STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075440	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at 3030 Park, The	3030 Park Avenue Bridgeport, CT 06604

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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 review of the clinical record, facility documentation, facility policy, and interview for 1 resident (Resident #30) reviewed for staff to resident altercation, the facility failed to ensure the resident was free from abuse. The findings include:Resident #30 was admitted to the facility in July 2025 with diagnoses that included nondisplaced fracture of the fifth cervical vertebra, concussion and edema of cervical spinal cord, and cervical disc disorder at C5-C6 level.The admission MDS dated [DATE] identified Resident #30 had intact cognition and was dependent with personal hygiene. Additionally, Resident#30 had no verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others).The reportable event form dated 10/21/25 at 11:00 AM identified Resident #30 was alert and oriented. NA #3 came into Resident #30's room while the resident had a visitor and became loud speaking about personal issues. Resident #30 asked NA #3 to leave. Two other staff members came into the room and NA #3 left the room. Resident #30 did not feel comfortable with NA #3. NA #3 was removed from the schedule and sent home immediately after counseling. The physician, resident representative, and the Administrator were notified and an investigation initiated. The nurse's note by the ADNS dated 10/21/25 at 12:23 PM identified NA #3 entered Resident #30's room while the resident had a visitor present. Person #1 and Resident #30 reported that NA #3 was speaking loudly and discussing personal issues. NA #3 was asked to leave the room. NA #3 was immediately removed from the floor, counselled and was sent home. Resident #30 was reassured that NA #3 had been removed from the floor. Resident #30 stated that she felt safe and was reassured that staff were available to address any concerns. Resident #30's family visited and was made aware of the incident.The social service note dated 10/21/25 at 3:57 PM identified she met with Resident #30 regarding the incident that occurred earlier that day involving NA #3. Resident #30 reported that between 10:00 AM - 11:00 AM, NA #3 entered the resident's room and began speaking loudly and yelling about some personal situation between her spouse and the land that they live on. At the time of the incident, Resident #30 had a visitor present. Person #1 asked NA #3 to please leave the room and to stop getting loud. Two additional staff members entered the room, and NA #3, who was yelling, finally left the resident alone. The social worker assessed Resident #30 following the incident. Resident #30 stated that he/she feels safe at the facility, now that NA #3 was sent home. Resident #30 stated most of the staff are all nice and he/she does not have a problem with anyone. Resident #30 was informed that NA #3 would no longer be assigned to provide care to him/her. Resident #30 stated that he/she thought NA #3 was his/her friend and does not understand why NA #3 became so angry with him/her. Resident #30 was observed to have a supportive family and social support system. Social services will continue to monitor Resident #30 and provide 1:1 room visits as needed for emotional support and comfort.A written statement from Person #1 (visitor) dated 10/21/25 (untimed) identified Person #1 was present in Resident #30's room when NA #3 entered the room and began speaking to Resident #30 in (continued on next page)

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	a loud tone regarding personal issues involving peaches. Person #1 indicated that NA #3's voice was raised and that NA #3 continued speaking over Resident #30 when the resident attempted to respond. Person #1 indicated that he/she asked NA #3 to stop speaking and informed NA #3 that she was inappropriate. Person #1 indicated NA #3 continued yelling despite being asked to stop. Person #1 indicated that NA #2 entered the room and was professional and attempted to provide care to Resident #30, while NA #3 continued yelling. Person #1 indicated he/she repeatedly asked NA #3 to stop talking. Person #1 indicated NA #4 entered the room and attempted to escort NA #3 out of the room. Person #1 indicated NA #4 was professional. Person #1 indicated that he/she began recording the incident. Person #1 indicated NA #3 then directed comments towards him/her (Person #1), stating he/she was a horrible person and not a good friend and they didn't like me.A written statement from NA #2 dated 10/21/25 (untimed) identified she entered Resident #30's room to obtain the resident vital signs. NA #2 indicated she heard NA #3 and Resident #30 arguing. NA #2 indicated Person #1 was present in the room and stated (that is enough). NA #2 indicated she did not know what was said during the argument. NA #2 indicated NA #4 entered the room to get NA #3. NA #2 indicated that she left the room at that time. A written statement from NA #4 dated 10/21/25 (untimed) identified that she went to look for NA #3 and located her in Resident #30's room. NA #4 indicated that she witnessed a loud conversation between NA #3 and Resident #30. NA #4 indicated