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	08/04/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of abuse, the facility failed to ensure the resident was free from a physical altercation with a staff member that led to the resident falling. The findings include:Resident #1's diagnoses included severe dementia with agitation, mild cognitive impairment and muscle weakness. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of four (4) indicating severe impaired cognition, required supervision assistance when ambulating and was independent for bed mobility and transfers. The Resident Care Plan dated 6/18/25 identified Resident #1 may have limited insight into his/her illness and abilities and may wander on the unit at times which puts him/her at risk for unsafe situations. Interventions directed to offer to help the resident and ask questions about what the resident was trying to do if he/she appears to be searching for something and redirecting the resident. A physician's order dated 6/18/25 directed Resident #1 was independent with transfers and ambulation without an assistive device. The nurse's note dated 7/2/25 at 9:07 PM identified at 6:50 PM Resident #1 had a fall in the hallway and was noted to be sitting on the floor with his/her head against the wall. The note indicated a staff member had witnessed Resident #1 attempting to exit the unit and striking said staff member, identifying that the staff member raised his arm to protect himself and Resident #1 lost their balance and fell onto the floor. The note identified the provider were notified of the incident and Emergency Services was called to transport Resident #1 to the Emergency Department (ED) for a medical and psychiatric evaluation. The nurse's note dated 7/3/25 at 4:14 AM identified Resident #1 returned from the hospital at approximately 3:30 AM and all testing that was performed was negative and no acute behavioral issues were noted. The Facility Reported Incident report dated 7/7/25 identified on 7/2/25 Resident #1 sustained a fall, however, after an investigation on 7/7/25 (five (5) days later), it was alleged Resident #1 was pushed by a staff member as Resident #1 was attempting to exit the memory care unit. The report indicated the incident was witnessed by three (3) staff members. Interview with a 3-11PM nurse aide, Nurse Aide (NA) #2, on 8/4/25 at 12:03 PM identified on 7/2/25 she was sitting in the hallway across from the elevator on the memory care unit, observing another resident when the charge nurse, Licensed Practical Nurse (LPN) #1 and NA #1 exited the elevator. NA #2 explained there is a glass enclosure outside of the elevator that required a code to be entered to exit the enclosure and get onto the unit, and Resident #1 was right outside the enclosure attempting to get to the elevator when LPN #1 and NA #1 were observed exiting the elevator into the enclosure. NA #2 identified both LPN #1 and NA #1 stood in the enclosure for a few minutes, but Resident #1 did not leave the area, so either LPN #1 or NA #1 entered the code, NA #1 opened the door and Resident #1 hit NA #1 twice in the head. NA #2 reported NA #1 put his head down and his hands out to defend himself and Resident #1 propelled backwards, falling on his/her bottom and then falling back and hitting his/her head hard against the wood paneling on the wall behind him/her Interview with Housekeeper #1 on 8/4/25 at 12:18 PM identified on 7/2/25 he was on the memory care unit when he observed NA #1 come through the enclosure door onto the unit, Resident #1 made contact with NA #1 and NA #1 pushed Resident #1 back causing Resident #1 to fall and Resident #1 just laid there on the floor and did not move following. Interview with NA #1 on 8/4/25 at 12:27 PM identified on 7/2/25 he was returning to the memory care unit via the elevator with LPN #1 and when the elevator door opened, he observed Resident #1 in the hallway, banging on the glass, attempting to get through the enclosure to the elevator. NA #1 reported that although Resident #1 was visibly agitated and banging on the glass enclosure, LPN #1, who was behind him, entered the code to get onto the unit and he opened the door slightly and attempted to slip through the door without letting Resident #1 through. NA #1 indicated Resident #1 then approached him, hit him on the left side of the face and the back of the head and identified that he then put his head down, arms up and pushed Resident #1 to get Resident #1 off him. NA #1 stated he should not have pushed Resident #1. Interview with LPN #1 on 8/4/25 at 12:56 PM identified on 7/2/25 at 6:40 PM she was exiting the elevator with NA #1 into the enclosure area prior to entering the unit when Resident #1 was observed at the door. LPN #1 reported Resident #1 was not moving away from the door, NA #1 approached the door of the enclosure, and she entered the code to open the door. LPN #1 identified NA #1 walked through the door ahead of her, Resident #1 then hit NA #1, NA #1 pushed Resident #1 forward causing Resident #1 to fall onto his/her bottom and then fall backwards hitting his/her head on the wall. LPN #1

