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	12/20/2024

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 0580 Level of Harm - Potential for minimal harm Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on review of the clinical record, facility policy, and staff interviews for 1 of 1 residents (Resident #121) reviewed for falls, the facility failed to notify a resident's responsible party after multiple falls. The findings include: Resident #121's diagnoses include Parkinson's Disease, cognitive impairment, and fluency disorder. Review of the face sheet in the electronic record identified Person #1 was the responsible party/Power of Attorney for Resident #121. The Resident Care Plan dated 8/28/23 identified Resident #121 had a history of falls with injury. Interventions included education on call bell usage and not leaving him/her unattended while sitting on the side of the bed. Facility Reportable Events dated 1/1/24 through 12/19/24 identified Resident #121 had fallen twelve times (1/11/24, 1/27/24, 1/28/24, 4/2/24, 4/4/24, 4/14/24, 4/24/24, 6/2/24, 8/10/24, 9/6/24, 10/11/24, 11/22/24). The facility failed to notify Resident #121's responsible party/Conservator regarding the falls occurring on 4/2/24 (no injury), 6/2/24 (no injury) and 10/22/24 (no injury). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #121 was cognitively intact, had unclear speech, required substantial assistance with chair/bed to chair transfers, and was reliant on a motorized wheelchair. Interview with the Assistant Director of Nursing (ADN) and the Director of Nursing (DNS) on 12/19/24 at 12:11 PM identified the facility failed to notify Resident #121's responsible party/Person #1 (4/2/24, 6/2/24, 10/11/24). The ADN and DNS failed to identify the reason the responsible party/Person #1 was not notified and noted the responsible party/Person #1 should have been notified each time Resident #121 fell . Review of the Fall Management Policy identified that a resident's physician and family/responsible party is to be notified in the event a resident falls.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observations, review of the clinical record, facility policy, and interview for 1 of 4 sampled residents, (Resident #12) reviewed for positioning and mobility, the facility failed to implement siderail pads according to the care plan and for 1 of 1 sampled residents (Resident #121) reviewed for falls, the facility failed to implement a care plan intervention related to falls. The findings include:. The findings include: 1. Resident #12's diagnoses included dementia with behavioral disturbance, muscle weakness, and involuntary movements. The annual Minimum Data Set assessment dated [DATE] identified Resident #12 was severely cognitively impaired, had no limitation in range of motion, and was totally dependent on staff for bed mobility, transfers, and eating. The Resident Care Plan dated 11/13/24 identified Resident #12 was a fall risk related to a history of falls. Interventions included the use of padded siderails and that siderail pads and floor mats were in place. Observation on 12/16/24 at 11:20 AM, identified Resident #12 was awake, in bed, moving his/her arms about, and had 4 quarter siderails in the up position. A blue siderail pad was noted on the floor between Resident #12 and his/her roommate, another was on the dresser located at the foot of the bed, and a third pad was wedged in the corner of the room on a smaller dresser, at the head of the bed, to the right of Resident #12. Observation on 12/17/24 at 9:38 AM identified Resident #12 was sleeping in bed with 4 quarter siderails up, without the benefit of siderail pads in use, and the siderail pads were noted to in the same position as they were the previous day. Observation on 12/18/24 at 8:52 AM identified Resident #12 in bed, asleep, without the benefit of siderail pads, which had been moved and were now located on both dressers in the resident's room. Interview with Nurse aide (NA) #7 on 12/19/24 at 11:37 AM identified that she had provided morning care for Resident #12 and that the siderail pads belonged to him/her, not the roommate. Resident #12 was noted out of bed being transported down the hall in his/her wheelchair. NA #7 stated it was the NA's responsibility to ensure the padded rails were in place, that the night shift normally placed the siderail pads, but if the siderail pads were missing, she would be responsible to ensure placement. Additionally, NA #7 identified the siderail pads, which had been missing during the surveyor observations, should have been in place to cover the siderails to prevent Resident #12 from injury if he/she attempted to get out of bed. Review of the Care Plan Policy dated 4/17/24 directed, in part, the comprehensive care plan is used to set goals and to indicate the discipline responsible to implement the interventions/approaches noted on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #121's diagnoses include Parkinson's Disease, heart failure, and reduced mobility. