STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075436	A. BUILDING _____ B. WING _____	**05/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observations, review of facility policies and staff interviews for one of six residents with potential exposure to COVID-19 (Resident #1), the facility failed to implement the necessary measures to prevent and control the spread of infection to a roommate (Resident #2). The findings include: Observations with the Director of Nursing on 5/22/2020 at 9:39 AM on a unit designated for residents with potential exposure to COVID-19 identified that Resident #1 was sharing a room with Resident #2 who was considered to be negative for COVID-19. During an interview at the time of the observation on 5/22/20 at 9:39 AM the Director of Nursing (DON) stated that Resident #1 was sharing a room with Resident #2 who had been monitored for fourteen days and no longer required continued observation for COVID-19 since he/she was now considered to be negative. The Director of Nursing stated that Resident #1, who required a specialized treatment in the community had been placed on transmission-based precautions starting on 5/19/20. Further interview with the Director of Nursing on 5/22/20 and subsequent review of the facility policy identified that an attempt was to be made not to cohort residents who were considered to be COVID-19 negative with residents who were being monitored for COVID-19. Additionally, the DON stated that there was a room available on a unit designated for residents who were considered to be negative for COVID-19, and Resident #2 could have been moved to that room.

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