STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075264	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Bloomfield	140 Park Ave Bloomfield, CT 06002

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 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** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was free from abuse. The findings include: a. Resident #2's diagnoses included depression and chronic pain. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was alert and oriented, had no behaviors, and ambulated with a walker independently. The Resident Care Plan (RCP) dated 9/3/2024 identified Resident #2 used antidepressant medication. Interventions directed to administer medications as ordered, and monitor for side effect. b. Resident #3's diagnoses included Parkinson's, bipolar disorder, borderline personality disorder, paranoid schizophrenia, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired, ambulated independently, and had no behaviors. The Resident Care Plan (RCP) dated 10/9/2024 identified Resident #3 had the potential to be physically aggressive related to poor impulse control, interventions included monitor, document, report as needed any signs or symptoms of resident posing danger to self and others. Record review identified there was no history of aggressive behaviors. Record reviews identified Resident #2 and #3 were roommates. Review of the facility Reportable Event Form dated 10/9/2024 at 10:00 PM identified Residents #2 and #3 (both were independent with transfers and ambulation) were in bed, when Resident #3 got out of bed and approached Resident #2. NA #2 observed Resident #2 attempted to push Resident #3 away from him/her and Resident #3 grabbed Resident #2's neck and hit him/her. Staff were in the hall and immediately separated the residents and Resident #3 was placed on one-to-one (1:1) monitoring and transferred to the hospital for evaluation. The report further identified no injuries were noted. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The summary dated 10/11/2024 identified NA #2 had just left the room after providing care for Resident #2 when NA #2 heard Resident #2 calling out for help, and as he entered the room, he observed Resident #3 standing over Resident #2 in the bed, and Resident #3 had his/her hands around Resident #2's neck. NA #2 removed Resident #3 from the room, and Resident #3 was agitated, confused and delusional stating Resident #2 had been screaming and NA #2 had been making too much noise in the room. Resident #2 stated he/she had put his/her arm out to direct Resident #3 away, and Resident #3 responded by hitting him/her on the arm and then grabbing Resident #2 by the neck. Resident #3 was sent to the hospital for evaluation. The summary indicated there had been no prior altercations between the roommates, the facility substantiated the allegation of abuse, and Resident #3's room would be changed upon return from the hospital. Review of NA #2's statement dated 10/9/2024, identified at about 10:04 PM he was in the hall charting outside the room when he heard someone calling for help. He entered the room and saw Resident #3's hands holding and suppressing down on the throat of Resident #2 and Resident #2 was calling out for help. NA #2 indicated he gently held Resident #3 from his/her back, placed his hands across Resident #3's arms and gently pulled Resident #3 away. Resident #2 was lying on his/her bed and two (2) NAs and a nurse responded and assisted separating the residents and let go of Resident #2. Review of LPN #1's statement dated 10/9/2024 indicated she was called to the room by an aide, and observed NA #2 was holding Resident #3 off from Resident #2, as Resident #3 was trying to get to Resident #2. She further indicated that she was able to hold Resident #3's hand and with another staff member able to re-direct and remove Resident #3 from the room. Although attempted, interviews with NA #1 and LPN #1 were not obtained during survey. On 11/4/2024 at 12:21 PM interview, clinical record review and facility documentation review with the DNS identified that the residents had no prior history of aggressive behaviors, the incident should not have occurred, and the facility substantiated abuse. Review of facility Abuse policy directed in part, residents will not be subjected to abuse by anyone, including, 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 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review and interview for 6 of 6 (Resident #1, #2, #3, #5, #6, #7) residents reviewed for abuse, the facility failed to ensure the MDS was accurate to include Section C (Cognitive Patterns) assessment was completed. The findings include: 1. Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] Section C was coded as dash (-), not assessed. 2. Resident #2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] Section C was coded as not assessed. 3. Resident #3's Quarterly Minimum Data Set (MDS) assessment dated [DATE] Section C was coded as not assessed. 4. Resident #4's Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] Section C was coded as not assessed. 5. Resident #6's Quarterly Minimum Data Set (MDS) assessment dated [DATE] Section C was coded as not assessed. 6. Resident #7's Quarterly Minimum Data Set (MDS) assessment dated [DATE] Section C was coded as not assessed. Interview, clinical record review and facility documentation review on 10/31/2024 at 1:25 PM with DNS identified that the social worker (SW) was responsible to complete Section C of the MDS. The DNS stated the RAI (Resident Assessment Instrument) manual directed that Section C should be completed with an annual, significant change, and quarterly MDS assessments. The DNS further stated Section C for Residents #1, #2, #3, #6 and #7's quarterly MDS assessment and Resident #4's Significant Change in Status MDS assessment data was not completed/or entered as not assessed. The DNS stated Section C assessments should have been completed and were not completed because the social worker recently left the facility, unexpectedly.2 Review of the facility Social Work Cognitive Patterns Assessment (MDS, Section C) policy directed in part, upon notification from the facility's MDS Coordinator that an MDS is due for a resident due to admission, Medicare A requirements, quarterly review or a change in the resident's condition, the social worker will either: conduct a BIMS interview with the resident in private or conduct a Staff Assessment for Mental Status using interaction with and observations of the resident, staff observation, and record review, if the resident is unable to be interviewed and complete and submit section C of an MDS 3.0 Assessment including assessment for symptoms of delirium. Review of RAI Version 3.0 Manual Section C: Cognitive Patterns directed that the items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions.