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	12/01/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for an allegation of misappropriation of resident property, the facility failed to safeguard a resident's personal valuables when Resident #1's cash money was removed from the facility's safe. The findings include:Resident #1's diagnoses included dementia, depression, and anxiety disorder. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had poor decision-making skills regarding tasks of daily living and required assistance from staff with activities of daily living. The nursing progress note dated 9/4/25 at 7:35 PM identified a nurse aide brought Resident #1 to the shower room to give Resident #1 his/her weekly shower and the nurse aide found $20.00 dollars in cash in Resident #1's brief, and later in Resident #1's room the nurse aide found $340.00 dollars cash hidden in Resident #1's soiled bedding, along with three (3) checkbooks. The note indicated all necessary parties were notified, Resident #1 was allowed to keep the $20.00 dollars on his/her person, and the $340.00 dollars and checkbooks were locked in the nursing narcotic box safe on the unit until the business office opened on 9/5/25. The social service progress note dated 9/5/25 at 3:09 PM indicated nursing informed social services that Resident #1 had $340.00 dollars in cash and three (3) checkbooks on his/her person, which were taken by the nurse and locked in the facility's safe. The Facility Reported Incident report dated 9/10/25 identified Resident #1's cash, which was stored in the facility safe, was noted to be missing from the facility safe on 9/10/25 at 4:00 PM. The investigation identified Resident #1 had $340.00 in cash and three (3) checkbooks found on 9/4/25 on Resident #1's person, which were placed in a biohazard bag by nursing and placed the bag in the nursing unit narcotic box. On 9/5/25 the money and checkbooks were then placed into the facility's locked safe by the [NAME] Assistant with the Administrator present for the facility to safeguard Resident #1's personnel belongings while at the facility. On 9/10/25, the money was identified as missing from the facility safe when the safe was opened by the Business Office Manager with the [NAME] Assistant present. The investigation determined that on 9/10/25 the Business Office Manager and [NAME] Assistant both left the office to attend a meeting earlier that day and the only person in the office alone was a Customer Service Liaison. Interview with the Business Office Manager on 9/25/25 at 11:10 AM identified the facility was asked on 9/5/25 to keep Resident #1's cash and three (3) checkbooks in the facility safe while Resident #1 resided at the facility, and the money was first identified as missing on 9/10/25 at 4:00 PM by herself and the Assistant Biller. The Business Office Manager indicated she and the Assistant Biller typically kept the key to the safe hidden in a pen holder on a desk in the office and the door to the office was locked when neither she nor the Assistant Biller was in the office. The Business Office Manager identified on 9/10/25 a Customer Service Liaison was assigned to work from the office so the door to the office was left open while she and the Assistant Biller went to a meeting because the Liaison did not have a key to the office. The Business Office Manager explained although she, the Assistant Biller, and the Administrator were the only ones to have access to the key to the facility safe, the key was left unsecured in a pen holder on a desk in the office when she and the Assistant Biller left for the meeting on 9/10/25. Interview with the Assistant Biller on 9/25/25 at 11:20 AM identified she had last seen the money in the facility safe, which she had placed into the safe with the Administrator present in early September. The Assistant Biller identified the money was first noticed as missing on 9/10/25 after she and the Business Office Manager saw the clear biohazard bag had been opened. Interview and review of the facility incident report with the Administrator on 9/25/25 at 12:05 PM identified at the beginning of September, she witnessed the Assistant Biller place Resident #1's cash money and three (3) checkbooks into the facility safe after nursing found the money and checkbooks on Resident #1. The Administrator indicated Resident #1's money and checkbooks were inside a biohazard bag, which was then placed into the facility's safe and on 9/10/25 at 4:30 PM, she was informed by the Business Office Manager that the money from the biohazard bag was missing. The Administrator explained she was unable to determine who was responsible for removing Resident #1's money from the safe, Resident #1 was reimbursed and the Customer Service Liaison resigned. Interview with Customer Service Liaison on 9/25/25 at 1:15 PM via phone indicated he/she was not sure what happened to Resident #1's money. Review of the facility Abuse Prevention Program Policy dated 5/25/25 defined misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent and directed that residents had the right to be free from

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, policies, and interviews, for one (1) of three (3) residents (Resident #4) reviewed for discharge, the facility failed to ensure the receiving provider's acceptance prior to transfer and failed to provide the receiving health care facility with the resident's discharge summary before the resident's arrival.Resident #4 had diagnoses that included anoxic brain damage, dementia with behavioral disturbance, fracture of the upper end of the left humerus, atrial fibrillation, malignant neoplasm of the prostate, and dysphagia.