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #121 was cognitively intact, required substantial assistance with chair/bed to chair transfers, was reliant on a motorized wheelchair, and was dependent on lower body dressing and putting on/taking off footwear. The Resident Care Plan dated 11/13/24 identified Resident #121 had a history of falls. Interventions included not leaving him/her on the edge of the bed unattended, the use of non-slip socks, and the use of side rails while in bed. An observation of Resident #121 on 12/16/24 at 11:51 AM, immediately after Nurse Aide (NA) #1 exited Resident #121's room, identified the resident was fully dressed and sitting on his/her right bed edge with his/her feet touching the floor. Resident #121 was unattended, and no staff were present in the room. An interview with NA #1 on 12/16/24 at 12:12 PM identified that NA #1 was aware that Resident #121 was sitting on the edge of the bed when he exited the room and should not have been left unattended due to Resident #121's history of falls. NA #1 noted the reason he left Resident #121 unattended was to provide non-urgent care to another resident. When asked if Resident #121 was still sitting on the edge of the bed, NA #1 visually verified that Resident #121 was still sitting on the edge of his/her bed and left him/her unattended for a second occurrence at the conclusion of the interview. An observation on 12/16/24 at 12:15 PM identified that the Director of Occupational Therapy/Physical Therapy (OT/PT) and Regional Director of Physical Therapy (PT) entered Resident #121's room. Continued observation of the room identified that the Director of OT/PT and Regional Director of PT exited Resident #121's room on 12/16/24 at 12:17 PM and left Resident #121 sitting on the edge of the bed unattended. An interview with the Director of OT/PT and Regional Director of PT on 12/16/24 at 12:19 PM identified they were aware Resident #121 was sitting at the edge of his/her bed unattended when they left the room. The Director of OT/PT noted he was very familiar with Resident #121's fall risk interventions and participated in the development of the care plan interventions. The Director of OT/PT failed to identify Resident #121 was not to be left unattended while sitting and noted it was the responsibility of all staff to follow the care plan to ensure safety interventions to prevent falls are followed. Subsequent to surveyor inquiry, the Director of OT/PT asked for staff assistance and Resident #121 was assisted off his/her bed and into a wheelchair. Review of the Care Plan Policy identified that an interdisciplinary team including nursing, social services, rehabilitation, and the resident be included in the development of the care plan and include identified problems with interventions to address the problem. 52073

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on observation, interviews and facility policy for 1 of 2 sampled residents (Resident #125) reviewed for Activities of Daily Living (ADL), the facility failed to accommodate a resident's grooming request in a timely manner. The findings include: Resident #125's diagnoses included general muscle weakness, chronic obstructive pulmonary disease and a need for assistance with personal care. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #125 was independent in making decisions with no cognitive deficits, required set up for eating and substantial/maximal assistance for personal hygiene. The interview for daily preferences identified it was very important for Resident #125 to choose what clothes to wear and choose between a tub bath, shower, bed bath or sponge bath. The Resident Care Plan dated 12/18/24 identified Resident #125 had an ADL self-care performance deficit. Interventions included assisting Resident #125 with daily routines and encouraging the resident to participate to the fullest extent possible with each interaction. The Nurse Aid care card instructed Resident #125 to be assisted with daily routines. Observation and interview with Resident #125 on 12/16/24 at 12:24 PM identified he/she was in bed with a beard that was approximately 3 inches long. Resident #125 stated I can't wait to be shaved, I don't usually have a beard like this. Adding that he/she had not been shaved at all since being admitted , and when he/she inquired about being shaved, was told he/she would have to wait until Wednesday when the hairdresser was in (2 days later). Observation and interview with Resident #125 on 12/18/24 at 9:31 AM identified the resident in his/her room sitting up in a chair, stating I'm going to see her (hairdresser) today, she's only here on Wednesdays, I'm finally going to get shaved, I've never had it this long. Interview with Licensed Practical Nurse (LPN) #4 on 12/18/24 at 10:12 AM identified the Nurse Aides were responsible for shaving the residents, and if a resident refused the care it was documented in the progress notes. Review of the nursing progress notes failed to identify refusals of care for Resident #125. LPN #4 added that Resident #125 was waiting for the hairdresser, but she now comes on Tuesdays, so one of the Nurse Aides would shave Resident #125 today. Interview with Nurse Aide (NA) #4 on 12/19/24 at 9:16 AM identified that she shaved Resident #125 yesterday (12/18/24) subsequent to surveyor inquiry, and the resident was so happy and grateful, because Resident #125 thought they had to pay to be shaved. A review of the policy for Personal Care dated 7/18/24 directed in part that nursing personnel will offer AM and PM care to all residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the policy for shaving patients/residents dated 9/18/24 directed in part that all male and female patients/residents will be shaved and or beard trimmed by nursing personnel according to individual personal preference.