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	05/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to act timely when therapy recommended to change the resident transfer status. The findings include: Resident #1 had a diagnosis of altered mental status and dementia. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 10 indicating moderately impaired cognition, had no behaviors and required partial assistance with transfers. The Resident Care Plan (RCP) dated 4/7/26 identified a risk for falls and self-care deficit. Interventions directed to ensure call light was within reach and provide assistance of two (2) with transfers with a rolling walker and ambulate with rehab only Physician order review failed to identify an order that directed transfer status. Facility Reportable Event (RE) dated 5/4/26 at 10:29 AM identified Resident #1 required assist of one (1) for transfers and had a witnessed fall on 5/2/2026 at 12:30 PM as a Nurse's Aide (NA) transferred Resident #1 into a wheelchair and his/her foot became caught in the wheelchair. Resident #1 lost balance and fell to the floor. And RN assessment identified a laceration above the right eyebrow and abrasions to the right knee and right thumb, and complained of a headache. The physician/APRN was notified, and Resident #1 was transferred to the hospital. Resident #1 returned to the facility with six (6) stitches to the right eyebrow laceration. Physician order dated 5/3/2026 (the day after the fall) directed two (2) assist for transfers. The facility RE summary dated 5/9/2026 identified was wearing non-skid socks at the time of the fall, and when the NA assisted with the transfer, Resident #1 stood up and quickly turned to the left catching his/her right foot on the front of the wheelchair causing him/her to pitch forward, pushing into the NA and landing on the floor. Despite the NA having a hold on him/her, she wasn't able to maintain the grasp as his/her weight pushed past her. The RCP was revised to encourage Resident #1 to sit on the edge of the bed for one (1) minute to allow blood pressure to accommodate the change in position and then to stand and slowly pivot with assist. The summary indicated the fall was caused by an abrupt quick turn while being transferred into the wheelchair to be toileted, causing the NA to lose her balance and not being able to prevent or intercede in the fall. The summary further indicated a recent UTI caused haste to get to the toilet and poor balance. Interview with NA #1 on 5/27/26 at 11:35 AM identified although the RCP directed two (2) staff for transfers, NA #1 stated Resident #1 required assist of one (1) staff for transfers. Interview failed to identify where NA #1 obtained information that directed one (1) staff to transfers. Interview with the Director of Rehabilitation (DOR) on 5/27/26 at 12 PM identified Resident #1 required an assist of one (1) to stand and pivot. The DOR stated she did not know why the care plan directed two (2) staff to assist. Further, rehab note dated 5/1/2026 indicated rehab changed Resident #1's transfer status to one (1) assist for transfers. Therapy's process to change resident orders was to enter the order into the electronic medical record (EMR) queue for nursing to obtain new orders. The DOR stated she thought rehab entered the change in status into the queue for nursing to obtain orders, however she was unable to identify the request was in the queue. The DOR stated that nursing may have deleted the request from the queue, and therapy's recommendation was never processed (acted upon). The DOR stated therapy should have entered the request into the queue for (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075371	A. Building B. Wing	05/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing to obtain updated physician orders, and the request should have been acted upon by nursing. Interview and record review with the Director of Nursing (DNS) on 5/27/26 at 1:15 PM identified although the RCP directed two (2) assist for transfers, the DNS stated Resident #1 required an assist of one (1) assist for transfers. The DNS stated therapy staff usually communicate changes in residents' status in morning report, and it was the responsibility of the unit manager to obtain the physician orders and update the care plan. Although both the DNS and NA #1 stated Resident #1 required one (1) staff for transfers, interview failed to identify how she and NA #1 were notified of the change to one (1) assist for transfers, and if the therapy recommendation from 5/1/2026 for transfer status was entered into the EMR queue for nursing to obtain new orders. A policy for acting upon therapy recommendations was not provided during survey.

