

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184</b></p> <p>Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of eight (8) sampled residents (Resident #5) who were reviewed for misappropriation of personal property, the facility failed to ensure a controlled medication, Methadone, was properly stored to prevent the removal of six (6) bottles from the facility. The findings include:</p> <p>Resident #5's diagnoses included opioid dependence and other psychoactive substance abuse.</p> <p>The Resident Care Plan dated 11/11/24 identified Resident #5 was at risk for substance abuse related to the history of addiction and currently receiving medication assisted therapy.</p> <p>A physician's order dated 12/10/24 directed to give, the medication used to treat opioid use disorder, Methadone HCL oral solution 10 milligrams (mg) per 5 milliliters (ml), give 140 mg orally once a day.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 was alert and oriented to person, place, and time and received opioid medications.</p> <p>The nurse's note dated 1/3/25 at 12:00 PM identified Resident #5 missed the daily dose of Methadone 140 mg, all parties were notified and an order directed to monitor for signs and symptoms of pain and withdrawal symptoms through 1/4/25 and administer an additional dose of Percocet 5-325 mg every eight (8) hours times two (2) doses, these doses are in addition to the scheduled Percocet every six (6) hours as needed. Upon assessment, Resident #5 denied pain, muscle aches, restlessness, irritableness, and/or withdrawal symptoms.</p> <p>The Medication Error Report dated 1/3/25 identified on 1/3/25 Resident #5 reported that he/she did not receive the scheduled dose of Methadone 140 mg at 6:00 AM. The report indicated the dose was omitted because the Methadone was missing.</p> <p>The nurse's note dated 1/3/25 at 8:50 PM identified Resident #5 reported moderate body aches, restlessness, withdrawal symptoms of anxiety, and irritableness. The note indicated an extra dose of Percocet 5-325 mg second dose was administered at 8:00 PM per the physician's orders, with good effect.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's investigation identified on 1/2/25 the Assistant Director of Nursing (ADON) picked up seven (7) vials of Resident #5's Methadone from the Methadone Clinic and brought them to the facility in a locked suitcase. Upon arrival to the facility, the ADON administered one (1) dose of the Methadone to Resident #5, then placed the remaining six (6) bottles on the supervisor's desk in the supervisor's office (not in the double locked cabinet designated for the Methadone) and closed the door, which automatically locked upon closing. The investigation identified on 1/3/25 the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1 attempted to administer the 6:00 AM dose of Methadone to Resident #5, but could not locate the medication, she then reported this to the 7AM-3PM Nursing Supervisor, RN #2. The investigation identified there was no count conducted of Resident #5's Methadone by two (2) Nursing Supervisors at the time the Methadone was brought into the facility and there was no count of the Methadone during shift to shift change between the evening and the night shifts.</p> <p>Interview with the 7AM-3PM Nursing Supervisor, RN #2, on 2/26/25 at 11:25 AM identified on 1/2/25, he walked into the locked supervisor's office and found six (6) bottles of Resident #5's Methadone sitting on the desk in front of the computer. RN #2 explained he placed the six (6) bottles of Methadone into the designated double locked cabinet for the Methadone supplies. RN #2 identified he did not perform a medication count with the ADON when the Methadone was brought into the facility on [DATE]. RN #2 identified he was made aware the Methadone was missing when Resident #5 reported that he/she had not received the 1/3/25 dose of Methadone at 6:00 AM. RN #2 indicated at that time, he began a search for the six (6) missing bottles but could not locate the bottles of Methadone and he reported this to the Director of Nursing (DON).</p> <p>Interview with the ADON on 2/26/25 at 12:36 PM identified on 1/2/25, she went to the Methadone Clinic and picked up seven (7) bottles of Methadone assigned to Resident #5. The ADON explained the seven (7) bottles these were placed in a locked suitcase for transport and when she arrived back at the facility, she administered Resident #5's 1/2/25 dose at 11:15 AM and placed the other six (6) bottles of Methadone in the supervisor's office on the desk with the door to the office locked. The ADON identified she did not place the medication in the double locked cabinet that is specific for the Methadone and she did not do a medication count with RN #2 when she placed the Methadone on the desk. The ADON identified facility policy directed when Methadone is brought to the facility, it is to be counted with a second Nursing Supervisor, documented on the reconciliation, on the chain of custody form and placed in the double locked cabinet designated for the Methadone.