STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075336	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southington Care Center	45 Meriden Ave Southington, CT 06489

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical records, and observations for 4 of 5 (Resident #43, #72, #89 and #92) sampled residents reviewed for dining, the facility failed to ensure a dignified dining experience. The findings include: 1. Resident #43 was admitted to the facility in December of 2023 with diagnoses that included dementia, depression, and nutritional deficits. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #43 was severely cognitively impaired and required maximum assist for activities of daily living, set up for meals, and no had active signs or symptom of swallowing disorders.Physician's orders dated 10/8/25 identified a low lactose, soft diet with small portions.The Resident Care Plan (RCP) dated 10/8/25 identified Resident #43 was at risk aspiration/dysphagia with interventions that included ensure receives correct diet and resident's family and visitors are educated on diet, alternate solids and liquids, and sit upright for 30 minutes after meals, and encourage resident to take small bites. The RCP did not reflect Resident #43 ate breakfast in the hallway.Observation on 12/18/25 at 9:30 AM noted Resident #43 was eating in the hallway along with 3 other residents (#72, #89, and #92) lined up against the right side of the wall in the hallway. Observation on 12/19/25 at 9:00 AM noted Resident #43 was eating breakfast in the hallway along with another resident (#92).2. Resident #72 was admitted to the facility in October 2024 with diagnoses that included dementia, anxiety and dysphagia (difficulty swallowing).The annual Minimum Data Set assessment dated [DATE] identified Resident #72 was severely cognitively impaired and required maximum assistance with activities of daily living, set up for meals, and no active signs and symptoms of swallowing disorders.The Resident Care Plan (RCP) dated 11/19/25 identified Resident #72 was at risk aspiration/dysphagia with interventions that included ensure receives correct diet and resident's family and visitors are educated on diet, alternate solids and liquids, and sit upright for 30 minutes after meals, and encourage resident to take small bites. The RCP did not reflect Resident #72 ate breakfast in the hallway. Physician's orders dated 11/22/25 identified a puree diet with extra gravy/sauce.Observation on 12/18/25 at 9:30 AM Resident #72 was eating in the hallway along with 3 other residents (#43, #89, and #92). lined up against the right side of the wall in the hallway.Observation on 12/19/24 at 9:10 AM Resident #72 was in his/her room at breakfast and was still asleep.3. Resident #89 was admitted to the facility in May 2024 with diagnoses that included Alzheimer's disease, severe protein-calorie malnutrition, and generalized anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #89 had a short/long term memory problem and was dependent on staff for all activities of daily living including eating and had no active signs and symptoms of swallowing disorders. The Resident Care Plan dated 10/12/25 identified Resident #89 required to be fed, ensure correct diet was provided, alternate solids and liquids, small bites and encourage to sit upright for 30 minutes after meals. The RCP did not reflect that Resident #89 ate breakfast in the hallway when the responsible party was not available to feed Resident #89.Physician's orders dated 10/15/25 identified Resident #89 received a regular, soft diet with puree fruit. In addition, physician orders directed to not to leave the patient alone in the room and keep in high traffic areas. Observation on 12/18/25 at 9:30 AM noted Resident #89 was being fed in the hallway outside of his/her room by the doorway. In addition, 3 other residents (#43, #72 and #92) were eating in the hallway lined up against the right side of the wall in the hallway.Observation on 12/19/25 at 9:00 AM noted Resident #89 was being fed in his/her room.4. Resident #92 was admitted to the facility in May 2022 with diagnoses that included dementia, nutritional deficiency, and dysphagia (difficulty swallowing). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #92 was severely cognitively impaired and required maximum assistance with activities of daily living, set up for meals, and no active signs and symptoms of swallowing disorders. Physician's orders dated 12/4/25 directed a soft diet with solid foods for pleasure and prune juice with breakfast. The Resident Care Plan (RCP) dated 12/19/25 identified Resident #92 was at risk for aspiration/dysphagia with interventions that included ensure receives correct diet and resident's family/visitors were educated on diet. Additionally, the RCP identified to alternate solids and liquids, to sit upright for 30 minutes after meals, and encourage resident to take small bites. The RCP did not reflect Resident #92 ate breakfast in the hallway.Observation on 12/18/25 at 9:30 AM noted Resident #92 was eating in the hallway along with 3 other residents (#43, #89, and #92) lined up against the right side of the wall in the hallway. Observation on 12/19/25 at 9:00 AM noted Resident #92 was eating breakfast in the hallway along with another resident (#43) Interview with RN #6 on 12/19/25 at 9:10AM identified that she

