STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075337	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Springs Care Center	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)
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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure an allegation of abuse/neglect was reported to the State Agency (SA). The findings include: Resident #1's diagnoses included multiple sclerosis, epilepsy, depression, anxiety and overactive bladder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of three), was dependent with ADL care and frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 5/12/2025 identified Resident #1 had a communication problem related to progressive multiple sclerosis, interventions directed to anticipate and meet needs. Further review identified potential impairment to skin integrity related to fragile skin and dependence for mobility, interventions included pressure relief wheelchair cushion and pressure relieving/reducing mattress to protect skin. A physician's order dated 5/15/2025 directed mechanical lift assist of two (2). Review of NA #1's statement dated 5/30/2025 identified NA #2 was assigned her (NA #1's) regular assignment which included Resident #1. NA #1 further indicated Resident #1's incontinence care was not provided until 1 PM on the 7 AM to 3 PM shift on 5/30/2025. NA #1's statement identified her concerns were reported to the supervisor at the end of 7 AM to 3 PM shift that day. Interview with RN #1 (RN supervisor) on 6/18/2025 at 10:14 AM identified that NA #1 gave her a statement about three weeks ago which included an allegation of care not being provided to Resident #1 until late in the 7 AM to 3 PM shift by the assigned aide (NA #2). RN #1 identified she submitted the written statement by NA #1 by sliding it under the door of the DNS/ADNS office at the end of her shift. RN #1 further indicated she did not confirm that the DNS or ADNS received the statement. RN #1 indicated NA #2 is regularly assigned to care for Resident #1 on the 7 AM to 3 PM shift. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 6/18/2025 at 2:26 PM indicated she was aware that an aide alleged lack of care for several hours for Resident #1 during the 7 AM to 3 PM shift on 5/30/2025 and care was not provided until late in the shift. The DNS indicated she was away at the time, and the ADNS was covering. The DNS indicated NAs should do rounds to provide care to residents every two (2) hours and as needed. The DNS identified the ADNS was currently away, and she was unable to locate or provide an investigation report. The DNS further indicated that the alleged concerns of neglect reported by NA #1 should have been reported to the SA. Upon surveyor inquiry, allegation of abuse report was submitted by facility to the SA. Although attempted, the ADNS was not available for interview. Review of the facility Abuse Policy dated 3/20/2024 directed in part residents will not be subjected to abuse by anyone, including but not limited to, facility staff. Allegations of abuse will be reported promptly and thoroughly investigated. Facility In-House Reporting: Whenever there is a witnessed, suspected, or alleged abusive action involving a resident, the following is initiated: the staff member who hears an allegation of abuse, or suspects or witnesses abuse will report immediately to their supervisor, The Administrator or on-call designee and Director of Nursing Services are to be notified immediately. The facility Administrator and Director of Nursing (or their designee) will be responsible for as needed reporting as described in the facility Reporting Allegations and Incidents Policy and Procedure. Investigation will be initiated within 24 hours of its discovery. The following measures will be taken to protect the resident during the period of investigation of alleged abuse: remove residents from alleged abuser, remove alleged abuser from the area of the resident. If an employee is the alleged abuser, he/she will be removed from the care of the resident and removed from the schedule pending outcome of the investigation. Investigation will begin, may include statements from witnesses and staff, consultation with family, physician, Department of Public Health and other state agencies as required, consultation with local law enforcement for suspected crimes and further action deemed as necessary depending on results of the investigation.

