STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155715	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Community Home	111 W Church Ave Seymour, IN 47274

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. Based on record review and interview, the facility failed to notify the physician and document physician's ongoing guidance for 1 of 19 resident records reviewed for notification of change. (Resident 4) Findings include:The clinical record for Resident 4 was reviewed on 12/03/2025 at 2:33 P.M. An admission Minimum Data Set (MDS) assessment, dated 10/23/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, fractures of the tibia, hypertension, renal failure, seizure disorder, anxiety, and depression. The resident's Electronic Medication Administration Record (EMAR) indicated the resident had the following physician orders:-Daily weight for chronic kidney disease, with a start date of 10/18/2025, and a discontinued date of 10/27/2025, and-Furosemide tablet 40 milligrams (mg), administer 1 tablet, once a day as needed for weight gain of two pounds or more in 24 hours and/or bilateral lower extremity swelling, with a start date of 10/18/2025. The resident did not receive the prescribed, as needed, Furosemide medication on the following dates when the resident gained two pounds or more:10/18/2025 - weight 219.0 10/19/2025 - weight 228.0, a weight gain of 9 pounds, 10/22/2025 - weight 223.010/23/2025 - weight 228.2, a weight gain of 5.2 pounds, and 10/24/2025 - weight 224.610/25/2024 - weight 230.0, a weight gain 5.4 pounds. The EMAR indicated the resident had a physician's order for the following:Offer chocolate high protein drink, twice a day, with a start date of 10/24/2025, and a discontinued dated of 11/21/2025.The record indicated the resident either drank none of the drink or refused the drink 29 times out of the 40 times the drink was offered in the month of November 2025. The Progress Notes lacked documentation the physician had been notified of the changes in the resident's weight or the refusals of the prescribed nutritional drink supplements. During an interview on 12/04/2025 at 12:10 P.M., Resident 4 indicated she did not like the chocolate drink supplement because it gave her diarrhea. She had refused it repeatedly. The facility had offered other flavors, but she just didn't want it. She had problems with her colon ever since she was young. During an interview on 12/04/2025 at 9:13 A.M., the Administrator indicated physician notifications were documented in the Progress Notes. During an interview on 12/05/2025 at 12:13 P.M., the DON indicated when a physician was notified, facility staff were to document in a Progress Note, on the Electronic Healthcare Record, the nature of the notification. When the staff received a response from the physician, they should document the response in a Progress Note as well. If staff did not give the prescribed, as needed, Furosemide for the weight gain, they should have documented in a Progress Note as to why. In regard to the chocolate dietary supplement drink, the nursing staff should have notified the NP to change the supplement to something agreeable with the resident. The resident recently had surgery prior to admission to the facility. During an interview on 12/05/2025, the DON indicated the resident had not been sent out to the emergency room for treatment since admission to the facility. The current Change in a Resident's Condition or Status policy, dated February 2018, was provided by the Administrator on 12/05/2025 at 1:50 P.M. The policy indicated, .The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician.when there has been.A need to alter the resident's medical treatment significantly.Refusal of treatment or medications.two.or more consecutive times.The nurse supervisor/charge nurse will record in the resident's medical (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
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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	record information relative to changes in the resident's medical/mental condition or status. 3.1-5(a)(3)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, record review, and interview, the facility failed to protect residents' personal health information for 2 of 4 observations conducted. Findings included 1. The 200 Hall was observed on 12/04/2025 at 10:23 A.M. Two Medication Carts were sitting in the hallway across from the nurse's station both. Both medication carts were unattended. One Medication Cart had an empty medication card laying on the top labeled with Resident 32's name. The medication was Losartan Potassium 100 milligrams (mg). A second Medication Cart had an empty medication card laying on the top labeled with Resident 40's name. The medication was Losartan HCTZ (Hydrochlorothiazide). No staff members were in the immediate area or near the medication carts. Two unidentified people walked past the cart. At 10:27 A.M., a staff member took the medication card for Resident 40 from the top of the medication cart, tore the top half of the card off, and disposed of the rest of the card. 2. The 200 Hall was observed on 12/05/2025 at 9:04 A.M. The medication cart was unattended at the time of the observation. A paper