</p> <p>Interview with the DON on 2/26/25 at 12:44 PM identified the policy for Methadone directed when the Methadone is picked up, it is returned to the facility in a locked suitcase and it is handed off to the Nursing Supervisor when it arrives to the facility with a count of the number of bottles received and verified with two (2) supervisors and documented, then placed in the locked cabinet designated for the Methadone. The DON identified on 1/2/25 when the ADON returned with Resident #5's Methadone, it was not counted with another staff member, and it was placed on the desk in the supervisor's office and not in the locked cabinet. The DON identified on 1/2/25 during shift change from evenings to nights, the outgoing and oncoming Nursing Supervisors did not perform a count of the number of Methadone bottles present for Resident #5. The DON identified on 1/3/25, it was reported by RN #2 that six (6) bottles of Resident #5's Methadone were missing. The DON indicated an investigation was initiated however the Methadone was not found.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the 3-11PM Nursing Supervisor, RN #3, on 2/26/25 at 2:23 PM identified she was on duty 1/2/25 and at the change of shift she did not do a count of the Methadone with the oncoming 11PM-7AM Nursing Supervisor, RN #1. RN #3 identified the facility policy directed to count the Methadone at the change of each shift.</p> <p>Although attempted, an interview with RN #1 was not obtained.</p> <p>The facility policy titled Controlled Substances, last revised 9/2018, directed in part, all controlled substances, Schedule II-IV, are stored and maintained in a locked cabinet or compartment. The policy further directed accurate inventory of all controlled medications is always maintained.</p> <p>The facility policy titled Methadone Protocol, last revised 11/25/24, directed, in part, The RN Supervisor and/or charge nurse is responsible for the storage and counting of the Methadone.</p> <p>The facility identified the deficient practices on 1/3/25 and implemented an immediate action plan:</p> <p>The resident will receive Percocet every eight (8) hours times two (2) doses. The resident will be going to the Methadone clinic in person on Saturday for scheduled dosing and will receive a take home bottle for Sunday. A staff member will return to the Methadone clinic on Monday for pickup of remaining bottles for the week. The resident will be monitored for signs and symptoms of pain or anxiety and will receive interventions as ordered.</p> <p>Any resident who receives Methadone has the potential to be affected by this alleged deficient practice.</p> <p>The staff member upon return from the Methadone clinic will count with the Nursing Supervisor and co-sign the chain of custody, then two (2) staff members will secure the Methadone in the locked cabinet. The Nursing Supervisors will count the Methadone using the chain of custody at each shift change, and document on the narcotic shift signature sheet located in the front of the Methadone book.</p> <p>Education was conducted with staff who handle Methadone on the Methadone policy and the controlled substance accountability policies.</p> <p>Random weekly audits of the Methadone process commencing on 1/4/25 will occur for thirty (30) days or until substantial compliance is achieved.</p> <p>Audits to be reviewed at the monthly QAPI meetings.</p> <p>The Director of nursing is responsible for the plan of correction.</p> <p>The Administrator and Director of Nursing are responsible for the plan.</p> <p>Compliance as of 1/6/25.</p> <p>The plan of correction was reviewed on 2/26/25 and the facility met all components for past non-compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43184</p> <p>Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of eight (8) sampled residents (Resident #5) who received Methadone (a controlled substance used to treat opioid addiction), the facility failed to ensure Resident #5's Methadone was stored per the facility policy to prevent the loss of the Methadone resulting in an omission of a dose and ensure the resident did not experience withdrawal symptoms. The findings include:</p> <p>Resident #5's diagnoses included opioid dependence and other psychoactive substance abuse.