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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 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. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for abuse, the facility failed to notified the Administrator and/or designee of a physical altercation between a staff member and the resident at the time of the incident and therefore the incident was not reported to the State Agency for five (5) days. The findings include:Resident #1's diagnoses included severe dementia with agitation, mild cognitive impairment and muscle weakness. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of four (4) indicating severe impaired cognition, required supervision assistance when ambulating and was independent for bed mobility and transfers. The Resident Care Plan dated 6/18/25 identified Resident #1 may have limited insight into his/her illness and abilities and may wander on the unit at times which puts him/her at risk for unsafe situations. Interventions directed to offer to help the resident and ask questions about what the resident was trying to do if he/she appears to be searching for something and redirecting the resident. The nurse's note dated 7/2/25 at 9:07 PM identified at 6:50 PM Resident #1 had a fall in the hallway and was noted to be sitting on the floor with his/her head against the wall. The note indicated a staff member had witnessed Resident #1 attempting to exit the unit and striking said staff member, identifying that the staff member raised his arm to protect himself and Resident #1 lost their balance and fell onto the floor. The note identified the provider were notified of the incident and Emergency Services was called to transport Resident #1 to the Emergency Department (ED) for a medical and psychiatric evaluation. The nurse's note dated 7/3/25 at 4:14 AM identified Resident #1 returned from the hospital at approximately 3:30 AM and all testing that was performed was negative and no acute behavioral issues were noted. The Facility Reported Incident report dated 7/7/25 identified on 7/2/25 Resident #1 sustained a fall, however, after an investigation on 7/7/25 (five (5) days later), it was alleged Resident #1 was pushed by a staff member as Resident #1 was attempting to exit the memory care unit. The report indicated the incident was witnessed by three (3) staff members. Interview with NA #1 on 8/4/25 at 12:27 PM identified on 7/2/25 he was returning to the memory care unit via the elevator with LPN #1 and when the elevator door opened, he observed Resident #1 in the hallway, attempting to get through the enclosure to the elevator, banging on the glass. NA #1 reported that although Resident #1 was visibly agitated and banging on the glass enclosure, LPN #1, who was behind him, entered the code to get onto the unit and he opened the door slightly and attempted to slip through the door without letting Resident #1 through. NA #1 indicated Resident #1 then approached him, hit him on the left side of the face and the back of the head and identified that he then put his head down, arms up and pushed Resident #1 to get Resident #1 off him. NA #1 stated he should not have pushed Resident #1. Interview with LPN #1 on 8/4/25 at 12:56 PM identified on 7/2/25 at 6:40 PM she was exiting the elevator with NA #1 into the enclosure area prior to entering the unit when Resident #1 was observed at the door. LPN #1 reported Resident #1 was not moving away from the door, NA #1 approached the door of the enclosure, and she entered the code to open the door. LPN #1 identified NA #1 walked through the door ahead of her, Resident #1 then hit NA #1, NA #1 pushed Resident #1 forward causing Resident #1 to fall onto his/her bottom and then fall backwards hitting his/her head on the wall. LPN #1 explained she was overwhelmed and shocked at what had happened, and she did make a comment about not wanting to deal with the situation and notified the Nursing Supervisor of the incident. LPN #1 identified on 7/2/25 although she wrote a statement and reported to both the Director of Nursing and Nursing Supervisor, Registered Nurse (RN) #1, that Resident #1 was pushed by NA #1 she felt she was not taken seriously until 7/7/25. Interview with the Director of Nursing (DON) on 8/4/25 at 1:26 PM identified that on 7/2/25 when RN #1 notified her of Resident #1's fall she called the facility and spoke with LPN #1, NA #1 and NA #2 who identified Resident #1 hit NA #1 and then lost his/her balance and fell. The DON identified when speaking with LPN #1, it was not communicated to her that NA #1 pushed Resident #1. The DON explained on 7/7/25, five (5) days later, the Director of Maintenance reported to her that she should view the camera footage from 7/2/25, as he had discovered some concerning footage. The DON identified when she viewed the footage, it was clear Resident #1 was pushed by NA #1, resulting in Resident #1 falling and an investigation was initiated. The DON identified Housekeeper #1 was not initially interviewed because she was unaware, he was present during the incident until he was viewed on the camera footage. The DON identified had she known Housekeeper #1 was present and the staff had consistent stories and

