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 03/06/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation/policies for two (2) of six (6) residents (Residents #1 and #2) reviewed for abuse, the facility failed to ensure a resident was free from abuse. The findings included:1.Resident #1 was admitted to the facility in December of 2014 and had diagnoses that included vascular dementia, schizophrenia, and anxiety disorder.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4), was dependent for personal hygiene, toileting, and bathing, and utilized a wheelchair for transportation. The Resident Care Plan (RCP) dated 12/22/25 identified a history of engaging in non-consensual sexual advances by others. Interventions directed close observation levels applied as indicated per policy.2. Resident #2 was admitted to the facility in July of 2008 and had diagnoses that included vascular dementia, schizophrenia, and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 6), required set-up/clean-up assistance with personal hygiene, oral hygiene, and toileting, and ambulated independently.The Resident Care Plan (RCP) dated 1/27/26 identified Resident #2 had dementia, which caused memory problems, affected thinking, problem-solving, and language skills. Interventions directed to not attempt to correct statements Resident #2 believed and provide simple responses.The Reportable Event Form completed by the Director of Nursing Services dated 2/9/26 at 1:50 PM identified the Recreation Assistant observed Resident #1 and Resident #2 kissing in the elevator, and Resident #2 with his/her hands in Resident #1's pants.Interview with the Recreation Assistant on 3/5/26 at 11:29 AM identified he/she entered the elevator from the main floor on 2/9/26 and observed Resident #1 sitting in his/her wheelchair kissing Resident #2, while Resident #2's hand was inside Resident #1's pants. The Recreation Assistant indicated when he/she asked Resident #2 what he/she was doing, Resident #2 immediately removed his/her hand from Resident #1's pants and told the Recreation Assistant to mind her business. The Recreation Assistant indicated Resident #1 and Resident #2 were immediately separated and reported the incident to the DNS.Interview with the Director of Behavioral Health and Social Services (DBHSS) on 3/5/26 at 12:08 PM identified Resident #2 was placed on close visual observation (one-to-one monitoring by a staff member) at 2:00 PM on 2/9/26. The DBHSS further indicated, he/she questioned Resident #2 about his/her behaviors in the elevator on 2/9/26, to which Resident #2 responded it was just a kiss. Interview with the Director of Nursing Services (DNS) on 3/5/26 at 1:40 PM identified both Resident #1 and Resident #2 were conserved, unable to consent to intimate touching, and deemed what occurred on 2/9/26 as inappropriate and sexual in nature. The DNS further identified abuse of any type was not tolerated, and residents had the right to be kept safe and free from abusive incidents/situations.The Abuse Policy dated 11/19/25 directed residents would not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy further identified sexual abuse included, but wasn't limited to, non-consensual sexual contact of any (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	type with a resident, sexual harassment, sexual coercion, or sexual assault. The Close Observation policy identified multiple levels of resident observation options that offer staff the choice of a close observation response that is proportional to the level of risk to resident safety or wellbeing and residents were placed on close observation when the physician, nursing supervisor or the interdisciplinary team deem it necessary to ensure their safety or the safety of others.

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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 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, interviews, and review of facility documentation and policies for two (2) of six (6) residents (Resident #1 and Resident #2) reviewed for abuse, the facility failed to conduct a thorough investigation after a resident-to-resident abuse incident. The findings included:1.Resident #1 was admitted to the facility in December of 2014 and had diagnoses that included vascular dementia, schizophrenia, and anxiety disorder.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 4), was dependent for personal hygiene, toileting, and bathing, and utilized a wheelchair for transportation. The Resident Care Plan (RCP) dated 12/22/25 identified a history of engaging in non-consensual sexual advances by others. Interventions directed close observation levels applied as indicated per policy.2. Resident #2 was admitted to the facility in July of 2008 and had diagnoses that included vascular dementia, schizophrenia, and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 6), required set-up/clean-up assistance with personal hygiene, oral hygiene, and toileting, and ambulated independently.The Resident Care Plan (RCP) dated 1/27/26 identified Resident #2 had dementia, which caused memory problems, affected thinking, problem-solving, and language skills. Interventions directed to not attempt to correct statements Resident #2 believed and provide simple responses.The Reportable Event Form completed by the Director of Nursing Services dated 2/9/26 at 1:50 PM identified the Recreation Assistant observed Resident #1 and Resident #2 kissing in the elevator, and Resident #2 with his/her hands in Resident #1's pants.Review of the investigation associated with the 2/9/26 incident involving Resident #1 and Resident #2 identified interviews with the witness (Recreation Assistant), Resident #1, and Resident #2 were completed. However, the facility failed to obtain interviews/statements from staff to determine how long Resident #1 and Resident #2 were unsupervised, or their location leading up to the time of the incident. Interview with NA #1, (assigned to Resident #2 on 2/9/26 from 7:00 AM to 3:00 PM) on 3/6/26 at 12:36 PM identified he/she had last seen Resident #2 between 1:00 PM and 1:15 PM on 2/9/26.Interview with LPN #1 (assigned to Resident #1 on 2/9/26 from 7:00 AM to 3:00 PM) on 3/6/26 at 1:30 PM identified he/she had last seen Resident #1 around 1:00 PM on 2/9/26.Interview with the Director of Nursing Services (DNS) on 3/6/26 at 2:35 PM identified the investigation process regarding the 2/9/26 incident between Resident #1 and Resident #2 should have included interviews with the residents involved and witnesses and further identified he/she should have interviewed facility staff to establish a timeline to determine how long the residents were away from their assigned floors and/or the whereabouts of the residents prior to the time the incident occurred. The Reportable Events-Reporting Allegations and Incidents; Investigation (CT) policy dated 7/23/25 identified the investigation procedure for reportable events involved interviewing the resident(s) to obtain additional information, interviewing witnesses who were not staff members, identifying staff who were potential witnesses, review of work schedules to identify which staff members were working at the time the incident may have occurred, and that every effort should be made to interview staff members who were potential witnesses before they left their shift.