laying face up on the top of a medication cart had a list of resident names and personal information. The unattended nurses station was observed. A paper laying face up on the nurse's station desk, had a list of resident names and personal health information. Several unidentified people walked past the nurse's station and the medication cart. During an interview, on 12/05/2025 at 9:06 A.M., RN 6 indicated paperwork with residents' information should not be left out in the open and proceeded to turn the papers face down. The current Safeguarding of Resident Identifiable Information policy, with a copyright date of 2024, was provided by the Director of Nursing on 12/05/2025 at 1:24 P.M. The policy indicated, .Medical records shall not be left in open areas where unauthorized persons could access identifiable resident information.Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons. 3.1-3(o)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to document residents' meal consumption for 3 of 4 residents reviewed for nutrition. (Residents 84, 4, and 72) Findings include: 1.The clinical record for Resident 84 was reviewed on 12/04/2025 at 11:57 A.M. An admission Minimum Data Set (MDS) assessment, dated 11/02/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, expressive language disorder, aphasia (a partial or total loss of language skills due to brain damage), diabetes, and dementia. The resident had complaints of pain or difficulty with swallowing or eating and was on a mechanically altered diet. The resident's current Nutritional Status Care Plan indicated she was at risk for impaired nutritional status and listed an Approach to monitor and record meal intakes, with a start date of 10/29/2025. The resident's Meal Consumption Record lacked documentation of meals for the following dates and times: -On 11/03/2025 at breakfast and lunch, -On 11/05/2025 at dinner, -On 11/06/2025 at breakfast and lunch, -On 11/14/2025 at lunch, -On 11/15/2025 at lunch, -On 11/18/2025 at lunch and dinner, -On 11/25/2025 at lunch, -On 11/26/2025 at lunch, -On 11/29/2025 at lunch, -On 11/30/2025 at dinner, and -On 12/01/2025 at dinner. 2. The clinical record for Resident 4 was reviewed on 12/03/2025 at 2:33 P.M. An admission MDS assessment, dated 10/23/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, fractures of the tibia, hypertension, renal failure, seizure disorder, anxiety, and depression. The resident's current Nutritional Status Care Plan indicated she was at risk for impaired nutritional status and listed an Approach to monitor and record meal intakes, with a start date of 10/22/2025. The resident's Meal Consumption Record lacked documentation of meals for the following dates and times: (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/01/2025 at breakfast and lunch, -On 11/03/2025 at breakfast and lunch, -On 11/05/2025 at breakfast, -On 11/08/2025 at dinner, -On 11/09/2025 at breakfast and lunch, -On 11/10/2025 at breakfast and lunch, -On 11/11/2025 at dinner, -On 11/08/2025 at dinner, -On 11/09/2025 at lunch and dinner, -On 11/10/2025 at breakfast and dinner, -On 11/11/2025 at dinner, -On 11/12/2025 at breakfast and lunch, -On 11/13/2025 at breakfast and lunch, -On 11/17/2025 at breakfast and lunch, -On 11/19/2025 at dinner, -On 11/20/2025 at breakfast, lunch, and dinner, -On 11/22/2025 at lunch, -On 11/23/2025 at dinner, -On 11/24/2025 at breakfast and lunch, -On 11/27/2025 at breakfast and lunch, -On 11/28/2025 at dinner, -On 12/01/2025 at breakfast and lunch, and -On 12/03/2025 at dinner. 3. The clinical record for Resident 72 was reviewed on 12/03/2025 at 2:41 P.M. A Quarterly MDS assessment, dated 11/18/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, peripheral vascular disease and hypertension. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Meal Consumption Record lacked documentation of meals for the following dates and times: -On 11/01/2025 at breakfast, lunch, and dinner, -On 11/02/2025 at breakfast, lunch, and dinner, -On 11/03/2025 at dinner, -On 11/04/2025 at dinner, -On 11/05/2025 at breakfast and dinner, -On 11/06/2025 at breakfast, lunch, and dinner, -On 11/07/2025 at dinner, -On 11/08/2025 at dinner, -On 11/09/2025 at lunch and dinner, -On 11/10/2025 at breakfast and dinner, -On 11/11/2025 at dinner, -On 11/12/2025 at dinner, -On 11/13/2025 at breakfast, lunch, and dinner, -On 11/14/2025 at breakfast and dinner, -On 11/15/2025 at breakfast, lunch, and dinner, -On 11/16/2025 at breakfast, lunch, and dinner, -On 11/18/2025 at breakfast and dinner, -On 11/19/2025 at dinner, -On 11/20/2025 at breakfast, lunch, and dinner, -On 11/21/2025 at breakfast and lunch, -On 11/22/2025 at dinner, -On 11/23/2025 at dinner, -On 11/24/2025 at breakfast, lunch, and dinner, (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 11/25/2025 at breakfast, lunch, and dinner, -On 11/26/2025 at breakfast, and dinner, -On 11/27/2025 at breakfast and lunch, -On 11/28/2025 at breakfast, lunch, and dinner, -On 11/29/2025 at breakfast, lunch, and dinner, -On 11/30/2025 at breakfast, lunch, and dinner, -On 12/01/2025 at dinner, and -On 12/02/2025 at breakfast, lunch, and dinner. During an interview, on 12/04/2025 at 11:27 A.M. Certified Nurse Aide (CNA) 3 indicated resident meal consumptions were document on the computer charting system. Every meal should be documented. They were able to document if the resident refused or if they were out of the facility. The current facility policy titled, Point of Care Documentation, updated January 2018, was provided by the DON on 12/04/2025 at 1:37 P.M. The policy indicated, .Resident documentation will occur accurately and timely.The Dietician will review weights and meal consumption records.Resident Food intake will be monitored and recorded by direct care staff. 