/27/24 directed for dental consults as needed. The quarterly MDS dated [DATE] identified Resident #26 had intact cognition, was always incontinent of bowel and bladder, required set up for meals, and was fully dependent on staff to assist with oral hygiene, bathing, and dressing. The care plan dated 10/10/24 identified Resident #26 had an ADL self-care performance deficit related to immobility. Interventions included to provide 1+ assist for personal hygiene/oral care. A dental group note dated 12/19/24 identified Resident #26 had observed decay at tooth #10 and teeth #8 - 9 were mobile on exam. The note identified Resident #26 requested to see an outside dental provider for treatment. The note also identified that action required by nursing home staff included appointment with an outside dentist for upper front teeth #8, #9, and #10. Interview with Resident #26 on 4/21/25 at 10:20 AM identified that he/she had not been scheduled for an appointment with an outside dentist for teeth #8, #9, and #10. Resident #26 identified he/she had outside dental work previously and it never took 4-5 months to get an appointment. Interview with Receptionist #1 on 4/23/25 at 2:30 PM identified that she was responsible for scheduling appointments and transportation for facility residents. Receptionist #1 identified that she had recently taken over dental specialty referrals beginning the end of 2024. Receptionist #1 identified that her understanding was that any consultations to outside providers referred by the dental provider were given to the DNS and once the DNS reviewed the form, Receptionist #1 identified was responsible to fill out an outside consult request form and fax the form to the outside specialty provider and place in the clinical record. Receptionist #1 identified that she was not instructed that those outside referrals also needed to be scheduled by her until 4/21/25. Receptionist #1 identified she had not been given any training previously on the dental provider referral forms but had been giving training on 4/21/25. Receptionist #1 identified going forward she would review all dental provider notes to determine if specialty referrals to outside providers were needed along with any appointment scheduling or transportation for facility residents. Subsequent to surveyor inquiry, Receptionist #1 identified on 4/23/24 at 2:54 PM that Resident #26 had a dental consult appointment scheduled with an outside dentist on 5/1/25 at 11:30 AM to address teeth #8-10. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/24/25 at 12 PM identified that the process for outside provider referrals included an email from an in-house dental provider (dental, podiatry, etc) to the DNS, Administrator, and Receptionist #1 to notify of the need for an outside provider for a facility resident. The DNS identified the previous process included Receptionist #1 providing the referral to the former ADNS for follow-up to ensure the referral was completed and the resident was scheduled for an appointment. The DNS identified that since the prior ADNS left, she was unsure how Receptionist #1 was handling the referrals and was unaware that outside provider referrals were not being scheduled. The facility policy on medical and professional services directed that the facility would ensure residents receive proper medical and professional services as outlined in the regulation to include vision hearing and dental care. The policy further directed that the facility would assist the resident in making appointments and arranging transportation to and from the practitioners specializing in the services outlined. 2. Resident #11 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM), need for assistance with personal care, and reduced mobility. The annual MDS dated [DATE] identified Resident #11 had intact cognition, was on a mechanically altered diet, and had obvious or likely cavity or broken natural teeth. The care plan dated 2/14/25 identified Resident #11 required staff assist for all ADLs. Interventions included staff set up to complete his/her own oral care. The care plan further identified that Resident #11 had a nutritional problem or potential nutritional problem related to DM, therapeutic/mechanically altered diet, obesity, and was at risk for weight gain due to medication side effects. Interventions included monitoring for signs and symptoms of hypo/hyper glycemia, aspiration, and diet tolerance. The Dental Group note dated 2/19/25 identified the following actions required by the nursing home staff: continue daily oral care and refer Resident #11 to oral surgeon for surgical extractions #8, 9, and 17 prior to denture fabrication. Observation and interview with Resident #11 on 4/21/25 at 2:35 PM identified that he/she had multiple unlevel, missing, and jagged teeth which he/she indicated limited places to chew. Resident #11 further indicated that he/she needs to have some teeth extracted but does not know where to go, and the facility had not made arrangements for the dental extractions. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Receptionist #1 on 4/23/25 at 2:32 PM identified that he/she had worked as the facility's receptionist since 2020 and recently began overseeing appointments and transportation. Receptionist #1 indicated that around the end of last year or beginning of this year was when he/she became responsible for overseeing scheduling follow-up appointments, prior to that it was the responsibility of DNS or ADNS. Receptionist #1 indicated that he/she was not fully trained and wasn't as clear as he/she should have been in the process. Receptionist #1 further indicated that on 4/21/25, the facility's Administrator had arranged for him/her to meet with a representative from the dental consulting service for additional education, and now he/she has a better understanding of her role in the process and how to better collaborate with the DNS or ADNS when scheduling follow-up appointments. Receptionist #1 identified that a follow-up dental appointment for Resident #11 had not yet been scheduled. Interview with the DNS on 4/23/25 at 5:01 PM identified that the process for scheduling follow-up appointments was different from the building that she had worked at prior. The DNS indicated that Receptionist #1 should be looking more closely at the consultant's recommendations and notifying the DNS or the ADNS when there needs to be a follow-up appointment scheduled. The DNS further indicated that a follow-up appointment from the dental consult dated 2/19/25 should have been scheduled by now. The Medical and Professional Services policy directs that the facility will ensure that residents receive proper medical and professional services as outlined in the regulation to include vision, hearing, podiatry, and dental care. The facility will assist the resident in making appointments and arranging transportation to and from the practitioner specializing in the services outlined above. Subsequent to surveyor inquiry Resident #11 was scheduled for a dental visit on 5/1/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, review of facility documentation, facility policy, and interviews, the facility failed to ensure that the kitchen's dry storage areas were maintained in a clean and sanitary manner; and failed to ensure that previously opened refrigerated items were labeled and dated; and failed to ensure that the sanitizing solution was maintained at the appropriate sanitizing levels; and failed to ensure that the high temperature dish machine rinse cycles maintained the appropriate temperatures; and failed to ensure that the temperature logs for sanitizing solution, dish machine, refrigerators, freezers, and resident meals were completed in their entirety and daily. The findings include: Observations and interview during an initial tour of the kitchen area on 4/21/25 at 7:29 AM with the Dietary Director identified the following. 1. Observation of the walk-in refrigerator identified two large packages of meat located on a tray on the bottom shelf of the refrigerator. The tan plastic tray identified a label with the word pulled written along with a date of 4/20 and then additional date below of 4/22. The label did not identify which item was pulled on 4/20, and there were no labels on the items to identify what they were. In addition, while the larger meat item located on the tray appeared to be a vacuum sealed package, a smaller package located at the front of the tray appeared to contain slices of raw meat with what appeared to be several layers of loose plastic wrap. Located in a black rectangular bucket next to the meat tray we're what appeared to be plastic bags with partially frozen meat pieces that appeared to be raw chicken. The bucket also had a label with the date pulled and 4/20 and the date 4/22 directly below. The meat located in the plastic bags was also not labeled. The Dietary Director identified that she assumed the label identified pulled 4/20 meant both items located in the tray and in the bucket were pulled on that date and that 4/22 was the discard date. The Dietary Director identified she believed the meat slices wrapped in plastic wrap were pork chops that had been marinated at some point but, due to no label, she was unable to identify when the pork chops were transferred from their original package, marinated, and then to the plastic wrap. The Dietary Director also identified she was not sure if the chicken was in the original packaging. 2. Observation of the dry storage area which was located in an adjacent open storeroom next to the kitchen identified multiple areas throughout the floor of debris and food items. In addition, located against the far right side of the storage room wall were observed to be 4-5 dead flying insects lying among multiple areas of debris that also included approximately 10 to 15 pieces of dried penne pasta. Additional debris was located throughout the storage area as well as underneath large shelves which stored boxed dry goods and large plastic containers of sugar and flour. An additional small, recessed storage area within the dry storage room which held boxes of corn starch on a metal wire shelf unit identified a large amount of debris around and under the wire shelf and located to the left of the shelf was a partially crushed box of corn starch with a large amount of white powdery debris located around the box. Multiple mouse and insect glue traps were also observed in the dry storage area. (continued on next page)

