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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 3 of 3 residents (Residents # 7, 12, and 16) reviewed for dental services, the facility failed to offer routine dental services to long-term care residents, per the facility policy. The findings include: 1. Resident #7 was admitted to the facility in 9/2024 with diagnoses that included Alzheimer's Disease and protein-calorie malnutrition. The annual MDS dated [DATE] identified Resident #7 had severely impaired cognition and was not edentulous (lacking teeth). The quarterly MDS dated [DATE] identified Resident #7 did not have mouth or facial pain, discomfort or difficulty with chewing. The care plan dated 11/17/25 failed to reflect Resident #7's need for routine dental services. Review of the clinical record failed to reflect Resident #7 had been offered or had received routine dental services or that Resident #7 or Resident #7's representative had refused routine dental services from 9/2024 through 1/2026, 16 months. 2. Resident #12 was admitted to the facility in 12/2024 with diagnoses that included Parkinson's Disease and dementia. The annual MDS dated [DATE] identified Resident #12 had severely impaired cognition and was not edentulous. The care plan dated 11/20/25 failed to reflect Resident #12's need for routine dental services. Review of the clinical record failed to reflect Resident #12 had been offered or had received routine dental services or that Resident #12 or Resident #12's representative had refused routine dental services from 12/2024 through 1/2026, 13 months. 3. Resident #16 was admitted to the facility in 3/2024 with diagnoses that included Alzheimer's Disease and malignant neoplasm of the connective and soft tissues. The annual MDS dated [DATE] identified Resident #16 had severely impaired cognition and was not edentulous. The care plan dated 12/26/25 failed to reflect Resident #16's need for routine dental services. Review of the clinical record failed to reflect Resident #16 had been offered or had received routine dental services or that Resident #16 or Resident #16's representative had refused routine dental services from 3/2024 through 1/2026 22 months. Interview with the Director of Social Services (SW #1) on 1/6/26 at 12:25 PM identified that 6 long term care residents resided at the facility, 3 of the 6 (Residents #6, 14, and 23) were receiving hospice services, and she was unaware who was responsible for coordinating routine dental services for the long-term care residents (Residents #7, 12, and 16) that were not receiving hospice services. Interview with the DNS on 1/6/26 at 2:06 PM identified that she had reviewed the clinical records of Residents # 7, 12, and 16 and was unable to find documentation that routine dental services were offered/discussed or completed with the residents and/or resident representatives. During an interview with the Administrator and DNS on 1/7/26 at 8:53 AM, the DNS identified that if a resident or family member requested dental services or if a resident had a dental related issue, then dental services would be arranged. The DNS further identified that routine dental services had not been offered to long-term care residents (that were not receiving hospice services) or discussed with their resident representatives, however, moving forward the option for dental services would be discussed during the resident's care plan meetings. The Administrator indicated that she was not aware that routine dental services were not being offered to long-term care residents, but she would expect them to be offered. The Administrator further indicated that following a discussion with the Director of Social Services, it was identified that she was unaware that the facility could utilize an on-site (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consulting practice that offers preventative care services, including dental. The Administrator identified that the plan moving forward would be that the social worker would discuss routine dental service needs for long-term care residents during the care plan meeting, the receptionist would be responsible for arranging transportation, and the nursing supervisor would be responsible for initiating care in the event of a dental emergency. The facility's Dental Services policy directs the facility to provide or arrange for comprehensive dental services for all residents, ensuring access to preventative, routine, and emergency dental care. Maintaining oral health is essential to overall health and quality of life for residents. The policy further directs that the facility is to ensure all residents have access to dental services, either through on-site dental care or by arranging transportation and appointments with external dental providers. The provision of regular dental services includes annual dental examinations, preventative care such as cleanings, fluoride treatments, oral hygiene education, and treatments for dental conditions, including fillings, extractions, and dentures. Social Services will coordinate dental services for residents with families and are responsible for assisting with scheduling dental appointments, arranging transportation to off-site dental visits, communicating with dental providers regarding specific needs, and assisting residents/representatives with obtaining reimbursements, if eligible. The policy directs detailed records of all dental services provided to residents are maintained, including dates and outcomes of dental examinations, details of preventative care and treatments received, and documentation of any dental issues identified and the follow-up actions taken.

