STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075371	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Home of Southbury Inc	990 North Main Street Southbury, CT 06488

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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #1) reviewed for behaviors, the facility failed to ensure the physician was notified when the resident was restless and agitated. The findings include: Resident #1 had diagnoses that included dementia with behavioral disturbance and adjustment disorder with disturbance of conduct. The nursing admission assessment dated [DATE] at 9:13 A.M. completed by RN #7 identified for Resident #1 restraints were not being used. The functional abilities and goals assessment dated [DATE] identified Resident #1 requires substantial assistance with ADLs and transfers, independent with bed mobility, and used a manual wheelchair. The initial social history assessment dated [DATE] at 2:25 P.M. identified Resident #1's family reports h/she has had increased confusion over the past few months. The social history assessment identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of two (2) indicative of severely impaired cognition. The care plan dated 1/17/25 identified Resident #1 used psychotropic antipsychotic medications related to delirium, restlessness, and agitation with interventions directing to monitor/record potential target behavior symptoms that would justify either elimination of or continued use of antipsychotics, administer medications as ordered and monitor for side effects and effectiveness. The physician's order dated 1/17/25 directed to administer escitalopram oxide (a medication used for depression and anxiety) oral tablet 5 milligrams one time a day, olanzapine (a medication used for agitation) 2.5 milligrams one time per day for agitation, and monitor for the following behaviors delirium, restlessness, and agitation and document every shift. The nurse's note dated 1/18/25 at 12:13 A.M. written by LPN #3 identified Resident #1 was sitting up in the wheelchair, restless at times, trying to get out of the wheelchair. The nurse's note dated 1/19/25 at 12:48 P.M. written by LPN #4 identified Resident #1 was noted removing dressing to lower extremities and dressing had to be re-done. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Lutheran Home of Southbury Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 990 North Main Street Southbury, CT 06488	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 1/19/25 at 11:53 P.M. written by LPN #3 identified Resident #1 is restless at times. LPN #3 identified Resident #1 was out of bed at 9:30 P.M. placed in wheelchair near the entrance of h/her door and monitored. The care card dated 1/20/25 identified Resident #1 is agitated at times. If Resident #1 is exhibiting behaviors, guide the resident away from the source of distress offer me a snack or drink and notify the nurse. Review of Resident #1's Medication Administration Record dated 1/20/25 identified RN #1 documented for the night shift (11 PM- 7 AM) Resident #1 had behaviors of hitting and kicking. Interview with RN #1 on 2/5/25 at 11:25 A.M. identified on 1/21/25 during the 11 PM - 7 AM shift Resident #1 had intermittent agitation and was restless. RN #1 identified Resident #1 sat in the wheelchair all night, did not sleep, and she tried to keep an eye on Resident #1 throughout the shift. RN #1 identified Resident #1 did not have any as needed medications ordered for insomnia, restlessness, or agitation. RN #1 identified she did not think it was necessary to call the on-call provider to get an as needed medication order because when she sat with Resident #1 h/she usually calmed down. RN #1 identified around 7:00 AM Resident #1 became more agitated, restless, and combative so she sat with Resident #1. Interview with NA #1 on 2/5/25 at 12:30 P.M. identified on 1/21/25 during the 11 PM - 7 AM shift he attempted to put Resident #1 into bed three times, but Resident #1 was restless and would not stay in bed. NA #1 identified Resident #1 stayed up all night in the wheelchair, Resident #1 would not stay still, and Resident #1 was restless, agitated, and made several attempts to stand up without assistance. NA #1 indicated RN #1 was aware that Resident #1 was restless and agitated. Interview with MD #1 on 2/5/25 at 2:17 P.M. identified on 1/21/25 when Resident #1 was agitated, restless, and could not sleep RN #1 should have called the on-call provider to report Resident #1's behaviors. MD #1 indicated the on-call provider would have ordered an as needed medication for Resident #1's behaviors. Interview with the DNS on 2/5/25 at 2:24 P.M. identified her expectation is if a resident is agitated, restless, unable to sleep and does not have an as needed medication order the nurse will call the physician and obtain an as needed order to address the behavior. The DNS identified on 1/21/25 when Resident #1 was restless, agitated, and could not sleep RN #1 