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), was frequently incontinent of bowel, occasionally incontinent of bladder, and required moderate assistance with personal hygiene, bed mobility, ambulation, and transfers. The MDS further identified Resident #4's goal for discharge was to be discharged to the community.The care plan dated 9/10/2025 identified Resident #4 wished to return to the community where he/she resided with his/her spouse. Interventions directed to establish a pre-discharge plan, evaluate progress, revise the plan as needed, make arrangements with required community resources to support independence post-discharge, prepare and give resident/family member/caregivers contact numbers for all community referrals.The nurse's note dated 9/10/2025 at 11:26 A.M. by Registered Nurse (RN) #3 (MDS coordinator), identified Resident #4's spouse was contacted to inform him/her that Resident #4 received a Notice of Medicare Non-Coverage (NOMNC) with the last covered day as 9/12/2025. RN #3 identified Resident #4's spouse requested to file an appeal. RN #3 indicated she provided Resident #4's spouse with the contact number and information needed to request an appeal.The nurse's note dated 9/11/2025 at 12:50 P.M. by RN #3 identified Resident #4 lost the appeal. RN #3 identified Resident #4's spouse offered to privately pay to keep Resident #4 at the facility but stated he/she could not afford it. RN #3 identified Resident #4's spouse stated he/she filed a second-level appeal and would pick Resident #4 up on 9/13/2025. RN #3 indicated social services would set up home care services.The nurse's note dated 9/12/2025 at 2:16 P.M. by Licensed Practical Nurse (LPN) #2 (MDS coordinator) identified she and Social Worker (SW) #2 spoke with Person #2 who had concerns about Resident #4 returning to prior living arrangements with his/her spouse secondary to Resident #4 being recently hospitalized , and the spouse unable to provide Resident #4 with the care he/she needed. LPN #2 indicated Person #2 arranged transportation, for Resident #4, to a short-term hospital. LPN #2 indicated that on 9/13/2025, the nursing staff would call Resident #4's spouse to call transportation.APRN #1's note dated 9/12/2025 at 10:31 A.M. identified Resident #4's insurance was requesting a discharge home. APRN #1 identified Resident #4 resided in a hotel with his/her spouse due to homelessness. APRN #1 identified Resident #4 needed to be discharged with 24-hour care because he/she could not care for himself/herself, was at high risk for falls, and was at high risk for rehospitalization.APRN #1's note dated 9/12/2025 at 2:13 P.M. identified Resident #4 was being transferred to the hospital.The nurse's note dated 9/13/2025 at 3:34 P.M. by LPN #3 identified Resident #4 was transferred to the hospital.Interview with SW #1 on 9/30/2025 at 9:45 A.M. identified that initially, Resident #4's discharge plan was to be discharged back to the community where Resident #4 lived with his/her spouse. SW #1 identified she was not involved when Resident #4's discharge plans changed on 9/12/2025 to Resident #4 being discharged to another healthcare institution. Interview with SW #2 on 9/30/2025 at 10:05 A.M. identified she was contacted by Person #2 on 9/12/2025 because Resident #4's spouse contacted him/her regarding Resident #4's discharge home on 9/13/2025. SW #2 indicated Person #2 stated Resident #4's spouse was recently hospitalized and could not take care of Resident #4. SW #2 indicated Person #2 reported he/she arranged transportation on 9/13/2025 to another health care institution. SW #2 identified that on 9/12/2025, she did not contact the receiving health care institution to confirm Resident #4's admission on [DATE]. SW #2 identified on 9/12/2025 and 9/13/2025, she did not contact, convey, or electronically transmit Resident #4's discharge summary to the receiving health care institution or health care provider.Interview with Person #2 on 9/30/2025 at 10:27 A.M. identified on 9/12/2025 he/she received a call from Resident #4's spouse, who reported Resident #4 was scheduled to be discharged on 9/13/2025 from the facility back to the hotel. Person #2 indicated Resident #4's spouse had been recently hospitalized and stated he/she was unable to care for Resident #4. Person #2 indicated Resident #4's spouse asked if he/she could help coordinate transportation to a short-term care hospital on 9/13/2025. Person #2 identified he/she spoke to SW #2 on 9/12/2025 to notify him/her of the arranged transportation on

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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 review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #4) reviewed for discharge, the facility failed to obtain a physician's order for discharge. The findings include:Resident #4 had diagnoses that included anoxic brain damage, dementia with behavioral disturbance, fracture of the upper end of the left humerus, atrial fibrillation, malignant neoplasm of the prostate, and dysphagia.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), was frequently incontinent of bowel, occasionally incontinent of bladder, and required moderate assistance with personal hygiene, bed mobility, ambulation, and transfers. The MDS further identified Resident #4's goal for discharge was to be discharged to the community.The care plan dated 9/10/2025 identified Resident #4 wished to return to the community where he/she resided with his/her spouse. Interventions directed to establish a pre-discharge plan, evaluate progress, revise the plan as needed, make arrangements with required community resources to support independence post-discharge, prepare and give resident/family member/caregivers contact numbers for all community referrals.The nurse's note dated 9/12/2025 at 2:16 P. M. by Licensed Practical Nurse (LPN) #2 (MDS coordinator) identified she and Social Worker (SW) #2 spoke with Person #2 who had concerns about Resident #4 returning to prior living arrangements with his/her spouse secondary to Resident #4 being recently hospitalized , and the spouse unable to provide Resident #4 with the care he/she needed. LPN #2 indicated Person #2 arranged transportation, for Resident #4, to a short-term hospital. LPN #2 indicated that on 9/13/2025, the nursing staff would call Resident #4's spouse to call transportation.APRN #1's note dated 9/12/2025 at 10:31 A.M. identified Resident #4's insurance was requesting a discharge home. APRN #1 identified Resident #4 resided in a hotel with his/her spouse due to homelessness. APRN #1 identified Resident #4 needed to be discharged with 24-hour care because he/she could not care for himself/herself, was at high risk for falls, and was at high risk for rehospitalization.APRN #1's note dated 9/12/2025 at 2:13 P.M. identified that Resident #4 was transferred to the hospital.The nurse's note dated 9/13/2025 at 3:34 P.M. by LPN #3 identified Resident #4 was transferred to the hospital.Interview and clinical record review with the DNS on 9/30/2025 at 2:10 P.M. failed to Identify documentation to reflect a physician's order was obtained when Resident #4 was discharged on 9/13/2025. The DNS identified that when a resident is being discharged , the charge nurse should ensure a physician's order is obtained for discharge. The DNS was unable to explain why a physician's order was not obtained to discharge Resident #4. Review of the facility's Transfer or Discharge Policy dated 12/2016, directed in part, that nursing services is responsible for obtaining orders for discharge.