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51182 Based on observations, review of the clinical record, facility policy, and interviews for 1 of 4 sampled residents (Resident #12) reviewed for skin conditions, the facility failed to follow a physician's order for the application of bilateral foot boots and for 1 of 1 sampled residents (Resident #18) reviewed for positioning, the facility failed to accurately transcribe a provider's order for positioning. Additionally, for 3 of 3 residents (Resident #35, Resident #118 and Resident #129) reviewed for Methadone therapy, the facility failed to ensure Methadone was available for administration. The findings include: 1. Resident #12's diagnoses included dementia, muscle weakness, abnormal posture, reduced mobility, and involuntary movements. The annual Minimum Data Set assessment dated [DATE] identified Resident #12 was severely cognitively impaired, had no limitation in range of motion, and was totally dependent on staff for bed mobility, transfers, and putting on and taking off footwear. The Resident Care Plan dated 11/13/24, identified Resident #12 was at risk for alterations in skin integrity which could lead to skin breakdown. Interventions included staff to monitor skin integrity and to apply and remove multi-podus boots as needed. A physician's order in effect on 12/16/24 directed bilateral soft multi-podus boots were to be applied at all times, staff could remove for care and reapply. Review of the Treatment Administration Record for bilateral multi-podus boot application from 12/16/24 through 12/19/24 identified a checkmark indicating that the multi-podus boots had been applied. Observation on 12/16/24 at 11:20 AM identified Resident #12 was awake, in bed with a black foot boot noted on the floor under Resident #12's bed and another foot boot on the dresser toward the foot of the bed. Observation on 12/17/24 at 9:38 AM identified Resident #12 was in bed, asleep, and there were (2) foot boots noted to be on the top of the dresser. Observation and interview on 12/18/24 at 8:52 AM with NA #8 identified Resident #12 in bed asleep. Although Resident #12 had the multi-podus boots in bed with him/her, the boots were not positioned on the resident. NA #8 indicated the resident frequently kicked his/her boots off and when she attempted to replace the boots, the resident ultimately refused. Once NA #8 explained to the resident, he/she needed boots placed, Resident #12 consented. Observation and interview on 12/19/24 at 11:56 AM with NA #7 identified Resident #12 was being wheeled in the wheelchair, down the hallway, without the benefit of his/her multi-podus boots. NA #7 indicated that Resident #12 wore the multi-podus boots for heel protection to prevent skin breakdown, only while in bed. NA #7 further stated that the staff followed the Resident Care Plan to direct care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/19/24 at 1:52 PM with the Regional Director, identified that NA staff would refer to the Resident Care Plan in order to know what care needed to be provided to residents. Further, any concerns or issues needed to be reported the charge nurse, and ultimately, it was the charge nurse's responsibility to ensure the care plan was being followed. Review of the Pressure Ulcer Policy indicated, in part, that a resident would receive care that was consistent with professional standards that would prevent or minimize the risk of a pressure ulcer. Interventions to minimize the risk for a pressure ulcer would be included in the resident's individual care plan. 2. Resident #18's diagnoses include heart failure, dementia, and Chronic Obstructive Pulmonary Disease (COPD). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 had severe cognitive impairment, was dependent with personal hygiene, and required maximal assistance with chair/bed to chair transfers and rolling left and right in bed. A physician order dated 10/9/24 directed that the head of Resident #18's bed should be elevated to prevent shortness of breath while lying flat, secondary to COPD and asthma, on every shift. The Resident Care Plan (RCP) dated 11/22/24 identified Resident #18 had chronic respiratory failure and COPD. Interventions included keeping the head of the bed elevated per Medical Doctor (MD), and monitoring for signs and symptoms of difficulty breathing and acute respiratory insufficiency. An observation on 12/16/24 at 11:18 AM identified Resident #18 was lying in bed, fully dressed in slacks and a long sleeve shirt, on his/her right side. The bed was in a flat position and the head of the bed was not elevated. An observation on 12/18/24 on 10:22 AM identified Resident #18 was lying in bed with the covers pulled up to his/her shoulders and positioned on his/her right side. The bed was in a flat position and the head of the bed was not elevated. An interview with Nurse Aide (NA) #1 