3.1-46(a)(1)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provided physician prescribed medications and appropriate dosage for 2 of 19 residents reviewed for pharmacy services. (Residents 4 and 3) Findings include:1.The clinical record for Resident 4 was reviewed on 12/03/2025 at 2:33 P.M. An admission Minimum Data Set (MDS) assessment, dated 10/23/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, fractures of the tibia, hypertension, renal failure, seizure disorder, anxiety, and depression. The Progress Notes indicated the resident was admitted to the facility on [DATE] at 5:20 P.M. The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication; Lacosamide 100 milligrams (mg) for seizures, with a start date of 10/17/2025:s on the following dates and times: -On 10/17/2025 at 7:00 P.M. to 10:00 P.M., due to medication being unavailable. -On 10/18/2025 at 7:00 A.M. to 10:00 A.M., due to medication being unavailable. The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication; Sitagliptin 50 mg for diabetes with chronic kidney disease, with a start date of 10/17/2025 on the following date: -On 10/18/2025 at 7:00 A.M. to 10:00 A.M., due to medication being unavailable. The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication, Enoxaparin (a blood thinner) syringe, 30mg/0.3 milliliters (ml), subcutaneous, for fracture, with a start date of 10/17/2025: -on 10/23/2025 at 7:00 P.M. to 10:00 P.M., due to medication being unavailable. The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication; Amitriptyline 10 mg, give 3 tabs, 30 mg, for depression, with a start date of 10/17/2025: -On 11/18/2025 at 7:00 P.M. to 10:00 P.M., due to medication being unavailable. The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication; Desvenlafaxine extended-release tab for depression, with a start date of 10/17/2025: -On 11/18/2025 at 7:00 A.M. to 10:00 A.M., due to medication being unavailable. The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication; Esomeprazole magnesium 40 mg, for Gastro-esophageal disease, with a start date of 10/17/2025: -On 11/18/2025 at 7:00 P.M. to 10:00 P.M., due to medication being unavailable. (continued on next page)

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Lutheran Community Home	111 W Church Ave Seymour, IN 47274

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication; Glimepiride 2 mg, for diabetes, with a start date of 10/17/2025: -On 11/18/2025 at 7:00 A.M. to 10:00 A.M., due to medication being unavailable. The resident's Electronic Medication Administration Record (EMAR) indicated they did not receive the following prescribed medication; Tizanidine 4 mg, for muscle spasms, with a start date of 10/17/2025: -On 11/17/2025 at 7:00 P.M. to 10:00 P.M., due to medication being unavailable. -On 11/18/2025 at 7:00 P.M. to 10:00 P.M., due to medication being unavailable. During an interview, on 12/05/2025 at 10:53 A.M., Nurse Practitioner (NP) 5 indicated they communicated with the facility daily. If a resident needed a medication, they could order it and get it that same day. If the facility had a newly admitted resident, they would get medications the day they came to the facility. They have the discharge order set for medications from the hospital. The nurses upload medication orders in the computer and the prescriptions get filled by their contracted pharmacy. They also had alternative places to get medications if they needed them. During an interview, on 12/05/2025 at 12:13 P.M., the Director of Nursing (DON) indicated residents' prescribed medications should be available to them. The facility had local pharmacies they could use if they needed too. Medications should be available. Medications ordered during the day were usually delivered that same night. Staff had an Emergency Drug Kit (EDK) onsite they could get medications from if they were available. Staff should notify the NP if they do not have medications available to get approval for waiting for the pharmacy delivery. The NP notification should be in the Progress Notes. The resident recently had surgery. The Progress Notes lacked documentation the NP had been notified of the delay in the medications or any process for monitoring or obtaining alternative treatment orders. A Progress Note, dated 11/18/2025, indicated medications had not been ordered until 11/17/2025. The pharmacy indicated there had been a glitch in their system and medications would not be delivered until the night of 11/18/2025. The current Unavailable Medications policy, with a copyright date of 2025, was provided by the DON on 12/05/2025 at 1:24 P.M. The policy indicated, .Staff shall take immediate action when it is known that the medication is unavailable.Notify