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	07/02/2026

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 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 review of facility documentation, Legionella water testing records, facility policies, and staff interviews reviewed for infection control, the facility failed to implement an effective Legionella water management monitoring program following repeated positive Legionella test results. Specifically, the facility continued monthly environmental testing despite ongoing positive findings from February 2026 through June 2026 and did not follow the post-remediation testing intervals recommended by the Healthcare Infection Control Practices Advisory Committee (HICPAC) guidance. The findings include:Review of Legionella water testing records revealed monthly environmental testing was conducted from December 2025 through June 2026. Documentation for January 2026 testing was not available; facility staff reported the sample was lost due to a shipping error. Review further identified multiple positive Legionella results during the review period, including:On 2/24/26, the bathroom sink in room [ROOM NUMBER] tested positive at 0.2 CFU/mL (Colony-Forming Units per milliliter).Repeat testing of the same location remained positive on 3/18/26 at 0.2 CFU/mL and on 4/15/26 at 0.1 CFU/mL.On 5/7/26, room [ROOM NUMBER] bathroom sink tested negative; however, the bathroom sink in room [ROOM NUMBER] (cold water) tested positive at 0.2 CFU/mL.On 6/8/26, room [ROOM NUMBER] bathroom sink (cold water) remained positive, increasing to 1.0 CFU/mL.Interview with the Director of Plant Operations and Laundry (DOPOL) and the Administrator on 7/2/26 at 11:30 AM revealed the facility had been managing a Legionella outbreak since June 2025. The Administrator stated the facility conducted environmental Legionella testing every two weeks until December 2025 after obtaining negative test results beginning in July 2025, at which time the facility transitioned to monthly testing. The Administrator acknowledged awareness of the HICPAC recommendation for biweekly post-remediation testing following a positive Legionella result, but indicated the guidance is a recommendation rather than a regulatory requirement. The Administrator further identified the facility continued monthly testing after December 2025 and performed remediation following each positive test. The DOPOL and Administrator identified that, in response to the positive Legionella test results obtained between February and June 2026, the facility replaced the affected plumbing fixtures and equipment rather than performing flushing as part of the remediation process.Interview with District Representative (DR) #1 on 7/2/26 at 2:30 PM identified he served as the skilled nursing facility representative since October 2025. DR #1 identified he was responsible for collecting the facility's Legionella water samples, with assistance from the DOPOL in accessing sampling locations. DR #1 identified he ensured each sample met the laboratory's required minimum volume and included water samples collected from various locations and temperatures. Upon receipt of the laboratory results, DR #1 emailed the findings and recommended corrective actions to the DOPOL and Administrator. DR #1 indicated the typical initial recommendation following a positive Legionella result was to flush the affected water system; however, he confirmed the facility elected to replace the affected plumbing fixtures and equipment instead, which he described as a more extensive and costly remediation measure. DR #1 further identified the testing company's Legionella sampling and follow-up recommendations mirrored the Centers for Disease Control and Prevention (CDC) guidance but deferred technical questions regarding the laboratory's (continued on next page)

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
	075336	A. Building B. Wing	07/02/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	testing methodology and recommendations to the company's laboratory technicians.Review of the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) guidance for environmental Legionella testing identified that, following remediation, HICPAC recommended collecting environmental culture samples at two-week intervals for three months. If Legionella was not detected during that period, HICPAC recommended monthly sampling for an additional three months, with the sampling plan adjusted based on trend data. If Legionella was detected during follow-up sampling, HICPAC recommended reviewing and modifying the water management program, performing additional remediation as indicated, and initiating a new six-month period of post-remediation follow-up sampling.Overall, the facility identified positive environmental Legionella test results and implemented corrective actions, including replacement of affected plumbing fixtures and equipment. However, the facility continued to obtain positive Legionella test results from February through June 2026 and maintained monthly environmental testing rather than following the post-remediation testing intervals recommended by the HICPAC. Facility representatives acknowledged awareness of the HICPAC recommendations but considered them guidance rather than regulatory requirements.Although requested, the facility did not have a policy specifically addressing Legionella; however, the facility did maintain an active water management plan that included Legionella prevention and control measures.