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	04/24/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Dietary Director identified the area had been cleaned the evening prior. 3. Observation of the 3 bay sink identified the left side pot sink contained sanitizing solution along with a large metal cooking pot. To the right of the 3 bay sink was a red sanitizing bucket. The Dietary Director was asked to perform a test on both the sanitizing solution within the red bucket and the sanitizing solution in the 3 bay sink. Both solutions tested at 100 PPM after with three attempts to test each. The Dietary Director also tested the solution directly from the sanitizing dispenser port that was used to fill the three base sink and the sanitizing bucket and each test strip listed at 200 PPM. Observation of the test strip container failed to identify an expiration date. The Dietary Director identified that she would contact the service company for the sanitizing solution to determine the issue and was unsure why the sanitizing solution in the bucket and sink tested lower than from the dispenser directly. The Dietary Director was also unable to identify how long the solutions had been in the sink and in the bucket and identified the facility policy was to change the solution if the solution appeared soiled. The Dietary Director also identified that the test strips used by the facility did not have an expiration date. 4. Observation of the high temperature dish machine identified that the rinse cycle temperatures were low. The Dietary Director attempted five wash and rinse cycles with the dish machine. While each wash cycle maintained a temperature above 160°, the rinse cycle temperatures registered at the following after 5 attempts: 1: 169° F. 2: 172° F. 3: 167° F. 4: 176° F. 5: 179° F. During the observation, Dietary Aide #1 was present and identified that the facility dish machine was fairly new and had had issues off and on maintaining a rinse temperature above 180°. The Dietary Director identified that she was aware at times the rinse temperature was below 180° but this was typically during the first one or two rinse cycles. The Dietary Director identified that she would contact the service provider for both the sanitizer solution and the high temperature dish machine to address the issues. 6. (continued on next page)

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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility kitchen daily monitoring sheets from 3/19/25 - 4/21/25 identified the facility tracked all monitoring for the kitchen including meal temperatures, pot sink and sanitizing solution readings, wash and rinse temperatures for the high temperature dish machine, refrigerator logs, and freezer logs on the same log sheet for each day. Review of the logs identified the following: Dish machine rinse temperatures below 180° F or were missing temperature readings on the following dates/times: 3/27/25 178°F (breakfast). 3/27/25 179°F (lunch). 3/29/25 179°F (dinner). 4/10/25 no wash/rinse temperatures documented (lunch/dinner). 4/11/25 no wash/rinse temperatures documented (dinner). 4/12/25 178°F (breakfast). 4/12/25 178°F (dinner). 4/13/25 178°F (breakfast). 4/14/25 174°F (breakfast). 4/14/25 174°F (lunch). 4/14/25 175°F (dinner). 4/15/25 176°F (breakfast). 4/16/25 178°F (breakfast). 4/16/25 no wash/rinse temperatures documented (dinner). Pot Sink/Sanitizer bucket PPM log with no staff initials verifying solution was at least 200 PPM or no checks documented: 3/23/25 no initial verification (breakfast/lunch). 3/24/25 no initial verification (dinner). 3/25/25 no initial verification (breakfast/lunch/dinner). 3/26/25 no initial verification (breakfast/lunch/dinner). 3/27/25 no initial verification (dinner). (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/28/25 no initial verification (breakfast/lunch/dinner). 3/29/25 no initial verification (breakfast/lunch). 3/30/25 no initial verification (breakfast/lunch/dinner). 3/31/25 no initial verification (breakfast/lunch/dinner). 4/1/25 no initial verification (breakfast/lunch/dinner). 4/2/25 no initial verification (breakfast/lunch/dinner). 4/3/25 no initial verification (breakfast/lunch/dinner). 4/4/25 no initial verification (breakfast/lunch/dinner). 4/5/25 no initial verification (breakfast/lunch/dinner). 4/6/25 no initial verification (breakfast/lunch/dinner). 