should have notified the physician and obtained an as needed order to address Resident #1's behaviors. Review of the facility's change in resident's condition or status policy direct the nurse will notify the attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #1) reviewed for restraints, the facility failed to ensure the resident was free of a physical restraint. The findings include: Resident #1 had diagnoses that included dementia with behavioral disturbance and adjustment disorder with disturbance of conduct. The nursing admission assessment dated [DATE] at 9:13 A.M. completed by RN #7 identified for Resident #1 restraints were not being used. The functional abilities and goals assessment dated [DATE] identified Resident #1 requires substantial assistance with ADLs and transfers, independent with bed mobility, and uses a manual wheelchair. The initial social history assessment dated [DATE] at 2:25 P.M. identified Resident #1's family reports h/she has had increased confusion over the past few months. The social history assessment identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of two (2) indicative of severely impaired cognition. The care plan dated 1/17/25 identified Resident #1 uses psychotropic antipsychotic medications related to delirium, restlessness, and agitation with interventions directing to monitor/record potential target behavior symptoms that would justify either elimination of or continued use of antipsychotics, administer medications as ordered and monitor for side effects and effectiveness. The physician's order dated 1/17/25 directed to administer escitalopram oxide (a medication used for depression and anxiety) oral tablet 5 milligrams one time a day, olanzapine (a medication used for agitation) 2.5 milligrams one time per day for agitation, and monitor for the following behaviors delirium, restlessness, and agitation and document every shift. The nurse's note dated 1/18/25 at 12:13 A.M. written by LPN #3 identified Resident #1 was sitting up in the wheelchair, restless at times, trying to get out of the wheelchair. LPN #2 indicated Resident #1 was able to be redirected from trying to get up from the wheelchair. The nurse's note dated 1/19/25 at 12:48 P.M. written by LPN #4 identified Resident #1 was noted removing dressing to lower extremities and dressing were re-done. LPN #4 identified Resident #1 was out of bed to the wheelchair for a short time, but insisted on going back to bed to rest this afternoon. The nurse's note dated 1/19/25 at 11:53 P.M. written by LPN #3 identified Resident #1 is restless at times, out of bed at 9:30 P.M. placed in wheelchair near the entrance of h/her door and monitored. The care card dated 1/20/25 identified Resident #1 self-propels in wheelchair for mobility. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Medication Administration Record dated 1/20/25 identified RN #1 documented for the night shift (11 PM- 7 AM) Resident #1 had behaviors of hitting and kicking. Review of the facility's accident and incident report dated 1/21/25 identified at approximately 8:00 A.M. RN #2 reported Resident #1 was found in the dayroom seated in h/her wheelchair with a sheet positioned around h/her waist and then tied to the wheelchair. RN #2 immediately removed the sheet, assessed Resident #1 for any injury, and no injuries were found. NA #1 and RN #1 who were on the floor were removed immediately pending investigation. The police, family, and MD #1 were notified. The nurse's note dated 1/21/25 at 8:25 A.M. written by RN #2 identified that Resident #1 was in the dining room seated in the wheelchair appearing very agitated. RN #2 identified a staff member who speaks Portuguese was communicating with Resident #1 and Resident #1 appeared to be more agitated. RN #2 indicated she notified APRN #1 new orders obtained to give trazodone 12.5 milligrams (mg) now. RN #2 identified Resident #1 received trazodone and appeared calmer. Interview with RN #2 on 2/5/25 at 7:35 A.M. identified on 1/21/25 between 7:45 A.M. and 8:00 A.M. when she entered the dining room RN #1 was standing up next to Resident #1 who was seated in h/her wheelchair with a white sheet draped from h/her waist to h/her upper legs. RN #2 identified she went over to see Resident #1 at which time she noted that Resident #1 is tied to the chair. RN#2 identified she immediately untied the sheet that was tied in a bow behind the back of Resident #1's wheelchair and removed the sheet. RN #2 identified RN #1 indicated she did not know who tied the sheet and she had just noticed that the sheet was tied when RN #2 walked into the dining room. RN #2 identified she assessed Resident #1 for any injuries and Resident #1 had no injuries, skin was intact without any redness or bruising. RN #2 identified she notified the on-call APRN and the DNS. Interview with RN #1 on 2/5/25 at 11:25 A.M. identified on 1/21/25 at approximately 2:45 A.M. Resident #1 was taking off h/her socks and pants off so she placed a fitted white sheet