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had sustained a fall, the facility failed to ensure vital signs were obtained and recorded accurately. The findings include:Resident #1's diagnoses included severe dementia with agitation, mild cognitive impairment and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of four (4) indicating severe impaired cognition, required supervision assistance with ambulation and was independent for bed mobility and transfers. The Resident Care Plan (RCP) dated 6/18/25 identified that Resident #1 may have limited insight into his/her illness and abilities and may wander on the unit at times which puts him/her at risk for unsafe situations. Interventions included offering to help him/her and ask questions about what the resident is trying to do if he/she appears to be searching for something and redirecting the resident. The nurse's note dated 7/2/25 at 9:07 PM identified that at 6:50 PM Resident #1 had a witnessed fall in the hallway and was noted to be sitting on the floor with his/her head against the wall. The note indicated Resident #1 was resistive to a skin check and range of motion assessment, the provider was notified of the incident and Emergency Services was called to transport the resident to the Emergency Department (ED) for a medical and psychiatric evaluation. Review of the eInteract Transfer Form dated 7/2/25 at 10:00 PM identified although Resident #1 was transferred to the hospital around 7:00 PM, the form indicated Resident #1's vital signs were obtained between 10:02 PM and 10:03 PM (three (3) hours after the incident). The nurse's note dated 7/3/25 at 4:14 AM identified Resident #1 returned from the hospital at approximately 3:30 AM and all testing that was performed was negative and no acute behavioral issues were noted. Interview with a 3-11PM nurse aide, Nurse Aide (NA) #2, on 8/4/25 at 12:03 PM identified following Resident #1's fall on 7/2/25 she did not touch Resident #1 or obtain vital signs. Interview with NA #1 on 8/4/25 at 12:27 PM identified following Resident #1's fall on 7/2/25 she did not touch Resident #1 or obtain vital signs. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, on 8/4/25 at 12:56 PM identified following Resident #1's fall on 7/2/25 she did not touch Resident #1 or obtain vital signs. Interview with the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, on 8/4/25 at 2:30 PM identified that following a resident fall, the procedure is to assess the resident for injuries, obtain their vital signs and neurological signs prior to notifying the family and the provider of the incident. RN #1 identified following Resident #1's fall on 7/2/25, the resident did not refuse, and she did not attempt to obtain vital signs, as staff had communicated to her Resident #1 had previously hit NA #1, so she did not want to further escalate Resident #1 as her goal was to keep Resident #1 safe. RN #1 explained when she went to complete the eInteract Transfer Form (assessment to help facilitate the transfer of the resident from the facility to an acute care hospital) in the Electronic Health Record (EHR) it would not allow her to lock the form and print it out until vital signs were entered, stating although she shouldn't have, she made up the vital signs and inputted them into the form so that it would lock and she could print it out. Interview with the Director of Nursing (DON) on 8/4/25 at 1:26 PM identified she was aware RN #1 did not obtain vital signs following Resident #1's fall, reporting that RN #1 communicated to her the eInteract Transfer Form wouldn't lock without vital signs being inputted so she entered incorrect vital signs into the EHR so that she could lock the assessment. The DON identified staff are prohibited from falsifying documentation, stating RN #1 was suspended for ten (10) days effective 7/14/25. The Change of Condition policy dated 4/17/24 directed, in part, that the RN Supervisor will do a follow-up assessment to ensure that the assessment is documented and reported to the physician. All assessment findings and relevant information should be compiled prior to calling the physician to ensure accuracy of information. The physician (or alternate) will be contacted to report findings. The nurse will obtain new orders as warranted from the physician. The resident and/or responsible party will be notified. The nurse will document in the nurse's notes regarding assessments, findings, changes, physician notification and resident and/or responsible party notification. Although requested, a policy on Nursing Documentation was not available.