4/7/25 no initial verification (breakfast/lunch/dinner). 4/8/25 no initial verification (breakfast/lunch/dinner). 4/9/25 no initial verification (breakfast/lunch/dinner). 4/10/25 no initial verification (breakfast). 4/10/25 no PPM done (lunch/dinner). 4/11/25 no PPM done (breakfast/lunch/dinner). 4/12/25 no initial verification (breakfast/lunch/dinner). 4/13/25 no initial verification (breakfast/lunch/dinner). 4/14/25 no initial verification (breakfast/lunch/dinner). 4/15/25 no PPM done (breakfast/lunch/dinner). 4/16/25 no PPM done (breakfast/lunch/dinner). 4/17/25 no PPM done (breakfast/lunch/dinner). 4/18/25 no PPM done (breakfast/lunch/dinner). 4/19/25 no PPM done (breakfast/lunch/dinner). (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/20/25 no PPM done (breakfast/lunch/dinner). 4/21/25 no PPM done (breakfast). All logs reviewed from 3/19/25 - 4/21/25 were partially or completely missing dietary staff initials to identify who completed the logs including daily meal temperatures, refrigeration temperatures and freezer temperatures. Interview with the Dietary Director identified that her expectation was that the daily monitoring logs were completed prior to each meal service and identified she was unsure why the logs were not completed fully and why she was not alerted regarding the low sanitizing rinse temperatures for the dish machine. Interview with the Dietary Director on 4/21/25 at 8:40 AM identified she had contacted the maintenance company to determine the issue related to the sanitizing solution PPM and the rents temperatures for the high temperature dish machine. Interview with the Dietary Director on 4/21/25 at 2:00 PM identified that the issue related to the sanitizing solution was due to expired test strips and indicated the service tech for the sanitizing solution and the dish machine advised her that the strips were expired. The Dietary Director also identified that the issue with the dish machine rinse temperatures was related to a facility hot water setting which was adjusted. A request then was made to the Dietary Director to provide documentation related to the issue with the sanitizer solution and resolution along with documentation related to the dish machine rinse temperatures which she identified she would be able to provide by 4/22/25. Interview with Dietary Aide #1 on 4/23/25 at 8:24 AM identified that the facility staff did not sign off on any daily cleaning assignment lists for the facility kitchen. Dietary Aid #1 identified that the Dietary Director recently initiated an audit sheet starting on 4/15/25 to ensure that the daily cleaning assignments were done however the audits included texting the Dietary Director to let her know that the daily cleaning assignments were done. The Dietary Director would then fill out an audit sheet stating that the areas were done without the areas actually being checked. Follow up observation of the facility kitchen with the Dietary Director on 4/23/25 at 8:28 AM, which occurred during breakfast service, identified the following: Observation of the 3-day emergency supply room identified a covered drain opening and what appeared to be a water valve with a flexible connection in the same area but located to the right of the 3 day emergency supply stock. Review of the area identified debris throughout the room with multiple dead black winged insects along with multiple black line shaped particles all similar in length approximately 1/8 of an inch in length scattered throughout the 3 day emergency supply room floor. In addition, multiple mouse and insect glue traps were observed in the 3 day emergency supply room. Interview with the Dietary Director identified the room was previously a shower room and was converted to a supply room, but she was not aware of any issues related to using the room for storage. The Dietary Director identified that she utilized a 7 day cleaning schedule with different areas of the kitchen to be addressed on each day for dietary cooks and dietary aids. The Dietary Director identified the daily cleaning assignment list was to be signed off by the staff member responsible for cleaning the assigned area. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the daily monitoring sheets for 4/22 and 4/23 with the Dietary Director at 9:50 AM identified on 4/22/25 the dish machine rinse temperature was 178°F. Additionally the pot sink sanitizer bucket PPM's were not obtained or documented for breakfast lunch and dinner. Review of the 4/23/25 log identified the log was completely blank. Interview with the Dietary Director and Dietary Aide #1 failed to identify why the daily monitoring sheet was blank including the pot sink and sanitizer bucket PPM log for breakfast, the dish machine temperature logs for wash and rinse cycles for breakfast, the refrigeration log morning check, and the food temperature log for all food items served at breakfast. When asked if food temperatures had been obtained for breakfast, and where they were