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility documentation, staff/resident interviews and review of the facility Quality Assurance and Performance Improvement (QAPI), the facility failed to develop a plan, monitor for effectiveness, and attempt new interventions to ensure resident laundry was repeatedly not returned timely and not lost. The findings include: Review of the Missing Items log books identified from December 2024 to December 2025 there were 53 Missing Items Report forms filled out for residents with missing laundry items that included clothing and/or blankets. The Missing Items Reports further identified 11 out of 53 residents had reported missing different clothing items 2 or more times.Review of the Missing Items Report forms from September 2025 to December 2025 identified 12 out of 21 Missing Items Reports were related to missing laundry items.Review of the Missing Items Report forms identified 52 out of 53 times residents were offered reimbursement for missing laundry items that could not be found. 1 out of 53 times the missing items was found and returned to the resident. 36 out of 52 times the resident received reimbursement for missing laundry items.The Resident Council meeting held on 12/17/25 at 11:00 AM was attended by 13 residents. Residents identified there was a concern related to laundry. Residents identified that laundering of facility linens was outsourced to a linen company and that the facility had recently changed their linen company. Residents identified the facility only washed the resident's personal laundry (clothing/blankets). Residents identified that the laundry hamper was part of a 3 section cart with 1 section for personal clothing, 1 section for linens, and 1 section for garbage. Residents identified that if a staff member mixed clothes in with linens they would go out to the linen company and might not come back. Residents identified that the laundry attendants would sometimes put laundry into the wrong room/closet which would delay the return of laundry to the correct resident. Residents identified that the laundry department says laundry should be returned within a few days, but sometimes it takes over a week and even more than 11 days to get items back. Residents identified there were 2 laundry attendants, and that both laundry attendants had a different way of managing the laundry.Review of the Missing Items Reports and interviews with residents in attendance at the Resident Council meeting identified 5 out of 13 residents in attendance had laundry items go missing in the past year. Interview with the Administrator on 12/19/25 at 10:10 AM identified he was aware of multiple missing resident laundry items but there was not a formal project initiated related to determining the root cause of missing laundry, a plan to resolve the issue of missing resident laundry and how the facility would monitor their measures instituted for effectiveness. The Administrator identified that the facility had recently changed linen companies, and the new linen company was more up-to-date with their management of laundry. The Administrator identified education had recently been done with the staff related to laundry, that there were signs on the laundry bins to direct the staff where to place laundry, and that staff received education on the laundry in orientation, (however residents continued to complain of missed laundry items).Interview with the Maintenance Director on 12/19/25 at 11:17 AM identified he was responsible for the laundry department. The Maintenance Director identified the linen vendor was changed around the end of October and it had been an initiative from the facility's management company. (Although the linen vendor had changed there continued to be Missing Items Reports filed by residents)Review of the Quality Assessment and Assurance (QAA) Committee members identified the Maintenance Director, Social Worker #2, Administrator, and the Quality Improvement Manager were among the 14 members of the QAA Committee.Review of the QAA Committee Meeting minutes dated June 24, 2025 failed to identify that Missing Items Reports were reviewed with the Grievances during the meeting. The minutes identified there was only 1 Grievance for May related to a broken vase. The minutes failed to identify 4 Missing Items Reports for residents related to missing personal laundry items. Review of the QAA Committee Meeting minutes dated July 29, 2025 failed to identify that Missing Items Reports were reviewed with the Grievances during the meeting. The minutes identified there were no Grievances for June. The minutes failed to identify 8 Missing Items Reports for residents related to missing personal laundry items.Minutes were not provided for the August QAA Committee meeting.Review of the QAA Committee Meeting minutes dated September 30, 2025 failed to identify that Missing Items Reports were reviewed with the Grievances during the meeting. The minutes identified there was 1 Grievance for August related to meal service and a motorized wheelchair. The minutes failed to identify 6 Missing Items Reports for residents related to missing personal laundry items.Review of the QAA Committee Meeting minutes dated October 28, 2025 failed to identify that Missing Items Reports were reviewed with the Grievances during the meeting. The minutes identified there were 2 allegations of abuse/Grievances for