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	12/16/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure neurological monitoring was completed timely after an unwitnessed fall in accordance with facility policy. The findings include:Resident #1's diagnoses included chronic obstructive pulmonary disease, morbid obesity and heart failure. The significant change in condition Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen, indicative of no cognitive impairment and used a wheelchair. The Resident Care Plan (RCP) dated 11/26/2025 identified limited physical mobility, non-ambulatory, and mobility by wheelchair. Interventions directed assist of one for wheelchair mobility. Review of facility reportable event dated 12/1/2025 at 6:45 PM identified Resident #1 was observed on the elevator floor after an unwitnessed fall from his/her wheelchair. Resident #1 was transferred to the hospital for evaluation and a fracture of the tip of the nose was identified. Additional information indicated another resident was assisting Resident #1 when the fall occurred (no staff witness), and when attempting to cross the elevator threshold, the wheels stopped and Resident #1 fell forward from the chair. The facility Fall Scene Investigation Report identified Resident #1 slid out of his/her wheelchair while trying to get onto the elevator when another resident was pushing the wheelchair. Facility summary dated 12/5/2025 identified a laceration noted on the tip of his/her nose with sutures placed at the hospital. Review of the facility Investigation of Reportable Event Guidelines Falls dated 12/1/2025 identified RN #1 signed and dated the form, however the section under neuro checks if appropriate was blank. Review of the Neurological Check Sheet identified the form directed to complete neurological checks every 15-minutes for four (4) times, then every 30-minutes twice, then hourly for four (4) hours, then every two (2) hours - four (4) times, then every four (4) hours - for four (4) times, then every eight (8) hours - for four (4) times. Additional review of the Neurological Check Sheet identified the form identified it was dated 12/1/2025 at 6:45 PM, and the vital signs (blood pressure, pulse, respirations), hand grasps, level of consciousness and pupil response were blank, and the line identified at 6:45 PM had no nurse initials. Further, although EMS did not arrive to the resident until 7:30 PM, the form had no additional neurological assessments identified as completed on 12/1/2025 (missing assessments at 6:45, 7:00, 7:15 and 7:30 PM). The one (1) hour assessments were marked to identify Resident #1 was at the hospital, and assessments resumed on 12/2/2025 at 6 AM, and two (2) of the four (4) hour assessments were noted to be blank. Nursing note dated 12/1/2025 at 9:25 PM (written by RN #1) identified Resident #1 was observed on the floor in the elevator after a fall from his/her wheelchair at 6:45 PM. Resident #1 reported falling from the wheelchair after being pushed by another resident, and fell face down. Bleeding was noted. The APRN was notified, and new orders were obtained to transfer Resident #1 to the hospital for evaluation. 911 was called and Resident #1 left the facility via ambulance at 7:45 PM. Review of the Emergency Medical Services (EMS) run sheet identified EMS was notified at 7:16 PM and arrived at the resident at 7:30 PM (45 minutes after the fall occurred). Review of hospital discharge paperwork dated 12/1/2025 identified a nasal bone tip fracture with mild depression (interval new), and left cheek region subcutaneous soft tissue swelling. Impression: new mildly depressed nasal bone fracture with associated left cheek probable soft tissue hematoma. Although several attempts were made, interview with RN #1 was not obtained during the survey. Interview and record review on 12/16/2025 at 1:58 PM with Administrator and DNS identified on 12/1/2025 at 6:45 PM Resident #1 fell forward from his/her wheelchair when another resident was pushing the wheelchair onto the elevator. The DNS stated the wheel got caught in the area between the floor and the elevator. Interview identified the fall occurred at 6:45 PM and Resident #1 left the facility at 7:45 PM. The DNS stated neurological assessments should be completed after an unwitnessed fall, and was unable to provide documentation that neurological assessments were completed prior to the arrival of EMS and Resident #1's transfer to the hospital, and that the assessments were completed for the two missing every four (4) hour assessments on the form. The DNS stated the neurological assessments should have been completed, and the nursing notes should have included information regarding neurological assessments and/or vital sign assessments if they were not included on the neurological assessment form. Review of facility Fall Management Program Policy directed in part, if a fall is unwitnessed or a head injury is suspected, to monitor neurological signs per physician orders (Refer to Policy - Neurological Assessment). Review of the facility Neurological Checks Policy dated