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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	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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 address any violations promptly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 3 of 3 resident (Resident #3, 28, and 32) reviewed for transmission based precautions, the facility failed ensure that appropriate signage was posted for Resident #3 who was on contact precautions, failed to ensure nursing staff adhered to appropriate infection control techniques for Resident #28, who was on droplet precautions, and failed to ensure nursing staff adhered to appropriate infection control techniques for Resident #32 who was on enhanced barrier precautions. The findings include: 1. Resident #3 was admitted to the facility in December 2025 with diagnoses that included metabolic encephalopathy, dysphagia, and urinary retention.The admission MDS dated [DATE] identified that Resident #3 had intact cognition, was frequently incontinent of bowel, required an indwelling urinary catheter, required substantial assistance from staff with bathing, and moderate assistance from staff for transfers and dressing. The admission MDS also identified that Resident #3 had a feeding tube in place upon admission to the facility.Review of the clinical record identified Resident #3 was transferred to the hospital on 1/1/26 for evaluation of shortness of breath. Resident #3 also had lab results that were positive for vancomycin resistant enterococcus (VRE) in the urine.A physician's order dated 1/2/26 directed Resident #3 required contact precautions due to VRE in the urine.The care plan 1/2/26 identified Resident #3 required enhanced barrier precautions (EBP) specifically related to the use of an indwelling urinary catheter, tube feeding care and contact precautions due to VRE in the urine. Interventions included to educate the resident, family, and staff regarding effective measures to prevent transmission.Review of facility provided transmission-based precautions line list on 1/5/26 identified that Resident #3 required EBP related to an indwelling urinary catheter and feeding tube and contact precautions for VRE.Observations on 1/5/26 at 8:45 AM and 9:40 AM identified signage posted at the right side of Resident #3's doorway identified enhanced barrier precautions (EBP) along with a PPE cart. Observation of the signage identified everyone entering the room must clean their hands when entering and when leaving the room and that providers and staff must also wear gloves and a gown for high contact resident activities. Further observation failed to identify any signage or instructions related to contact precautions.Review of the nursing care card on 1/5/26 failed to identify documentation related to enhanced barrier precautions or contact precautions for Resident #3.Interview with RN #1 (Infection Control Nurse) on 1/6/26 at 1:30 PM identified that she remembered placing signage for contact precautions outside Resident #3's doorway but was unable to provide the specific date or why the signage was not in place as of 1/5/26. RN #1 also identified that if the signage was not in place, the nurse assigned to the resident would be able to review the physician's order, but she was not sure if the need for transmission-based precautions would carry over to the nurse aide care card.The facility policy on transmission-based precautions (TBP) directed that the facility would implement transmission-based precautions when caring for residents who are known or suspected to be infected or colonized with infectious agents that required additional measures to prevent transmission. The policy further directed that contact precautions were indicated for residents or with known or suspected infections that were spread by direct or indirect contact and included VRE, and that transmission-based precautions would be initiated based on clinical assessment, laboratory confirmation, or physicians order. The policy also directed that appropriate signage indicating the type of precautions required would be placed outside of the resident's room, and all healthcare professionals, including housekeeping and ancillary staff. would be informed of the necessary precautions. 2. Review of a hospital Discharge summary dated [DATE] identified Resident #28 tested positive for influenza A on 12/28/25.Resident #28 was admitted to the facility in January 2026 with diagnoses that included influenza, atrial fibrillation, and hypothyroidism.The admission nursing assessment dated [DATE] at identified Resident #28 was alert and oriented x 3 upon admission to the facility. The nursing (continued on next page)

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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment further identified that Resident #28 was continent of bowel, incontinent of bladder, and required moderate assistance from staff with toileting, dressing, and set up by staff for eating. The nursing admission assessment also identified that Resident #28 had been placed on droplet precautions due to a diagnosis of influenza A.Review of the care plan dated 1/2/26 failed to identify interventions related to Resident #28's diagnosis of influenza A and need for droplet precautions.A physician's order dated 1/5/26 directed droplet precautions until 1/7/26 at 11:59 PM.Review of the facility provided transmission-based precautions line list on 1/5/26 identified that Resident #28 required droplet precautions due to flu.Observation on 1/5/26 at 9:00 AM identified signage posted at the right side of Resident #28's doorway which identified Droplet Precautions along with a PPE cart. Observation of the signage identified everyone stop before entering the room must clean their hands when entering and when leaving the room and make sure their eyes, nose, and mouth were fully covered before room entry. The signage also identified photos depicting use of a mask along with use of a face shield or goggles. Further observation identified that NA #1 