on 12/18/24 at 10:29 AM identified he was not aware of any positioning needs for Resident #18 and noted positioning needs would be listed on the NA Care Card. The NA Care Card, located on the inside of Resident #18's closet, failed to reflect positioning advisement including keeping the head of the bed elevated to prevent shortness of breath while lying flat. An interview with Licensed Practical Nurse (LPN) #3 on 12/18/24 at 10:35 AM identified there was an electronic physician positioning order but the order was not on the NA Care Card for the NAs to follow. Additionally, LPN #3 indicated the MDS Coordinator was responsible for ensuring positioning orders were entered onto the NA Care Card. An interview with LPN #5/MDS Coordinator #1 on 12/18/24 at 10:56 AM identified that a physician order was in the system but not being reflected on the NA Care Card. She noted she was uncertain as to the reason the order was not added to the NA Care Card. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with MDS Coordinator #2 on 12/18/24 at 11:08 AM identified he was responsible for ensuring the physician's order for positioning was accurately transcribed into the electronic health record and noted the reason the order had not been transcribed properly was the facility transitioned to a new electronic health record system and he was uncertain of how to use it. Subsequent to surveyor inquiry, the positioning order was entered into Resident #18's Care Card. An interview with the Director of Nursing Services (DNS) on 12/18/24 at 11:10 AM identified she was aware that there was an ongoing issue with orders not being properly transcribed to the NA Care Card, and noted a process for all orders to be reviewed quarterly was assisting the facility in correcting the missing transcriptions. Review of the Physician Orders- Transcription Policy identified that orders will be transcribed by a licensed nurse and entered into the appropriate worksheets within the electronic health record. The Physician Order Sheet and Kardex Editing Policy identified the computerized Kardex should be checked against the treatment Kardex for changes, additions, or deletions. 3a. Resident #35 was admitted to the facility in July 2020 with a diagnosis of Opioid Dependence. A physician's order dated 9/17/24 directed to administer Methadone (a medication used to treat Opioid Use Disorder) 10 milligrams (mg)/milliliter (ml) give 10.5 ml (105 mg) for Opioid dependence once daily getting from Methadone clinic. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #35 as having intact cognition. The Resident Care Plan dated 10/23/24 identified a problem with Opioid Dependence. Interventions included to monitor for signs of overdose and attempt to wake Resident #35 by shaking and calling his/her name if exhibiting symptoms, if unsuccessful in arousing, call 911 and administer Narcan as ordered. A nurse's note dated 11/6/24 at 4:09 PM identified that Resident #35 did not receive his/her daily Methadone medication that morning. A Medication Error Report dated 11/6/2024 identified that Methadone 105 mg liquid once a day was not given to Resident #35 due to an oversight by the facility regarding the pick up day of the medication from the Methadone clinic. Resident #35 had reported he/she did not receive daily Methadone and the Medication Error Report indicated that Resident #35 had no ill effects from the missed dose. A review of the Medication Administration Record (MAR) dated 11/6/24 identified Methadone daily dose of 105 mg for 6:00 AM was not documented as being administered by the charge nurse. b. Resident #118 was admitted to the facility in April 2023 with diagnosis of Opioid Dependence. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #118 had intact cognition. The Resident Care Plan dated 10/2/24 identified a problem of Opioid Dependence. Interventions included to provide Resident #118 with Methadone as directed, prepare Methadone and ensure Resident #118 was able to take without assistance. Physician's orders dated 10/30/24 directed to administer Methadone (a medication used to treat Opioid Use Disorder) 10 milligrams (mg)/milliliter (ml) give 12 ml (120 mg) once a day for Opioid Dependence. A nurse note dated 11/6/24 at 4:31 PM identified that Resident #118 was continuously yelling at the supervisor and kept knocking on door due to the missing Methadone dose. The Advanced Practice Nurse (APRN) gave an order for one time dose of Oxycodone 10 mg (pain medication) to replace the missed dose of Methadone. The Medication Error Report dated 11/6/24 identified Methadone 120 mg liquid once a day and was not given due to an oversight by the facility regarding pick-up day from the Methadone clinic and that Resident #118 had reported he/she did not receive daily Methadone. The Medication Error Report indicated that Resident #118 had no ill effects from the missed dose. A review of the Medication Administration Record dated 11/6/2024 identified that Methadone 120 mg daily dose for 6:00 AM was not documented by the charge nurse as being administered. In addition, a one-time dose of Oxycodone 10 mg was documented as being administered on the MAR by the charge nurse at 4:33 PM. c. Resident #129 was admitted to the facility in December 2022 with diagnosis of Opioid Dependence. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #129 as being severely cognitively impaired. The Resident Care Plan 8/30/24 identified a problem of Opioid Dependence. Interventions included that Resident #129 was on a tapering dose of Methadone and to monitor for any symptoms of taper/withdrawal. A physician's order dated 9/30/24 directed to administer Methadone (a medication used to treat Opioid Use Disorder) 10 milligrams (mg)/milliliter (ml) give 6.5 ml (65 mg) once a day for opioid addiction. A nurse's note dated 11/6/24 at 4:35 PM identified that Resident #129 missed a daily dose of Methadone 105 mg daily (correct Methadone dose was 65 mg once a day and not 105 mg) due to inadvertently overlooking the picking up of the medication from the clinic. Additionally, the nursing note identified that nursing would monitor for any signs and symptoms of withdrawal and maintain the same Methadone dose and schedule. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Error Report dated 11/6/24 identified Methadone 55 mg (correct Methadone dose was 65 mg once a day and not 55 mg) once a day was not given due to an oversight by the facility regarding the pick-up day from the Methadone clinic and that Resident #129 had no ill effects from the missed dose. A review of Medication Administration Record (MAR) dated 11/6/24 at 6:00 AM identified that Methadone daily dose of 65 mg was not signed as being administered by the charge nurse. A review of Medication Error Reports for Resident #35, Resident #118 and Resident #129 and an interview with the Assistant Director of Nursing (ADNS) on 12/18/24 at 12:55 PM revealed that the ADNS was responsible for obtaining Methadone from the clinic. She indicated at that time she had no formal way of tracking dates to pick-up Methadone from the clinics. Additionally, she indicated on the date of errors (on 11/6/24) she did not realize that she needed to pick-up Methadone from the clinic for the residents. After the medication errors, she now uses a monthly calendar to keep track of dates for pick-up. Interview with the Director of Nursing (DNS) on 12/18/24 at 1:00 PM verified that ADNS was responsible for picking up the Methadone. The facility was using 3 clinics at the time the medication errors occurred. The facility is no longer using that Methadone clinic and now the facility is only using 2 clinics. A review of the Methadone policy dated 6/3/2024 directed, in part, that a list of all current residents on Methadone will be maintained by the DNS. A designated staff person will be assigned to pick up Methadone from the clinic on the Care Center's designated pick up day. The supervisor and/or charge nurse are responsible for storing and counting of the Methadone, as well as distributing to the residents for administration. 51756 52073

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on interviews and record review for 1 of 5 residents (Resident #107) reviewed for unnecessary medications, the facility failed to follow pharmacy recommendations. The findings include: Resident #107's diagnoses included gastro esophageal reflux disease (GERD), Wernicke's encephalopathy, and anxiety. A physician order dated 4/1/24 directed Pantoprazole (a medication to treat GERD) 1 tablet be given daily. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #107 had a short/long term memory problem and required set up with eating and upper body dressing. The MDS further identified Resident #107 required supervision with personal hygiene and maximal assistance with oral hygiene. Pharmacy Medication Regimen Review dated 9/10/24 identified Resident #107 was receiving crushed medications without an order to do so and Pantoprazole (a medication used to treat GERD) 40 milligrams (mg) which was enteric coated and cannot be crushed. Consultant Pharmacist recommendations included adding an order to crush medications where appropriate, as well as switching the Pantoprazole 40 mg to Omeprazole 20 mg capsule daily which offers the same efficacy and can be opened and administered by opening the capsules into apple sauce. The Resident Care Plan dated 9/17/24 identified Resident #107 had altered respiratory status/difficulty breathing related to potential for aspiration and recent diet downgrade. Interventions included administering medications as ordered and monitoring of effectiveness. A physician's order dated 10/28/24 directed Resident #107 may have medications crushed in apple sauce every shift. A physician's order dated 10/29/24 through 12/11/24 directed Resident #107 receive Omeprazole 20 mg tablet once a day (49 days after pharmacy recommendations). A physician's order dated 12/12/24 directed Resident #107 receive Omeprazole 20 mg oral capsule (previous physician orders dated 10/29/24 directed tablet form) delayed release once a day (86 days after pharmacy recommendations) and the Omeprazole tablet was discontinued. An interview and record review with Regional Registered Nurse (RN) #1 on 12/19/24 at 11:20 AM identified that the Director of Nursing Services was responsible for Medication Regimen Reviews and recommendations from the pharmacist. She could not identify the reason the 9/10/24 pharmacy recommendations to change from Pantoprazole 40 mg to Omeprazole 20 mg capsules was not initiated until 12/12/24, or the reason the Omeprazole was ordered as a tablet and not a capsule from 10/29/24 to 12/11/24. RN #1 added that the facility does not use capsules and tablets interchangeably. (continued on next page)