kept both the Dietary Director and Dietary Aide #1 failed to provide an answer. The Dietary Director and the Dietary Aid one also failed to identify how they ensured that breakfast items were served at the appropriate safe holding temperatures. Subsequent to the follow up observations made on 4/23/25, a request was made to the Dietary Director to provide documentation related to the daily cleaning logs for the kitchen to include the staff signature sheets. A second request was also made to the Dietary Director to provide documentation related to the issue with the sanitizer solution and resolution along with documentation related to the dish machine rinse temperatures. Interview with the Dietary Director on 4/23/25 at 11:30 AM identified that she did not utilize an actual log to track which staff completed daily cleaning assignments in the kitchen. The Dietary Director identified that she previously used a dry erase laminated cleaning assignment list that staff would sign off for their specific shift. Once that day's cleaning assignment was completed, the dry erase list would be cleaned and used the following day. The Dietary Director further identified that she now used a daily assignment list which she implemented 4/2025 and identified daily cleaning assignments which the Dietary Director visually audited to determine if the areas were clean. The Dietary Director identified she would call or text staff on the weekends to determine if their assigned areas were cleaned as she was not physically in the building, however she would check the areas every Monday morning. The Dietary Director identified that the dry storage areas were to be cleaned weekly. Review of the daily cleaning assignments for cooks and dietary aids identified that the AM and PM cook were responsible every Tuesday to organize the dry stock and paper room, where the 3 day supply room was located. Review of the daily assignment lists failed to identify any daily cleaning assignments related ensuring the dry storage and 3 day supply area were maintained in a clean and sanitary manner. Further review of the daily cleaning schedule utilized by the kitchen staff prior to April 2025 also failed to identify any daily cleaning assignment related to ensuring that the dry storage and 3 day supply area were maintained in a clean and sanitary manner. Review of the daily cleaning schedule utilized prior to April 2025 failed to identify any cleaning assignments related to the dry storage or 3 day supply area. Although requested, the facility failed to provide documentation related to the issue with the sanitizer solution and resolution along with documentation related to the dish machine rinse temperatures. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on cleaning schedules directed it was the responsibility of the dietary department to maintain all areas of the facility's kitchen and related areas in a clean and sanitary manner. The policy further directed that the food service director was responsible to identify, assign, monitor and manage the cleanliness of their department. The policy also directed that cleaning schedules were unique to each dietary department based on its specific and unique areas and equipment. Areas to be cleaned would be identified by the frequency of cleaning as needed including daily cleaning, weekly cleaning, and monthly cleaning. The policy also directed that the food service director would assign daily, weekly and monthly cleaning assignments, monitor the areas completed as required, and employees would be directed to initial each task to indicate that the cleaning task was completed. The policy also directed that the food service director would monitor and manage the daily, weekly, and monthly cleaning schedules by reviewing the cleaning schedules for initials and then reviewing the work as completed. The food service director should also identify new areas that needed cleaning and attaching them to the cleaning schedule as necessary. Review of the manufacturer's instructions for Simoniz Syb Quat 10 Plus, the Quat solution utilized by the facility for the pot sink and red sanitizing buckets, directed that the sanitizing solution should test between 200 - 400 PPM (for active quat) to ensure that the sanitizing solution level was effective. The facility policy on food storage directed that the purpose of the policy was to serve safe food and always demonstrate safe food handling in compliance with local, state, and federal guidelines. The policy directed that food storage, including dry storage, refrigerators, freezers and chemical rooms should always be clean and sanitary. The policy also directed that the facility utilized a date marking policy in conjunction with the food storage policy to ensure that closed or open foods would be maintained by an expiration or use by dating system. The policy also directed that perishable food items including potentially hazardous food opened or prepared would be clearly