entered Resident #28's room to provide his/her meal tray. NA #1 was observed with a surgical mask but no other PPE in place prior to entering Resident #28's room. NA #1 did not perform hand hygiene on entering the room. NA #1 was observed placing Resident #28 meal tray on the bedside table and providing setup, and then attempting to assist Resident #28 with removal of his/her surgical mask. NA #1 provided the call bell to Resident #28 and exited the room. NA #1 did not perform hand hygiene upon exiting the room and attempted to enter another resident's room but stopped upon surveyor inquiry.Interview with NA #1 immediately following the observation identified that she did not see the PPE cart or droplet precaution sign directly outside of Resident #28's room and was not aware the resident was on droplet precautions. NA #1 was unable to identify why she did not perform hand hygiene and also identified that she should have donned appropriate PPE prior to entering Resident #28's room.Observation on 1/6/26 at 12:15 PM identified NA #2 entered Resident #28's room to provide his/her meal tray. NA #2 was observed with a surgical mask in place and did not perform hand hygiene or don PPE prior to entering the room. During this observation, Resident #28 was observed sitting upright in bed with a bedside table positioned directly in front of him/her. NA #2 was observed placing the meal tray on Resident #28's bedside table. While placing the tray, Resident #28, who was not masked, was observed coughing directly towards NA #2 who was approximately 2 feet from the resident. NA #2 was observed continuing to set up Resident #28's meal tray during the coughing episode, and following setup was observed exiting Resident #28's room. NA #2 did not perform hand hygiene prior to or upon exiting the room.Interview on 1/6/26 at 12:18 PM with NA #2 identified she did not see the PPE cart or droplet precaution sign position directly outside of Resident #28's room and was not aware Resident #28 was on droplet precautions. NA #2 also identified that she did not perform hand hygiene before or after exiting Resident #28's room. NA #2 identified that she should have performed hand hygiene and used appropriate PPE.Interview with RN #1 (Infection Control Nurse) on 1/6/26 at 1:30 PM identified she was unable to provide any explanation as to why nursing staff were not donning and doffing PPE for residents who required enhanced barrier precautions (EBP) or transmission-based precautions (TBP). RN #1 identified the signage related to any resident on EBP or TBP along with the PPE carts were placed in a way that required all staff and visitors to pass by the sign and the cart before entering a resident's room. RN #1 further identified that she had recently completed in service education regarding EBP, TBP, and the use of appropriate PPE in 12/2025. RN #1 identified that she would provide additional education to all staff related to EBP, TBP, and PPE use.Observation on 1/7/26 at 9:55 AM identified LPN #3 and LPN #4 standing outside of Resident #28's room at a medication cart. LPN #3 and LPN #4 were observed wearing surgical masks and entering Resident #28's room. LPN #3 and LPN #4 did not perform hand hygiene or donning any PPE prior to entering the room. LPN #4 was observed at Resident #28's bedside. LPN #3 was observed entering Resident #28's bathroom momentarily and then stepping out and exiting the room. LPN #3 was not observed performing hand hygiene prior to leaving the room and was observed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	obtaining a device from the bottom of the medication cart and entering another residence room located directly across the hallway. LPN #4 continued at Resident #28's bedside and then exited the room. LPN #4 was not observed performing hand hygiene prior to exiting the room and returning to the medication cart. LPN #3 was observed returning to the medication cart. Interviews with LPN #3 and LPN #4 immediately following the observations identified LPN #3 precepting LPN #4. LPN #3 identified that she was aware Resident #28 had been on droplet precautions but had been notified in morning report that the precautions would be ending that day. LPN #3 identified that she did not review the resident's orders and believed the information she received in morning report meant that Resident #28 was no longer on precautions despite the signage and PPE cart still in place. LPN #3 and LPN #4 both identified that for droplet precautions, hand hygiene should be performed prior to entering the room and donning appropriate PPE would include a gown and surgical mask with gloves. LPN #3 did not identify any other PPE needed, while LPN #4 identified a face shield would also be needed.Interview on 1/7/26 at 10:10 AM with RN #1 related to the observations of LPN #3 and LPN #4 identified that Resident #28's orders should have been reviewed to determine when he/she was going to be taken off droplet precautions. RN #1 identified that if there was any question related to whether Resident #28 was still on droplet precautions, nursing staff should assess the resident for symptoms first and were expected to always err on the side of caution and don the appropriate PPE. RN #1 also identified that TBP signage had not been removed, and this would also be an indicator that Resident #28 continued to require droplet precautions.Review of facility education documentation identified NA #1 received infection control and prevention education on 5/6/25.Review of facility education documentation identified NA #2 and LPN #3 received EBP, TBP, respiratory infection protocols, and donning/doffing PPE in 12/2025. Review of facility education documentation identified LPN #4 received infection control and prevention education on 12/17/25.The facility policy on transmission-based precautions (TBP) directed that the facility would implement TBP when caring for residents who are known or suspected to be infected or colonized with infectious agents that required additional measures to prevent transmission. The policy further