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	075337	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Springs Care Center	33 Roy St Meriden, CT 06450

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and record review with the Regional Director Pharmacist #1 on 12/19/24 at 11:59 AM identified that pharmacy Medication Regimen Reviews were expected to be followed up on within 30 days. She also identified that Omeprazole was a delayed release and worked best when ordered as a capsule so that it can be released slowly over 24 hours. Additionally, crushing the tablet versus opening the capsule into applesauce might not be as effective in acid suppression and potentially lead to an increase in gastrointestinal (GI) symptoms. Review of the Drug Regimen Review-Monthly facility policy directed that the physician or licensed designee shall respond to the Drug Regimen Review within 7 to 14 days or more promptly.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31357 Based on clinical record review, review of facility policy, and interviews for 1 of 5 sampled residents (Resident #154) reviewed for unnecessary medications, the facility failed to conduct a baseline Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving an antipsychotic medication. The findings include: Resident #154's diagnoses included dementia, anxiety, and Post Traumatic Stress Disorder (PTSD). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #154 was severely cognitively impaired and required partial/moderate assistance with bed mobility and transfers and was dependent on staff for personal hygiene. The Resident Care Plan (RCP) dated 11/19/24 identified Resident #154 used a psychotropic medication. Interventions directed to administer psychotropic medications as ordered, consult with the pharmacy and consider dosage reductions, and monitor and document any adverse reactions including tardive dyskinesia. A physician's order dated 12/2/24 directed to administer Risperdal (an antipsychotic medication) 1 mg twice daily. Interview and review of the clinical record with the Social Worker (SW) #1 identified that per the facility policy AIMS assessments were completed every 6 months, the facility policy did not include conducting a baseline AIMS assessment on admission, and the AIMS didn't need to be conducted until 6 months following the residents admission. SW #1 indicated that psychiatry services was responsible to conduct the AIMS assessments. Interview with RN #1 on 12/20/24 11:50 AM identified that the facility policy did not include performing AIMS testing on admission, that the purpose of the AIMS test was to identify abnormal movements, and that AIMS assessments were conducted every 6 months to identify changes from 1 assessment to the next. Interview and review of pharmacy recommendations with Pharmacist #1 identified that the pharmacist had made a recommendation on 12/11/24 for a baseline AIMS assessment to be conducted so the facility could determine if there were any changes involving involuntary movements. Pharmacist #1 indicated that she didn't immediately make recommendations for an AIMS at this facility to give the psychiatric provider an opportunity to conduct the AIMS assessment. Review of the pharmacy consultant recommendations identified that Resident #154 was recently admitted on an antipsychotic drug therapy. Baseline AIMS test recommended after admission and every 6 months thereafter to assess for the potential development and progression of side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with RN #1 and the ADNS on 12/20/24 at 1:14 PM identified that the psychiatric provider was responsible to conduct the AIMS assessments, the payment provider had approved psychiatric services to see Resident #154 today (12/20/24), and that in the event the psychiatric provider was not available an RN could have conducted an AIMS assessment. Review of the facility AIMS assessment and psychotropic drug use policies failed to include baseline AIMS testing on admission.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51867 Based on observations, staff interviews, and review of facility policy during a tour of the Dietary Department, the facility failed to ensure food was stored under clean conditions, failed to ensure facility prepared foods were discarded within 72 hours, and failed to ensure food items that had been removed from the original outer container had expiration or opened dates. The findings include: During a tour of the Dietary Department and interview with the Director of Food Service on 12/16/24 at 11:00 AM identified the following: A. A room described as the cold room contained 1 large refrigeration unit and 1 large freezer unit. The tile floor in the cold room was noted to be littered with a white, dusty, powdery, material. Shoe prints were visible throughout the cold room floor and an old green garden hose was stored on the floor. The Director of Food Services reported that sheetrock had recently been