</p> <p>The Resident Care Plan dated 11/11/24 identified Resident #5 was at risk for substance abuse related to the history of addiction and currently receiving medication assisted therapy.</p> <p>A physician's order dated 12/10/24 directed to give, the medication used to treat opioid use disorder, Methadone HCL oral solution 10 milligrams (mg) per 5 milliliters (ml), give 140 mg orally once a day.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 was alert and oriented to person, place, and time and received opioid medications.</p> <p>The nurse's note dated 1/3/25 at 12:00 PM identified Resident #5 missed the daily dose of Methadone 140 mg, all parties were notified and an order directed to monitor for signs and symptoms of pain and withdrawal symptoms through 1/4/25 and administer an additional dose of Percocet 5-325 mg every eight (8) hours times two (2) doses, these doses are in addition to the scheduled Percocet every six (6) hours as needed. Upon assessment, Resident #5 denied pain, muscle aches, restlessness, irritableness, and/or withdrawal symptoms.</p> <p>The Medication Error Report dated 1/3/25 identified on 1/3/25 Resident #5 reported that he/she did not receive the scheduled dose of Methadone 140 mg at 6:00 AM. The report indicated the dose was omitted because the Methadone was missing.</p> <p>The nurse's note dated 1/3/25 at 8:50 PM identified Resident #5 reported moderate body aches, restlessness, withdrawal symptoms of anxiety, and irritableness. The note indicated an extra dose of Percocet 5-325 mg second dose was administered at 8:00 PM per the physician's orders with good effect.</p> <p>The nurse's note dated 1/4/25 at 6:48 AM identified Resident #5 was monitored through the night for signs and symptoms of withdrawal and Resident #5 displayed no signs and symptoms of discomfort or distress.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's investigation identified on 1/2/25 the Assistant Director of Nursing (ADON) picked up seven (7) vials of Resident #5's Methadone from the Methadone Clinic and brought them to the facility in a locked suitcase. Upon arrival at the facility, the ADON administered one (1) dose of the Methadone to Resident #5, then placed the remaining six (6) bottles on the supervisor's desk in the supervisor's office (not in the double locked cabinet designated for the Methadone) and closed the door, which automatically locked upon closing. The investigation identified on 1/3/25 the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1 attempted to administer the 6:00 AM dose of Methadone to Resident #5, but could not locate the medication, she then reported this to the 7AM-3PM Nursing Supervisor, RN #2. The investigation identified there was no count conducted of Resident #5's Methadone by two (2) Nursing Supervisors at the time the Methadone was brought into the facility and there was no count of the Methadone during shift to shift change between the evening and the night shifts.</p> <p>Interview with the ADON on 2/26/25 at 12:36 PM identified on 1/2/25, she went to the Methadone Clinic and picked up seven (7) bottles of Methadone assigned to Resident #5. The ADON explained the seven (7) bottles these were placed in a locked suitcase for transport and when she arrived back at the facility, she administered Resident #5's 1/2/25 dose at 11:15 AM and placed the other six (6) bottles of Methadone in the supervisor's office on the desk with the door to the office locked. The ADON identified she did not place the medication in the double locked cabinet that is specific for the Methadone and she did not do a medication count with RN #2 when she placed the Methadone on the desk. The ADON identified facility policy directed when Methadone is brought to the facility, it is to be counted with a second Nursing Supervisor, documented on the reconciliation, on the chain of custody form and placed in the double locked cabinet designated for the Methadone.</p> <p>The facility policy titled Controlled Substances, last revised 9/2018, directed in part, all controlled substances, Schedule II-IV, are stored and maintained in a locked cabinet or compartment. The policy further directed accurate inventory of all controlled medications is always maintained.</p> <p>The facility policy titled Methadone Protocol, last revised 11/25/24, directed, in part, The RN Supervisor and/or charge nurse is responsible for the storage and counting of the Methadone.