directed that Droplet precautions were indicated for residents with known or suspected infections spread by large respiratory droplets including influenza. The policy directed measures that included use of surgical masks within 6 feet of the resident, resident placement in a room with the closed door and enhanced respiratory hygiene and cough etiquette. The policy further directed that the facility would ensure appropriate PPE was readily available near the entrance of each room that required TBP, staff would be trained on proper use, donning, and doffing of PPE and supervisory staff would monitor compliance of PPE use and provide corrective action and retraining as necessary.The facility policy on personal protective equipment PPE directed that the facility was committed to ensuring the safety of residents, staff, and visitors by implementing the proper use of PPE to prevent the transmission of infections and exposure to hazardous substances. The policy also directed that types of PPE included gloves, gowns, masks, respirators, and eye protection. The policy also directed that selection of PPE should be based on the type of exposure anticipated and the recommended sequence for donning PPE to ensure maximum protection should include use of a gown, mask or N-95, goggles or face shield, and gloves. 3. Review of a hospital Discharge summary dated [DATE] identified Resident #32 was hospitalized from [DATE] to 1/2/26 due to influenza A and hyponatremia. The discharge summary further identified that Resident #32 developed acute urinary retention and required an indwelling urinary catheter. Resident #32 was admitted to the facility in January 2026 with diagnoses that included hyponatremia, hypertension, and pneumonia.The nursing admission assessment dated [DATE] identified Resident #32 was alert and oriented. The assessment also identified that Resident #32 was continent of bowel, had an indwelling urinary catheter, and required moderate assistance from staff with transfers, bathing, and dressing.The care plan dated 1/5/26 identified Resident #32 had an indwelling urinary catheter. Interventions included enhanced barrier precautions for indwelling catheter use.A physician's order dated 1/5/26 directed enhanced barrier precautions related to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indwelling catheter use.Review of facility provided transmission-based precautions line list on 1/5/26 identified that Resident #32 required EBP related to an indwelling urinary catheter.Observation on 1/6/26 at 12:00 PM identified signage posted at the left side of Resident #32's doorway which identified enhanced barrier precautions (EBP) along with a PPE cart. Observation of the signage identified everyone entering the room must clean their hands when entering and when leaving the room and that providers and staff must also wear gloves and a gown for high contact resident activities which included changing linen. NA #5 was observed entering Resident #32's room and performing a linen change. NA #5 was observed with a surgical mask on but no other PPE. NA #5 began to apply a clean fitted sheet, then exited the room, utilized hand sanitizer, obtained a clean blue disposable gown from the PPE cart located outside of the room, and then placed the gown on a recliner inside of Resident #32's room. NA #5 then exited the room.Observation on 1/6/26 at 12:33 PM identified NA #5 entered Resident #32's room and closed the door. NA #5 was not observed performing hand hygiene or stopping at the PPE cart prior to entering. Observation upon entering the room identified NA #5 attempting to exit Resident #32's bathroom while donning disposable gloves. NA #5 identified she was donning PPE to provide care and complete the linen change but did it in the resident's bathroom as she had additional PPE supplies there.Interview with RN #1 (Infection Control Nurse) on 1/6/26 at 1:30 PM identified she was unable to provide an explanation as to why nursing staff were not donning and doffing PPE for residents who required enhanced barrier precautions (EBP) or transmission-based precautions (TBP). RN #1 identified the signage related to any resident on EBP or TBP along with the PPE carts were placed in a way that required all staff and visitors to pass by the sign and the cart before entering a resident's room. RN #1 further identified that she had recently completed in service education regarding EBP, TBP, and the use of appropriate PPE in 12/2025. RN #1 identified that she would provide additional education to all staff related to EBP, TBP, and PPE use.Interview on 1/6/26 at 1:44 PM with NA #5 identified she was aware that Resident #32 was on enhanced barrier precautions and also was aware that high contact activities requiring PPE included changing the residents' linens. NA #5 identified that she was in a hurry and realized after completing part of the linen change she should have donned PPE. NA #5 identified this was not typical practice for her and that she usually always made sure to read the signage and on the appropriate PPE whenever providing care for residents and that she was also aware to don PPE prior to entering and before exiting a resident's room but was unable to identify why she did not follow her typical practice in this case.Review of facility education documentation identified NA #5 received EBP, TBP, respiratory infection protocols, and donning/doffing PPE in 12/2025. The facility policy on enhanced barrier precautions directed that it was the policy of the facility that EBP would be implemented in conjunction with standard precautions during high contact resident activities when caring for residents that had an increased risk for acquiring a multi drug resistant organism (MDRO) such as a resident with indwelling medical devices, which included indwelling urinary catheters. even if the resident was not known to be infected or colonized with a MDRO. The policy further directed that use of PPE to donning of a gown and gloves during high contact resident activities would be used to reduce transmission of MDROs.