marked at the time of preparation to indicate the date of preparation. The facility policy on the dish machine directed that the purpose of the policy was to ensure proper sanitary dish washing with high temperature dish machines. The policy directed that conventional high temperature dishwasher machines must reach a water temperature in accordance with the manufacturer's specifications for wash and final sanitizing rinse. The policy directed that the dietary staff record dish machine temperatures on a dish machine temperature log prior to operating the dish machine and/or after each meal service. Any unusual or substandard readings were to be reported immediately to the nutritional services director and or maintenance department and corrective action should be taken immediately including discontinuing the use of the dish machine, waiting 10 minutes and rechecking temperatures, if the temperatures remain substandard discontinuing the use of the dish machine and reporting the concern to the food service director and or maintenance department. The policy also directed to take direction from the nutrition service director and or maintenance director and if no contact was made with either, discontinue use of the dish machine and manually ware wash all equipment and wares. The facility policy on the pot sink directed that the pot sink water/sanitizer level must be high enough to completely immerse or submerge all wares to be cycled, and staff should check the sanitizer manufacturer's recommendations. The policy also directed that pot sinks would be emptied, cleaned, and refilled as they became contaminated with excessive food, food residual, grease, or every four hours. The policy also directed those contaminants decreased the chemical sanitizers effectiveness including food, grease, dirt, and other chemicals. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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Touchpoints at Chestnut	171 Main St East Windsor, CT 06088

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy on Sanitizer Bucket use directed that the purpose of the policy was to provide guidelines and directions related to proper sanitizer bucket use in order to maintain sanitary conditions of work areas and equipment. The policy directed to prepare sanitizer solution using a Quaternary Ammonium product (Quat) and follow the manufacturer's instructions and levels of chemical. The policy further directed to prepare the sanitizer solution in the pot sink, test to proper titration, and fill needed sanitizer buckets from this one tested source. The policy also directed to test the PPM (the measurement of chemical to water ratio), using a test strip made for Quat product. The policy further directed to ensure the test strips were in good condition and not expired. After checking the sanitizer level was accurate, dietary staff were to log and verify sanitizer levels on the PPM log.

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	075436	A. Building B. Wing	04/24/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility documentation, facility policy, and interviews for reviewed for staffing, the facility failed to provide and track the 12 hours of education for the nurse's aides per year. The findings include: Interview with the ADNS on 4/24/25 at 7:19 AM indicated that she was responsible for the staff education in the facility including the mandatory training once a calendar year. The ADNS indicated that the annual mandatory education for 2024 was provided through education boards with post tests. Interview with RN #1 (corporate regional educator and Infection Preventionist) on 4/24/25 at 7:20 AM indicated that she was aware that the nurse's aide must have 12 hours of education per year. Interview with the ADNS on 4/24/25 at 9:08 AM indicated she has been the facility staff development nurse for the last 4 months. The ADNS indicated that the yearly mandatory education poster boards and post tests take an employee approximately 45 minutes to an hour to complete. The ADNS indicated she does not recall how long the dementia training took to complete. The ADNS indicated that she does not have any tracking system for the number of hours of education each year that each nurse's aide did during 2024, she would check with RN #1. An interview with RN #1 on 4/24/25 at 9:13 AM indicated that she tracks the nurse's aide's education on the back of each post test as there is a maximum amount of time given to complete each topic and post test. RN #1 indicated that tracks the nurse's aide's name and the date it was completed, but not the number of hours it takes. RN #1 indicated that the dementia care education is a read and sign with a post test. RN #1 indicated that there were eight 1-hour modules and a post test of 28 questions to account for the 8 hours. RN #1 indicated that she automatically gives all nurse aides the following credit of time if they did a post test: dementia was 8 hours, IV