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	05/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure a resident with dementia who was known to require assistance with transfers and only able to ambulate with therapy, was transferred without injury. The findings include: Resident #1 had a diagnosis of altered mental status and dementia. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 10 indicating moderately impaired cognition, had no behaviors and required partial assistance with transfers. The Resident Care Plan (RCP) dated 4/7/26 identified a risk for falls and self-care deficit. Interventions directed to ensure call light was within reach and provide assistance of two (2) with transfers with rolling walker and to ambulate only with rehab. Physician order review failed to identify an order directed transfer status. Facility Reportable Event (RE) dated 5/4/26 at 10:29 AM identified Resident #1 required assist of one (1) for transfers and had a witnessed fall on 5/2/2026 at 12:30 PM as a Nurse's Aide (NA) transferred Resident #1 into a wheelchair and his/her foot became caught in the wheelchair. Resident #1 lost balance and fell to the floor. And RN assessment identified a laceration above the right eyebrow and abrasions to the right knee and right thumb, and complained of a headache. The physician/APRN was notified, and Resident #1 was transferred to the hospital. Resident #1 returned to the facility with six (6) stitches to the right eyebrow laceration. Nursing note dated 5/2/26 at 12:57 PM identified Resident #1 was transferred to the hospital at approximately 12:58 PM. Physician order dated 5/3/2026 (the day after the fall) directed two (2) assist for transfers. The facility RE summary dated 5/9/2026 identified was wearing non-skid socks at the time of the fall, and when the NA assisted with the transfer, Resident #1 stood up and quickly turned to the left catching his/her right foot on the front of the wheelchair causing him/her to pitch forward, pushing into the NA and landing on the floor. Despite the NA having a hold on him/her, she wasn't able to maintain the grasp as his/her weight pushed past her. The RCP was revised to encourage Resident #1 to sit on the edge of the bed for one (1) minute to allow blood pressure to accommodate the change in position and then to stand and slowly pivot with assist. The summary indicated the fall was caused by an abrupt quick turn while being transferred into the wheelchair to be toileted, causing the NA to lose her balance and not being able to prevent or intercede in the fall. The summary further indicated a recent UTI caused haste to get to the toilet and poor balance. Interview with NA #1 on 5/27/26 at 11:35 AM identified although the RCP directed two (2) staff for transfers, NA #1 stated Resident #1 required assist of one (1) staff for transfers. On 5/2/2026 she attempted to transfer Resident #1 from the bed into the wheelchair (without a second staff member) and Resident #1 stood up faster than usual. As Resident #1 stood up, he/she began to pivot before fully standing up and Resident #1 tripped over his/her foot, causing him/her to lose balance and fall. NA #1 stated she did not use a gait belt when transferring Resident #1 because it was not in the plan of care and she did not think she should have used a gait belt. Interview with the Director of Rehabilitation (DOR) on 5/27/26 at 12 PM identified Resident #1 required an assist of one (1) to stand and pivot and she did not know why the care plan directed two (2) staff assist. The DOR stated if a gait belt had been used for the transfer it could have prevented the fall. Interview and record review with the Director of Nursing (DNS) on 5/27/26 at 1:15 PM identified the RCP directed two (2) staff for transfers. The DNS stated a gait belt was not required to be used for the transfer, however Resident #1 had no contraindications for use of a gait belt. Interview failed to identify why Resident #1 was not transferred in accordance with the current plan of care, why a gait belt was not used for a resident with dementia that required assistance with transfers and who had a recent UTI that may cause haste to get to the toilet and poor balance, as described in the RE summary. Review of facility Gait Belt (Transfer Belt) Policy dated 3/10/22 directed in part, gait belts may be used for (continued on next page)

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	05/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all transfers of residents who require the assistance of 1 or 2 persons, and the purpose was to enhance safety and protection of the resident during transfers. Gait belts are not mandatory or appropriate for all circumstances and individual plans of care will address specific resident needs; the following residents may be exceptions to the use of gait belts: colostomy, ileostomy, rib fractures, severe degenerative disease, history of pathological fractures, recent surgery in the area of the belt, gastrostomy tube and other conditions identified by the interdisciplinary care team.