that she asked NA #3 to step out of the room. NA #4 indicated she apologized to Resident #30 regarding the incident. NA #4 indicated she reported the incident to the supervisor.A written statement from NA #3 dated 10/21/25 (untimed) identified that NA #4 informed her that Resident #30 was discussing her personal business. NA #3 indicated she went to Resident #30's room to ask the resident why she was discussing her personal business. NA #3 indicated Person #1 began yelling at her and then pulled out a phone and began recording. NA #3 indicated NA #2 and NA #4 approached the room and Person #1 started yelling at her to leave the room while she was still talking to Resident #30. NA #3 indicated she and Resident #30 began yelling at each other. NA #3 indicated NA #4 attempted to remove her out of the room. NA #3 indicated she and Resident #30 were friends and family. NA #3 indicated she was sorry for her behavior and confrontation and was aware the incident was a serious matter. The summary report dated 10/23/25 at 2:49 PM identified NA #3 entered Resident #30's room to speak with the resident regarding a statement that the resident reportedly made to another staff member. NA #3 indicated the visitor began yelling at her and recording her. NA #3 had a verbal confrontation with the visitor in the presence of Resident #30 in the room. NA #4 asked NA #3 to leave the room, and NA #3 left. NA #3 was sent home pending an investigation. After completion of the investigation, receiving and reviewing of staff statements, NA #3 will not be allowed in Resident #30's room.The care plan dated 10/27/25 identified Resident #30 had an altercation/conflict with a staff member who came into her room and confronted him/her about a personal situation. Interventions included reassure the resident as needed. Staff to encourage the resident to socialize and attend activities. Interview with NA #3 on 1/5/26 at 2:40 PM identified she has been employed by the facility since June 2025. NA #3 indicated she was not assigned to Resident #30 on 10/21/25 at the time of the incident. NA #3 indicated Resident #30 was a family friend. NA #3 indicated NA #4 informed her that Resident #30 was discussing her personal business within the facility. NA #3 indicated she entered Resident #30's room and asked the resident if it was true that the resident had been speaking about her and her family. NA #3 indicated she takes full responsibility for her behavior, for confronting Resident #30, and speaking loudly in an aggressive manner towards Resident #30. NA #3 indicated that before Resident #30 could respond, Person #1 instructed her to leave the room. NA #3 indicated she made a hand gesture towards Person #1 and stated she was not speaking to him/her, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then turned towards Resident #30. NA #3 indicated Resident #30 denied making the statements and attempted to explain. NA #3 indicated she mentioned the name of Resident #30's child during the verbal altercation. NA #3 indicated Resident #30 instructed her not to mention his/her child's name and Resident #30 stated that he/she would call the police. NA #3 indicated Person #1 used foul language toward her and began recording the interaction on the phone. NA #3 indicated Person #1 started recording after she had already confronted Resident #30. NA #3 indicated NA #4 entered the room and told her she had to leave. NA #3 indicated NA #2 was in the room when she was questioning Resident #30. NA #3 indicated she was loud and arguing with Person #1 in the presence of Resident #30. NA #3 indicated she was removed from the schedule pending investigation. NA #3 indicated she was educated on abuse. NA #3 indicated since the incident she has not provided care to Resident #30.Interview with RN #3 on 1/6/26 at 11:15 AM identified she was the RN Supervisor on 10/21/25 at the time of the incident. RN #3 indicated she was notified of the incident involving NA #3, Resident #30, and Person #1 by NA #2. RN #3 indicated NA #2 informed her that she needed to go to Resident #30's room and remove NA #3 due to NA #3 arguing with Resident #30. RN #3 indicated she immediately went to Resident #30's room. RN #3 indicated she observed Resident #30 in bed and Person #1 was sitting by the bedside. RN #3 indicated no staff members were present in the room at that time. RN #3 indicated she asked Resident #30 what happened and if the resident was okay. RN #3 indicated Resident #30 stated he/she was fine. RN #3 indicated she told Resident #30 that he/she did not appear fine and appeared to have been crying. RN #3 indicated Person #1 told her, there is a rude nurse aide here who is very disrespectful, and Person #1 recorded her. RN #3 indicated she asked to review the recording. RN #3 indicated the video showed Person #1 telling NA #3 to leave the room, and the NA #3 responding no, no, and stating that she and Resident #30 were friends. RN #3 indicated the video also showed NA #4 attempting to remove NA #3 from the room. RN #3 indicated NA #3 and Person #1 were loud during the recording. RN #3 indicated after reviewing the video, she consoled Resident #30 and ensured the resident was alright. RN #3 indicated Resident #30 told her that NA #3 and their family were friends and that NA #3 was upset because