was competency was counted as 1 hour, pain was 1 hour, skill/competency was counted as 2 hours, and mandatories are 3 hours last year with poster boards. RN #1 indicated that she gave all nurse's aides 3 hours for doing the mandatory education, but neither is not in the room during the education or post tests. Review of the following Employees' education and competency records: 1. Interview with NA #5 on 4/24/25 at 9:38 AM indicated the mandatory education was on poster boards in the staff break room and it took 15 -20 minutes to complete with the answer sheet present on the table for each topic to copy. NA #5 indicated she does not recall if it was a video or poster board but the dementia training was about 30 minutes. NA #5 indicated that there is no one in the break room to answer questions but you have the answer sheets. NA #5 indicated there has never been someone lecturing on a topic for dementia or the mandatories so we can ask questions. 2. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with NA #9 on 4/24/25 at 9:15 AM indicated that she did not do the mandatory education packet for 2024 because she went out on leave from February 2024 until September 2024. NA #9 indicated that she only did the dementia training that was about 40 minutes of a video and then did a post test so approximately 1 hour total. NA #9 indicated that the competency sheet and post tests were in the break room on poster boards with the answer keys and no one observed her performance skills to sign off on her competencies. NA #9 indicated she just drew a line down the form and signed it. 3. Interview with NA #10 on 4/24/25 at 9:54 AM indicated the annual mandatories for 2024 were poster boards in the break room and there was no one there to answer questions, but the answer keys were there on the table. NA #10 indicated that it took her 1 hour to complete all mandatory education. NA #10 indicated that the dementia training for 2024 was a video that was about 20-30 minutes, and she did a post test about 30 minutes. 4. Interview with NA #11 on 4/24/25 at 10:06 AM indicated the mandatory education was in the break room with poster boards and the answer keys were there and it took about 1 hour to complete. NA #11 indicated that the dementia training during 2024 was a video for 30 minutes and the post test was another 30 minutes. There was no other education that she could recall. 5. Interview with NA #12 on 4/24/25 at 10:30 AM indicated the mandatory education is repetitive. NA #12 indicated there are poster boards for each mandatory topic in the break room with the answer key on the table to copy. NA #12 indicated it took about 1 hour to complete. NA #12 indicated the dementia training was on a video and she did a post test that all took 30-40 minutes. The interview with RN #1 on 4/24/25 at 10:40 AM indicated that the answer key was left with the poster boards for the staff to be able to verify their answers, the dementia video and the skills/competency check list were in the break room and the post test was there for the staff to make sure the answers were correct. RN #1 indicated she stated the amount of time on the post tests was the amount of time that would be the maximum for staff to complete it, but no one was present to know how long it took the staff. RN #1 indicated that she was aware that the nurse's aides had not completed all 12 hours of education for 2024, based on nurse's aide statements they only received 3-4 hours of education during 2024. An interview with the Corporate COO on 4/24/25 at 11:06 AM indicated that he is aware there were issues with the way staff education and competencies were being done during 2024. (continued on next page)

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	075436	A. Building B. Wing	04/24/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility assessment dated [DATE] identified the facility's staffing plan to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs. Nurse aide competency including, without limitation, dementia management, abuse prevention, and areas of weakness identified in performance reviews. Nurse's aide competency training is completed on skills day of new hire orientation and annually thereafter as part of mandatory, annual employee education. Additionally, training is conducted periodically as determined by facility management. Topics include compliance and ethics training, infection control training, behavioral health including mental illness, psychosocial disorders, trauma, and post-traumatic stress disorder, abuse, neglect, and exploitation training, resident rights, effective communication, non-pharmacological interventions, are provided to all employees at the new hire orientation and annually thereafter, including posttests, A posttest is given to ensure understanding of the material. Although requested, a facility policy for mandatory staff education, competencies, and the 12 hours of education for nursing staff were not provided.