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184</b></p> <p>Based on clinical record reviews, review of facility documentation, facility policies, and interviews for one (1) of eight (8) sampled residents (Resident #5) who received a controlled medication, the facility failed to ensure a supply of Methadone (a controlled substance used to treat opioid addiction) was counted upon arrival to the facility and during the change of shift, and was stored in a secured cabinet per the facility's policy. The findings include:</p> <p>Resident #5's diagnoses included opioid dependence and other psychoactive substance abuse.</p> <p>A physician's order dated 12/10/24 directed to give, the medication used to treat opioid use disorder, Methadone HCL oral solution 10 milligrams (mg) per 5 milliliters (ml), give 140 mg orally once a day.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 was alert and oriented to person, place, and time and received opioid medications.</p> <p>The nurse's note dated 1/3/25 at 12:00 PM identified Resident #5 missed the daily dose of Methadone 140 mg, all parties were notified and an order directed to monitor for signs and symptoms of pain and withdrawal symptoms through 1/4/25 and administer an additional dose of Percocet 5-325 mg every eight (8) hours times two (2) doses, these doses are in addition to the scheduled Percocet every six (6) hours as needed. Upon assessment, Resident #5 denied pain, muscle aches, restlessness, irritableness, and/or withdrawal symptoms.</p> <p>The Medication Error Report dated 1/3/25 identified on 1/3/25 Resident #5 reported that he/she did not receive the scheduled dose of Methadone 140 mg at 6:00 AM. The report indicated the dose was omitted because the Methadone was missing.</p> <p>The facility's investigation identified on 1/2/25 the Assistant Director of Nursing (ADON) picked up seven (7) vials of Resident #5's Methadone from the Methadone Clinic and brought them to the facility in a locked suitcase. Upon arrival at the facility, the ADON administered one (1) dose of the Methadone to Resident #5, then placed the remaining six (6) bottles on the supervisor's desk in the supervisor's office (not in the double locked cabinet designated for the Methadone) and closed the door, which automatically locked upon closing. The investigation identified on 1/3/25 the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1 attempted to administer the 6:00 AM dose of Methadone to Resident #5, but could not locate the medication, she then reported this to the 7AM-3PM Nursing Supervisor, RN #2. The investigation identified there was no count conducted of Resident #5's Methadone by two (2) Nursing Supervisors at the time the Methadone was brought into the facility and there was no count of the Methadone during shift to shift change between the evening and the night shifts.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the 7AM-3PM Nursing Supervisor, RN #2, on 2/26/25 at 11:25 AM identified on 1/2/25, he walked into the locked supervisor's office and found six (6) bottles of Resident #5's Methadone sitting on the desk in front of the computer. RN #2 explained when he found the six (6) bottles of Methadone, he placed the six (6) bottles of Methadone into the designated double locked cabinet for the Methadone supplies. RN #2 identified he did not perform a medication count with the ADON when the Methadone was brought into the facility on [DATE]. RN #2 identified he was made aware the Methadone was missing when Resident #5 reported that he/she had not received the 1/3/25 dose of Methadone at 6:00 AM.</p> <p>Interview with the ADON on 2/26/25 at 12:36 PM identified on 1/2/25, she went to the Methadone Clinic and picked up seven (7) bottles of Methadone assigned to Resident #5. The ADON explained the seven (7) bottles these were placed in a locked suitcase for transport and when she arrived back at the facility, she administered Resident #5's 1/2/25 dose at 11:15 AM and placed the other six (6) bottles of Methadone in the supervisor's office on the desk in front of the computer instead of in the double locked cabinet designated for Methadone and closed the door, which automatically locked upon closing. The ADON identified she did not place the medication in the double locked cabinet that is specific for the Methadone and she did not do a medication count with RN #2 when she placed the Methadone on the desk. The ADON identified facility policy directed when Methadone is brought to the facility, it is to be counted with a second Nursing Supervisor, documented on the reconciliation, on the chain of custody form and placed in the double locked cabinet designated for the Methadone.