she believed Resident #30 had been speaking about her to other staff members. RN #3 indicated Resident #30 denied making such statements. RN #3 indicated she assured Resident 30 that NA #3 would no longer enter the room or provide care. RN #3 indicated she immediately reported the incident to the ADNS. RN #3 indicated she and the ADNS located NA #3 and removed her from the unit to the ADNS office. RN #3 indicated the ADNS asked NA #3 to explain what happened and NA #3 provided her account of the incident. RN indicated NA #3 was instructed to leave the facility. Interview with NA #4 on 1/7/26 at 6:38 AM identified she went to look for NA #3 and found NA #3 in Resident #30's room. NA #4 indicated NA #2, NA #3, and Person #1 were present in the room. NA #4 indicated she observed NA #3 speaking to Resident #30 in a loud tone of voice. NA #4 indicated she was not present when NA #3 began arguing with Resident #30. NA #4 indicated she asked NA #3 to leave the room, and NA #3 exited the room but returned right back and continued to argue in a loud tone of voice with Resident #30 and Person #1. NA #4 indicated she was unable to understand the specific content of the conversation. NA #4 indicated NA #3 appeared upset and angry. NA #4 indicated Person #1 reported she had video-recorded the incident and was going to notify the DNS. NA #4 indicated Resident #30 appeared shocked, frazzled, and was crying about the incident. NA #4 indicated Resident #30 said he/she didn't know why NA #3 was acting that way towards him/her. NA #4 indicated she consoled Resident #30. NA #4 indicated no staff member should speak to a resident the way NA #3 was speaking to Resident #30. NA #4 indicated after leaving Resident #30's room, she spoke with NA #3 regarding the incident. NA #4 indicated while speaking with NA #3, RN #3 approached her and discussed the incident involving NA #3 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Resident #30. NA #4 indicated she had received in-service training regarding abuse.Interview with NA #2 on 1/7/26 at 7:39 AM identified she was assigned to Resident #30 on 10/21/25 at the time of the incident. NA #2 indicated she entered Resident #30's room to obtain vital signs. Upon entering the room, NA #2 indicated she observed NA #3 and Resident #30 arguing in a loud tone of voice. NA #2 indicated NA #3 appeared angry and was speaking loudly while arguing with Resident #30. NA #2 indicated NA #3 made a comment regarding Resident #30's child and Resident #30 stated to not talk about his/her child and began cursing at NA #3. NA #2 indicated the argument between NA #3 and Resident #30 escalated and became louder. NA #2 indicated she observed Person #1 take out his/her phone following the argument between NA #3 and Resident #30. NA #2 indicated NA #4 entered the room and attempted to remove NA #3 from the room. NA #2 indicated she then left the room and notified the supervisor.Interview with the ADNS on 1/7/26 at 7:47 AM identified she was notified by RN #3 that NA #3 was in Resident #30's room speaking loudly to the resident and a visitor. The ADNS indicated she went to the resident's room and observed no staff present in the room. The ADNS indicated she asked Resident #30 if he/she was okay, and the resident stated he/she was alright. The ADNS indicated Person #1 appeared upset. The ADNS indicated Person #1 showed her and RN #3 a video of the incident. The ADNS indicated Resident #30 said he/she felt safe. The ADNS indicated she notified the DNS, and NA #3 was sent home. The ADNS indicated this behavior was not the expectation of the facility and that NA #3 should have carried herself in a professional manner during work. Interview with Person #1 on 1/7/26 at 9:30 AM identified NA #3 entered Resident #30's room and approached the resident's bed. Person #1 indicated NA #3 was calm at first and talking about peaches; however, NA #3 then began ranting, raving, and rambling in a loud tone of voice. Person #1 indicated that she asked NA #3 to stop. Person #1 indicated she did not know why NA #3 was angry but indicated that NA #3 was not happy. Person #1 indicated NA #2, and NA #4 entered the room and NA #4 told NA #3 she had to leave. Person #1 indicated NA #3 continued yelling at Resident #30, saying to the resident (you are talking about me). Person #1 indicated Resident #30 was in shock, scared, and was visibly crying. Person #1 indicated Resident #30 said to Person #1 that he/she did not know what just happened, that he/she was just lying here and being attacked. Person #1 indicated Resident #30 was confused about the incident. Person #1 indicated Resident #30 spoke to his/her child regarding the incident. Person #1 indicated Resident #30 told RN #3 that he/she was laying there minding his/her own business and was being attacked. Person #1 indicated NA #4 observed Resident #30 crying and she attempted to console the resident. Person #1 indicated she showed the video of the incident to RN #3 and the ADNS and sent the video to the DNS.Review of the recording video was conducted with the Administrator and the DNS on 1/7/26 at 11:55 AM identified the recording video began after NA #3 had already confronted Resident #30. The video showed NA #4 attempting remove NA #3 from the resident's room. NA #4 was observed saying to NA #3, let's go, two times. NA #3 was observed leaning over Resident #30's bed and speaking in a loud voice, stating, you don't want to talk, you don't want to call. NA #3 exited the room and stood in the hallway, then reentered the room and approached Resident #30's bedside, stating, I heard something and I came to ask Resident #30. Resident #30 was observed stating, but if you came nicely. NA #3 was again observed leaning over the bed and speaking in a loud voice to Resident #30. Resident #30's speech was observed but was not clearly understandable on the recording. NA #3 exited the room, and NA #4 was observed closing the resident's room door. NA #4 was observed apologizing to Resident #30, stating I'm sorry okay. I'm sorry for what just happened. Resident #30 responded, who doesn't like me, what did I do. The recording ended at that time.Interview with the Administrator on 1/7/26 at 12:00 PM identified she was informed of the incident by the DNS in the afternoon. The Administrator indicated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DNS informed her NA #3 was speaking loudly to a visitor in Resident #30's room. The Administrator indicated the DNS informed her that Person #1 had recorded a video of the incident. The Administrator indicated she and the DNS had reviewed the video, which showed NA #3 speaking in a loud tone to Person #1 while NA #4 attempted to get NA #3 to leave the room. The Administrator indicated she was unaware of events that occurred prior to the video recording. The Administrator indicated during the facility's investigation, NA #3 admitted to entering Resident #30's room to confront the resident regarding the resident discussing NA #3's personal business. The Administrator indicated during the facility investigation it was not reported to her or the DNS that NA #3 had argued with Resident #30 in a loud and angry tone prior to the video recording. The Administrator indicated NA #3 was educated that confronting Resident #30 was inappropriate and unprofessional. The Administrator indicated NA #3 was sent home and provided education regarding abuse prior to returning to work and was not assigned to Resident #30. Interview with the DNS on 1/7/26 at 12:10 PM identified she was involved in the facility's Mutual Aid Program drill conducted on 10/21/25 and confirmed the facility participated in the drill. The DNS indicated she was notified of an incident by the ADNS at approximately 12:00 PM on the date of the incident. The DNS indicated that when she arrived at the facility sometime after 3:00 PM, a visitor sent her a video recording. The DNS indicated the ADNS informed her that NA #3 had been in resident room speaking loudly to the visitor. The DNS indicated NA #3 was sent home. The DNS indicated she notified the Administrator when she received the video. The DNS indicated the Administrator, and she reviewed the video, which showed NA #3 speaking in a loud tone to Person #1, while NA #4 attempted to get NA #3 to leave the room. The DNS indicated she was unaware of events that occurred prior to the video recording. The DNS indicated during the facility's investigation, NA #3 admitted to entering Resident #30's room to confront the resident regarding the resident discussing NA #3's personal business. The DNS indicated during the facility's investigation it was not reported to her, the ADNS, and the Administrator that NA #3 had argued with Resident #30 in a loud and angry tone prior to the video recording. Review of the facility abuse policy identified the facility is committed to providing a safe and nurturing environment for all residents. We uphold a zero-tolerance policy for any form of abuse or neglect. All staff members are required to adhere to this policy and take immediate action if abuse or neglect is suspected or identified. Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Verbal abuse refers to any use of oral, written and/or gestured language that includes disparaging and/or derogatory terms to residents on their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. Mental abuse - verbal or nonverbal infliction of anguish, pain, or distress that results in psychological or emotional suffering. Includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation. Mistreatment - inappropriate treatment or exploitation of a resident. All staff will be trained in orientation and at minimum annually regarding prevention of abuse and their responsibility to report it.Review of the facility resident rights policy identified the facility is committed to promoting and protecting the rights of each resident. Residents have the right to make informed choices, participate in decisions regarding their care, and enjoy a living environment that respects their dignity and individuality. This policy outlines the rights of residents and the facility's obligations to uphold these rights. Residents have the right to be treated with dignity, respect, and consideration by all staff members and other residents. Staff will receive training on resident's rights to ensure they understand and uphold these rights in their daily interactions. The facility will implement monitoring procedures to ensure compliance with resident's rights and (continued on next page)

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