STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075251	A. BUILDING _____ B. WING _____	**08/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOUCHPOINTS AT FARMINGTON	**SCOTT SWAMP RD FARMINGTON, CT 06032**

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 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, a review of the facility documentation, and a review of the facility policy for one sampled resident (Resident #1), the facility failed to transcribe a physician's order for the use of [REDACTED]. The findings include: Resident #1's [DIAGNOSES REDACTED]. Review of the hospital discharge summary dated 8/13/20 directed Bi-Pap overnight, with settings of 20/6 cmH20 (centimeters of water column), with 40% flow of oxygen. The resident admission profile dated 8/13/20 identified Resident #1 was alert and oriented to person, place and time. The care plan dated 8/15/19 identified Resident #1 had respiratory issues that required him/her to use a Bi-Pap, however Resident #1 chose not to use Bi-Pap. Interventions directed to continue to offer and encourage Resident #1 to use BI-Pap, monitor for respiratory distress or issues during care rounds, provide assistance as needed to facilitate breathing e.g. raise head of bed, use oxygen as indicated, respiratory consult as indicated, provide education and encouragement in regards to risk arising from his/her choice, monitor oxygen saturation every shift as indicated. A physician's order dated 8/17/20 directed to apply Trilogy NIR with 2 liters per minute of oxygen at night and naps, with maximum pressure settings of 30 PS, minimum 6 EPAP, maximum 14 EPAP,minimum 4 breath rate auto, AVAPS rate 1 VT 445. If unable to tolerate, place on Bi-Pap 2 liters per minute of oxygen. Review of the clinical record failed to identify the physician's order for Bi-Pap was transcribed upon Resident #1's admission to the facility and the daily use or refusal of Bi-pap was not documented in the clinical record from 8/13/20 through 8/16/20 (4 days). Interview and review of the clinical record with the Director of Nursing (DON) on 8/23/20 at 12:55 PM failed to identify a physician's order was transcribed for the use of Bi-Pap overnight as per the hospital discharge summary. The DON indicated the expectation for the admitting nurse was to verify the order for Bi-Pap with a physician and transcribe the order onto Resident #1's clinical record. The DON identified she knew the admitting nurse verified the order for Bi-Pap as the admission nurse's note indicated that Bi-Pap was set up by an oxygen company. Further interview with the DON identified Resident #1 refused the use of [MEDICAL CONDITION] on four occassions and was not documented in the resident's clinical record and should have been. Interview with the Respiratory Therapist #1 (RT) on 8/27/20 at 1:55 PM identified he was contacted by the facility on 8/13/20 at11:27 AM regarding Bi-Pap administration for Resident #1. RT#1 indicated he arrived at the facility on 8/13/20 between 2:30 PM and 3:00 PM, set up Resident #1 with the an appropriate mask and set up the Bi-pap machine. Interview with RN #1 on 8/27/20 at 2:11 PM identified it was a mistake on his part, that he forgot to transcribe the order for Bi-pap onto Resident #1's clinical record. RN #1 indicated the Bi-Pap was ordered from the contracted company and Resident#1 received the equipment on the day he/she was admitted to the facility. The facilites policy for the admission nursing process directed in part that the admission nursing process and documentation was to begin as soon as possible on all new admissions. Prior to beginning the assessment, the nurse would review the discharge summary and the W-10. The licensed nurse was responsible for completing the admission documentation. Every section of the admission document should be addressed.

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