

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/16/2026
NAME OF PROVIDER OR SUPPLIER Lutheran Home of Southbury Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety 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 observations, review of the clinical record, facility documentation and facility policy, and interviews for one resident (Resident #1) reviewed for accidents, the facility failed to ensure staff responded appropriately to wander guard alarms and failed to ensure staff visually verified residents before re-setting alarms, resulting in the resident leaving the nursing unit without staff knowledge. Further, the facility failed to maintain a secured exit door in proper working order and failed to ensure staff searched for a resident timely when an exit door alarm sounded, resulting in Resident #1 exiting the facility without staff knowledge or supervision. The failures resulted in the finding of Immediate Jeopardy. The findings include: Resident #1 was admitted 4/2026 with diagnoses that included dementia, major depressive disorder, and anxiety. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of four out of fifteen (4/15), indicating severe cognitive impairment, had no wandering behaviors and ambulated with supervision. Elopement Risk assessment dated [DATE] identified a new assessment was completed due to new exit-seeking behaviors, and the score identified Resident #1 was high risk for elopement (score 22). The facility determined Resident #1 required enhanced elopement prevention interventions, including the application of a wander guard bracelet to the left ankle. The Resident Care Plan dated 4/24/26 identified a risk for elopement/wandering as evidence by disoriented to place, history of attempts to leave the facility unattended, and wandering aimlessly. Interventions directed to assess for elopement risk, identify wander patterns, distract and redirect as needed, wander guard device to left ankle, and monitor for placement and function of the wander guard. Facility reportable event (RE) dated 6/20/26 at 1:30 PM identified Resident #1 eloped from the facility, was returned to the building with no injuries identified and was placed on one-to-one (1:1) observation. The facility RE summary dated 6/25/26 identified Door #7 was equipped with a wander guard alarm, however the electronic magnet was malfunctioning, and only intermittently engaged when the door was tested. Resident #1 exited the unit at 1:35 PM, exited through Door #7 at 1:38 PM, NA #2 silenced Door #7 alarm at 1:42 PM and Resident #1 was observed outside at 2 PM (25 minutes after he/she exited the unit). Review of the facility video surveillance with the Administrator and Director of Nursing (DON) on 7/15/2026 at 2:15 PM identified Resident #1 followed behind a visitor and another resident when they exited the unit. Dietary Aide (DA) #1 was observed speaking with NA #1 immediately after Resident #1 exited the unit, and NA #1 then proceeded through the alarmed unit exit door, briefly looked into the immediate area outside the unit, and returned to the nursing unit without identifying Resident #1 had exited the secured area. Continued review identified Resident #1 exited the facility through a secured exterior door (Door #7) at approximately 12:30 PM and at approximately 12:35 PM, NA #2 was observed silencing Door #7's wander guard alarm, without (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	visually assessing the exterior of the facility or looking through the door windows to determine the source of the alarm. Video surveillance further identified NA #2 entered the adjacent nursing unit and communicated with LPN #1 at approximately 12:38 PM. Neither staff member was observed responding to the activated wander guard alarm, initiating a search for Resident #1, or implementing the facility's elopement response procedures before resuming their assigned duties. Interview with DA #1 on 7/15/2026 at 11:40 AM identified that on 6/20/2026, DA #1 and DA #2 were on Resident #1's unit when a visitor and another resident were exiting the unit. DA #1 observed Resident #1 following immediately behind the couple through the secured doorway. The wander guard alarm activated and DA #1 asked NA #1 Is he/she allowed out of the unit? NA #1 responded yeah, that's his/her spouse and DA #1 then silenced the alarm and allowed the people to exit the unit. About five (5) minutes later DA #1 observed Resident #1 alone in the common area adjacent to the kitchen, and she did not intervene because she continued to believe Resident #1 had been authorized to leave the secured unit. Interview with NA #1 on 07/16/2026 at 10:15 AM identified on 6/20/2026 a visitor and resident were leaving the unit and the alarm sounded. The dietary staff asked her if they were allowed to leave, and she proceeded through the doorway to verify who exited the unit and she did not see Resident #1 had left the unit. NA #1 indicated she did not verify the identity of the resident who activated the wander guard alarm or determine whether another resident had exited the secured unit before staff silenced the alarm. Interview with NA #2 on 7/15/2026 at 1:25 PM identified that on 6/20/2026, she heard the wander guard alarm at secured exterior (Door #7) sound and she silenced the alarm. NA #2 stated looked through the door windows, however, she confirmed she did not open the door, exit the building, or conduct a search of the exterior to determine the source of the alarm or verify whether a resident had exited the facility, and she notified LPN #1 that the exterior door alarm had sounded. Interview with LPN #1 on 7/15/2026 at 2:35 PM identified she did not recall NA #2 notifying her that the exterior Door #7 wander guard alarm had sounded on 6/20/2026, and she was later informed that Resident #1 had eloped from the facility. LPN #1 confirmed she did not respond to the activation of the wander guard alarm, assess the secured exit, or participate in locating Resident #1 at the time of the event because she was unaware the resident had exited the facility. Review of the Elopement of a Resident Policy dated 3/1/2022 identified in part, staff will be trained on the Center's door security system and were required to response to a sounding alarm; if alarm sounds and no resident is at or outside of the door, an accounting of all residents will be conducted immediately. Staff witnessing a confused resident or an identified elopement risk resident attempting to leave the Center will intervene as appropriate to redirect the resident to a safe area and prevent elopement. Review of facility documentation identified staff education was initiated on 6/22/26 and included staff response to wander guard alarms, and notification of doors identified to not function properly. Audits were initiated on 6/21/26, with results reviewed by QAPI. Based on review of facility documentation, past non-compliance was identified.		