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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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to investigate an allegation of abuse/neglect. The findings include: Resident #1's diagnoses included multiple sclerosis, epilepsy, depression, anxiety and overactive bladder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severe cognitive impairment (Brief Interview for Mental Status (BIMS) score of three), was dependent with ADL care and frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 5/12/2025 identified Resident #1 had a communication problem related to progressive multiple sclerosis, interventions directed to anticipate and meet needs. Further review identified potential impairment to skin integrity related to fragile skin and dependence for mobility, interventions included pressure relief wheelchair cushion and pressure relieving/reducing mattress to protect skin. A physician's order dated 5/15/2025 directed mechanical lift assist of two (2). Review of NA #1's statement dated 5/30/2025 identified NA #2 was assigned her (NA #1's) regular assignment which included Resident #1. NA #1 further indicated Resident #1's incontinence care was not provided until 1 PM on the 7 AM to 3 PM shift on 5/30/2025. NA #1's statement identified her concerns were reported to the supervisor at the end of 7 AM to 3 PM shift that day. Interview with RN #1 (RN supervisor) on 6/18/2025 at 10:14 AM identified that NA #1 gave her a statement about three weeks ago which included an allegation of care not being provided to Resident #1 until late in the 7 AM to 3 PM shift by the assigned aide (NA #2). RN #1 identified she submitted the written statement by NA #1 by sliding it under the door of the DNS/ADNS office at the end of her shift. RN #1 further indicated she did not confirm that the DNS or ADNS received the statement. RN #1 indicated NA #2 is regularly assigned to care for Resident #1 on the 7 AM to 3 PM shift. Interview with the DNS on 6/18/2025 at 2:26 PM indicated she was aware that an aide alleged lack of care for several hours for Resident #1 during the 7 AM to 3 PM shift on 5/30/2025 and care was not provided until late in the shift. The DNS indicated she was away at the time, and the ADNS was covering. The DNS indicated NAs should do rounds to provide care to residents every two (2) hours and as needed. The DNS identified the ADNS was currently away, and she was unable to locate or provide an investigation report. The DNS further indicated that the alleged concerns of neglect reported by NA #1 should have been reported to the SA. Although attempted, the ADNS was not available for interview. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Abuse Policy dated 3/20/2024 directed in part residents will not be subjected to abuse by anyone, including but not limited to, facility staff. Allegations of abuse will be reported promptly and thoroughly investigated. Facility In-House Reporting: Whenever there is a witnessed, suspected, or alleged abusive action involving a resident, the following is initiated: the staff member who hears an allegation of abuse, or suspects or witnesses abuse will report immediately to their supervisor, The Administrator or on-call designee and Director of Nursing Services are to be notified immediately. The facility Administrator and Director of Nursing (or their designee) will be responsible for as needed reporting as described in the facility Reporting Allegations and Incidents Policy and Procedure. Investigation will be initiated within 24 hours of its discovery. The following measures will be taken to protect the resident during the period of investigation of alleged abuse: remove residents from alleged abuser, remove alleged abuser from the area of the resident. If an employee is the alleged abuser, he/she will be removed from the care of the resident and removed from the schedule pending outcome of the investigation. Investigation will begin, may include statements from witnesses and staff, consultation with family, physician, Department of Public Health and other state agencies as required, consultation with local law enforcement for suspected crimes and further action deemed as necessary depending on the results of the investigation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and facility documentation, the facility failed to follow infection prevention and control guidelines by failing to ensure resident room sink faucet filters were changed once expired. The findings include: Observation during tour of the facility on [DATE] at 9:05 AM identified dated resident room sink faucet filters in rooms [ROOM NUMBERS] were dated [DATE] (7 days past expiration date), rooms 204, 206, 208, 211, 214, and 217 filters were dated [DATE] (6 days past expiration date). Review of [NAME]-Aquasafe Water Filter manufacturer's instructions last updated [DATE] indicated the water filter is designed to be used for a maximum of one calendar month (31 days) following initial connection. Interview on [DATE] at 12:13 PM with facility Maintenance Director identified that the facility was following a water management program for an infectious agent, and filters were being used, maintained and replaced at faucet sites. He identified that he and the maintenance assistant were responsible for changing the filters, the facility was using filters that lasted 31 days and some lasted 62 days and that the date on the filters indicated when the filter was last changed. The Maintenance Director indicated he was not aware that several filters were dated as changed over 31 days ago and that he would go through the whole house and change filters as needed. Observation on [DATE] at 1:26 PM identified that filters were changed in rooms 106, 118, 204, 206, 208, 211, 214 and 217 and were dated [DATE]. Interview on [DATE] at 1:36 PM with the Maintenance Director identified that the facility did not keep records/logs of water filter changes and indicated that he had been offsite at another facility, and identified the Maintenance Assistant, in his absence, should have changed the filters. During an interview on [DATE] at 2:26 PM with the DNS and RN #2 (Corporate Clinical Director), RN #2 identified that the building had a known infectious agent in the water and the water was being monitored. RN #2 further identified that the 30 day (31 day) sink faucet filters in rooms 106, 118, 204, 206, 208, 211, 214 and 217 should have been changed when due.