physician of inability to obtain medication upon notification of awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold. The current Pharmacy Services policy, with a copyright date of 2025, was provided by the DON on 12/05/2025 at 1:24 P.M. The policy indicated, .It is the policy of this facility to ensure that pharmaceutical services.are provided to meet the needs of each resident.The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs. 2. The clinical record for Resident 3 was reviewed on 12/03/2025 at 10:19 A.M. A Quarterly MDS assessment, dated 11/14/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, fractures, anemia, hypertension, depression, (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and dementia. A physician's order, dated 03/21/2025 through 07/17/2025, indicated the resident was to receive Depakote 125 mg, three times a day for dementia. A Progress Note, dated 06/11/2025 at 8:15 A.M., indicated the resident had a current order for Depakote 125 mg, three times a day. The writer found a medication card of Depakote 250 mg for the resident. The resident received 250 mg (double the ordered dose) of the medication three times a day for 4 and a half days. The medication card was pulled from the medication cart as it was a medication error. A Progress Note, dated 06/11/2025 at 10:30 A.M., indicated the DON and SSD were made aware of the medication error. The resident's family and the pharmacy were made aware of the medication error. A Progress Note, dated 06/11/2025 at 11:41 A.M., indicated the Nurse Practitioner was notified of the resident's Depakote medication error. There was a new order to obtain the Depakote level the next morning. The residents Depakote lab was reviewed by the Nurse Practitioner on 06/12/2025 with no new orders. During an interview, on 12/04/2025 at 10:40 A.M., RN 4 indicated when administering medications, she would make sure the physician's order matched the medication card. If the two didn't match, then she would look at the resident's progress note and find out if the order changed. During an interview, on 12/04/2025 at 1:43 P.M., the DON indicated in June the pharmacy sent the wrong medication card for the resident. They sent 250 mg tablets, but the resident was supposed to get 125 mg tablets. Nursing staff administered the 250 mg tablets. When administering medications the nurse should verify the right dose of medication was being given. The current, undated, facility policy titled, Medication Error was provided by the DON on 12/04/2025 at 2:52 P.M. The policy indicated, .Medications shall be administered.According to physician's order. The current, undated, facility policy titled, Medication Administration was provided by the DON on 12/04/2025 at 2:52 P.M. The policy indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.Ensure that the six rights of medication administration are followed:.Right dosage.Compare medication source (bubble pack, vial, etc.) with MAR [Medication Administration Record] to verify resident name, medication name, form, dose, route, and time. 3.1-25(b)(1)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to maintain medication storage areas appropriately related to undated medication and a staff member's personal items for 1 of 4 medication carts reviewed (300 Hall Medication Cart), and a resident's personal items for 1 of 3 medication rooms reviewed (300 Hall Medication Room). Findings included:1.Medication storage areas on the 300 Hall were observed on 12/04/2025 at 10:46 A.M., With RN 2, and included, but were not limited to, the following: a. The 300 Hall Medication Cart contained a Lispro insulin pen for Resident 92 that was not labeled with an open date. The RN indicated the pen had not been opened yet, it had been out of the refrigerator since Friday, 11/28/2025, and she would date the pen when she opened it. The pen was good for 28 days. Usually, it was the same day, when a pen was removed from the refrigerator and when it was opened. An insulated coffee cup with a lid was in a drawer of the medication cart sitting next to clean health care supplies. The RN identified the coffee cup as being their own. b. In the 300 Hall Medication Room, in a cabinet labeled Wound Supplies, a pack of cigarettes, along with two loose cigarettes, and a lighter, were laying on a shelf next to a box of insulin safety syringes. RN 2 indicated she thought the cigarettes had been confiscated from a resident. The Lispro insulin package insert indicated unused insulin pens should be stored in the refrigerator at 36 degrees farenheit to 46 degrees farenheit, insulin pens, unopened, not in use, at room temperature, were good for 28 days. Therefore, the pen should have been labeled with a date the day it was taken out of the refrigerator.During an interview, on 12/05/2025 at 12:34 P.M., the Director of Nursing (DON) indicated staff's personal items should not be stored in the medication carts. The resident's cigarettes should have been discarded or sent home with the family. The current Medication Storage policy, with a copyright date of 2025, was provided by the DON on 12/05/2025 at 1:24 P.M. The policy indicated, .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature .segregation, and security .3.1-25(o)