over h/her legs. RN #1 indicated she brought Resident #1 who was seated in the wheelchair over near the nurse's station in the hallway and kept Resident #1 with her. RN #1 identified at approximately 5:30 A.M. she started passing morning medications and Resident #1 was still in the wheelchair in the hallway. RN #1 indicated while she was passing medications as she entered and exited other residents' rooms, she could see Resident #1 and she kept checking on Resident #1 to ensure h/she was not attempting to stand up without assistance. RN #1 indicated at approximately 6:30 A.M. she noted that Resident #1 was becoming restless, so she wheeled Resident #1 to the dining room. RN #1 indicated she planned on sitting in the lounge with Resident #1 because when she sat with Resident #1 h/she would calm down. RN #1 indicated she left the lounge for a few minutes and then returned to sit with Resident #1. RN #1 indicated she noticed Resident #1 had a flat white sheet draped h/her not white fitted sheet she had placed on Resident #1 earlier in the shift. RN #1 indicated she stood up as she noticed the sheet was tied in a bow behind Resident #1's wheelchair RN #2 walked into the dining room. RN #1 identified she and RN #2 immediately untied the sheet. RN #1 indicated when she wheeled Resident #1 into the dining room, she did not see any sheet tied behind Resident #1's wheelchair and thought the staff from day shift tied the sheet. RN #1 indicated NA #1 did not ask her or notify her that he had tied a sheet around Resident #1. RN #1 indicated she did not assist NA #1 in tying the sheet around Resident #1. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on 2/5/25 at 12:30 P.M. identified on 1/21/25 during the 11 PM - 7 AM shift he attempted to put Resident #1 into bed three times, but Resident #1 was restless and would not stay in bed. NA #1 identified Resident #1 was a fall risk. NA #1 indicated Resident #1 stayed up all night in h/her wheelchair and made several attempts to stand up without assistance. NA #1 identified at approximately 4:30 A.M. he called RN #1 to inform her that he was putting a sheet around Resident #1 because he needed to start his last rounds and if he left Resident #1 h/she would fall. NA #1 identified with Resident #1 seated in the wheelchair he placed a flat white sheet around Resident #1's waist and loosely tied it in a bow behind the back of the wheelchair. NA #1 identified he was supposed to untie the sheet around Resident #1's wheelchair before he left but forgot. NA #1 identified although he was aware that he is not supposed to physically restrain residents he felt it was the only way to prevent Resident #1 from falling out of the wheelchair. Interview with MD #1 on 2/5/25 at 2:17 P.M. identified when NA #1 placed the sheet around Resident #1's waist and tied it behind the back of the wheelchair although it was unethical, he believes NA #1 was attempting to prevent Resident #1 from falling not trying to harm Resident #1. MD #1 indicated Resident #1 was not at risk for injuries when h/she was tied with a sheet in the wheelchair because the sheet was tied around Resident #1's waist. Interview with the DNS on 2/5/25 at 2:24 P.M. identified on 1/21/25 when RN #2 reported she found Resident #1 seated in h/her wheelchair with a sheet tied around h/her an investigation was immediately initiated. The DNS identified on 1/21/25 that NA #1 and RN #1 were the staff assigned to Resident #1 when RN #2 found Resident #1 tied with a sheet and they were suspended pending the outcome of the investigation. The DNS identified on 1/21/25 during an interview with RN #1 reported during the 11 PM - 7 AM shift Resident #1 was disrobing so she covered Resident #1's bare legs with a sheet that was not tied, at the end of shift she was sitting with Resident #1 in the lounge when RN #2 walked in she noticed the sheet was tied. The DNS identified RN #1 indicated at the same time RN #2 walked in she noticed the sheet tied behind Resident #1's wheelchair and RN #1 reported she had not seen the sheet tied before then. The DNS identified on 1/21/25 during an interview with NA #1 he reported on 1/21/25 Resident #1 had been up all night was uncooperative and couldn't stay still for even a moment and NA #1 was worried Resident #1 would fall so right before the last rounds started NA #1 put a sheet around Resident #1's waist and tied it loosely behind the wheelchair. The DNS identified the facility does not use sheets to physically restrain residents. The DNS identified NA #1 should have never placed the sheet around Resident #1's waist and tied the sheet behind the wheelchair. Review of the facility's use of restraint policy identified physical restraints are defined as any manual, physical, mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement, and practices that inappropriately utilize equipment to prevent residents mobility are considered restraints and are not permitted including tucking sheets so tightly that a resident cannot move.