replaced. Further, the substance on the floor, where footprints were observed, was from sheetrock dust and debris that had dried following the work. Although the Director of Food Service had requested housekeeping services to come clean and buff the floor, no one had assisted to clean the area. Subsequent to the initial tour with the Director of Food Services, the cold room tile floor was cleaned, and the green hose was removed. B. Observation in the dry storage room identified a 32-ounce bag of crisped rice cereal that was 85% full and a 32-zounce bag of orzo that was approximately 1/3 full without the benefit of an expiration date. The original boxes could not be located to reference the manufacturer's expiration date. C. Observation in the cold room walk-in refrigerator identified the following: A half metal container 2/3rds full of chopped Salisbury steak was dated 12/12/24 (4 days old) A sixth metal container half full of cranberry sauce was dated 12/5/24 (11 days old) A half metal container full of sliced turkey breast dated 12/10/24 (6 days old) A sixth metal container 2/3rds full of cucumber salad dated 12/13/24 (3 days old) A full metal container full of sliced turkey breast dated 12/11/24 (5 days old) A sixth metal container 2/3 full of rice/orzo dated 12/13/24 (3 days old) A sixth metal container full of chopped pineapple dated 12/12/24 (4 days old) A half metal container full of pancakes dated 12/12/24 (4 days old) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Director of Food Services indicated that the policy was to discard facility prepared foods within 72 hours after preparation and that the cook on duty was responsible to ensure food was discarded according to the policy. Subsequent to surveyor inquiry, the Director of Food Service began to discard the out of date items. D. Observation of the kitchen wall in the area between the ice machine and the housekeeping closet identified tiles that were broken, cracked, and missing. The wall behind the broken and missing tiles was noted to be dusty and crumbling and debris was noted on the floor below. Review of the Food Storage policy dated 4/29/20 identified food storage, including dry storage, refrigerators, freezers and chemical rooms, shall always be clean and sanitary. The facility uses the Date Marking Policy in conjunction with the Food Storage Policy ensuring ready-to-eat closed or open foods maintain an expiration or use-by dating system. Additionally, the Food Storage policy identified that ready prepared leftovers shall be discarded within 72 hours of the date originally prepared.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on interviews, and record review for 1 of 2 residents (Resident #112) reviewed for antibiotic use, the facility failed to monitor a resident on long term antibiotics per the facility antibiotic stewardship policy. The findings include: Resident #112's diagnoses included hemiparesis and hemiplegia affecting the left side, infection and inflammatory reaction due to internal left knee prosthesis, and epileptic seizures. The physician's order dated 9/30/24 directed to give Ciprofloxacin 500 milligrams (mg) 1 tablet twice a day (no end date was indicated). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #112 was cognitively intact, required set up help for eating and toileting, and was independent for transfers. The Resident Care Plan dated 11/5/24 identified Resident #112 had an infection of the left knee and was receiving antibiotic treatment. Interventions included administering the antibiotic per the physician orders and to follow the facility policy and procedure for line listing, summarizing and reporting infections. Interview and record review with the Infection Preventionist, Licensed Practical Nurse (LPN) #6 on 12/18/24 at 12:50 PM identified she tracked antibiotic use but could not identify tracking Resident #112 on the antibiotic list since she only had her/him documented as a one-time antibiotic dose in October 2024. A follow up interview with LPN #6 on 12/18/24 at 1:22 PM identified Resident #112 had been on antibiotics since April 2024 for suppressive therapy, she was unaware of Resident #112's current antibiotic use, and that per the facility antibiotic stewardship policy, the resident should have been monitored. Subsequent to surveyor inquiry Resident #112 was added to the antibiotic monitoring list. Interview and record review with the Infection Preventionist, Licensed Practical Nurse (LPN) #6 on 12/18/24 at 12:50 PM identified she tracks antibiotic use, but could not identify tracking Resident #112 on the antibiotic list, since she only had her/him documented as a one-time antibiotic dose in October 2024. A follow up interview with LPN #6 on 12/18/24 at 1:22 PM identified Resident #112 has been on antibiotic since April 2024 for suppressive therapy, adding she appreciated this being brought to her attention, that she/he should have been on the antibiotic monitoring and that Resident #112 was now added to the antibiotic monitoring list. A review of the facility Antibiotic Stewardship Policy dated 10/22/21 directed in part to promote a culture of improved antibiotic use in the long term care setting, with the goal of preventing the spread of resistant bacteria