</p> <p>Interview with the DON on 2/26/25 at 12:44 PM identified the policy for Methadone directed when the Methadone is picked up, it is returned to the facility in a locked suitcase and it is handed off to the Nursing Supervisor when it arrives to the facility with a count of the number of bottles received and verified with two (2) supervisors and documented, then placed in the locked cabinet designated for the Methadone. The DON identified on 1/2/25 when the ADON returned with Resident #5's Methadone, it was not counted with another staff member, and it was placed on the desk in the supervisor's office and not in the locked cabinet. The DON identified on 1/2/25 during shift change from evenings to nights, the outgoing and oncoming Nursing Supervisors did not perform a count of the number of Methadone bottles present for Resident #5. The DON identified on 1/3/25, it was reported by RN #2 that six (6) bottles of Resident #5's Methadone were missing. The DON indicated an investigation was initiated however the Methadone was not found.</p> <p>Interview with the evening supervisor (RN #3) on 2/26/25 at 2:33 PM identified she did not do a count of Resident #5's Methadone with the night supervisor (RN #1) during shift change on 1/2/25. RN #3 identified facility policy directed a count of Methadone bottles at the change of shift. RN #3 identified she could not give a reason as to why she did not count the Methadone bottles, but she should have counted the Methadone bottles with RN #1.</p> <p>Although attempted, an interview with the night supervisor (RN #1) was unable to be obtained.</p> <p>The facility policy titled Controlled Substances, last revised 9/2018, directed in part, all controlled substances, Schedule II-IV, are stored and maintained in a locked cabinet or compartment. The policy further directed accurate inventory of all controlled medications is always maintained.</p> <p>The facility policy titled Methadone Protocol, last revised 11/25/24, directed, in part, The RN Supervisor and/or charge nurse is responsible for the storage and counting of the Methadone.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility identified the deficient practices on 1/3/25 and implemented an immediate action plan:</p> <p>The resident will receive Percocet every eight (8) hours times two (2) doses. The resident will be going to the Methadone clinic in person on Saturday for scheduled dosing and will receive a take home bottle for Sunday. A staff member will return to the Methadone clinic on Monday for pickup of remaining bottles for the week. The resident will be monitored for signs and symptoms of pain or anxiety and will receive interventions as ordered.</p> <p>Any resident who receives Methadone has the potential to be affected by this alleged deficient practice.</p> <p>The staff member upon return from the Methadone clinic will count with the Nursing Supervisor and co-sign the chain of custody, then two (2) staff members will secure the Methadone in the locked cabinet. The Nursing Supervisors will count the Methadone using the chain of custody at each shift change, and document on the narcotic shift signature sheet located in the front of the Methadone book.</p> <p>Education was conducted with staff who handle Methadone on the Methadone policy and the controlled substance accountability policies.</p> <p>Random weekly audits of the Methadone process commencing on 1/4/25 will occur for thirty (30) days or until substantial compliance is achieved.</p> <p>Audits to be reviewed at the monthly QAPI meetings.</p> <p>The Director of nursing is responsible for the plan of correction.</p> <p>The Administrator and Director of Nursing are responsible for the plan.</p> <p>Compliance as of 1/6/25.</p> <p>The plan of correction was reviewed on 2/26/25 and the facility met all components for past non-compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>43184</p> <p>Based on clinical record reviews, review of facility documentation, facility policies, and interviews for seven (7) of eight (8) sampled residents (Residents #5, #6, #7, #8, #10, #11, and #12) who were reviewed for accurate documentation, the facility failed to ensure the Medication Administration Record (MAR) reflected documentation that the residents received the medication when administered. The findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #5 was admitted with the diagnosis of opioid dependence. A physician's order dated 12/10/24 directed to administer Methadone HCL oral solution (a medication to treat opioid addiction) 10 milligrams (mg) per 5 milliliters (ml), give 140 mg orally once a day. Review of the February 2025 MAR identified there was no documentation in the Electronic Medical Record (EMR) that the Methadone was administered on six (6) of twenty-five (25) days (2/1/25, 2/5/25, 2/10/25, 2/20/26, 2/22/25, and 2/23/25).</li> <li>2. Resident #6 was admitted with the diagnosis of opioid dependence. A physician's order dated 1/21/25 directed to administer Methadone HCL oral Solution 5 mg/5 ml, give 60 mg by mouth once a day. A physician's order dated 2/7/25 directed to Administer Methadone HCL 5 mg/5 ml give 60 mg by mouth once a day. A physician's order dated 2/11/25 directed to administer Methadone HCL oral Solution 10 mg/5 ml, give 60 mg orally once a day. Review of the February 2025 MAR identified there was no documentation in the EMR the Methadone was administered on twelve (12) of twenty-four (24) days (2/1/25, 2/5/25, 2/12/25, 2/13/25, 2/17/25, 2/18/25, 2/19/25, and 2/21/25 through 2/25/25).</li> <li>3. Resident #7 was admitted with the diagnosis of opioid dependence with unspecified opioid induced disorder. A physician's order dated 1/6/25 directed to administer Methadone HCL oral solution 10 mg/5 ml, give 45 mg by mouth once a day. Review of the February 2025 MAR identified there was no documentation in the EMR the Methadone was administered on twelve (12) of twenty-five (25) days (2/1/25, 2/4/25, 2/5/25, 2/6/25, 2/8/25 through 2/12/25, 2/19/25, 2/21/25, and 2/22/25).</li> <li>4. Resident #8 was admitted to the facility with the diagnosis of opioid dependence. A physician's order dated 1/6/25 directed to administer Methadone HCL 10 mg/5 ml, give 120 mg once a day. Review of the February 2025 MAR identified there was no documentation in the EMR the Methadone was administered on nine (9) of twenty-five (25) days (2/1/25, 2/5/25, 2/9/25, 2/10/25, 2/11/25, 2/14/25, 2/18/25, 2/21/25, and 2/22/25).</li> <li>5. Resident #10 was admitted to the facility with the diagnosis of opioid abuse. A physician's order dated 2/20/25 directed to administer Methadone HCL oral solution 10 mg/5 ml, give 90 mg by mouth once a day. Review of the February 2025 MAR identified there was no documentation in the EMR the Methadone was administered on three (3) of five (5) days (2/20/25 through 2/23/25).</li> <li>6. Resident #11 was admitted to the facility with the diagnosis of opioid dependence. A physician's order dated 1/6/25 directed to administer Methadone HCL oral solution 10 mg/5 ml, 105 mg by mouth once a day. Review of the February 2025 MAR identified there was no documentation in the EMR the Methadone was administered on eleven (11) of twenty (25) days (2/1/25, 2/4/25, 2/5/25, 2/6/25, 2/8/25, 2/9/25, 2/10/25, 2/12/25, 2/20/25, 2/22/25, and 2/23/25).</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Silver Springs Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  33 Roy St Meriden, CT 06450	
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)		
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>7. Resident #12 was admitted to the facility with the diagnosis of opioid dependence. A physician's order dated 11/14/24 directed to administer Methadone Concentrate 10 mg/ml orally once a day. Review of the February 2025 MAR identified there was no documentation in the EMR the Methadone was administered on thirteen (13) of twenty-five (25) days (2/1/25, 2/4/25, 2/5/25, 2/6/25, 2/8/25 through 2/12/25, 2/15/25, 2/20/25, 2/22/25, and 2/23/25).</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/26/25 at 12:36 PM identified the facility policy on administration of medication directed each medication given was to be documented in the EMR. The ADON identified the Nursing Supervisors are responsible for ensuring the MARs are accurate.</p> <p>Interview with the Director of Nursing (DON) on 2/26/25 at 12:44 PM identified the facility policy directed that when Methadone was given it was signed off in the EMR as well as the chain of custody form. The DON indicated for Residents #5, #6, #7, #8, #10, #11, and #12 the February MARs did not have consistent documentation the Methadone was administered. The DON identified it was the Nursing Supervisor's responsibility to ensure signage that the medications were administered.</p> <p>The facility policy titled Controlled Substances, last revised 8/2020, directed in part, accurate inventory of all controlled medications is always maintained. When a controlled substance is administered, the licensed nursing personnel administering the medication immediately enters the following information on the accountability records and the MAR: date and time of administration and initials of the nurse administering the dose, completed after the medication has been administered.</p> <p>The facility policy titled Methadone Protocol, last revised 11/2024, directed, in part, the nurse will sign the MAR after each dose.</p>		