STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525476	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Home	831 Pine Beach Rd Marinette, WI 54143

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the right to be free from verbal abuse by staff for 1 resident (R) (R4) of 4 residents in a total sample of 8 residents.Staff witnessed Certified Nursing Assistant (CNA)2 be verbally abusive to R4.Findings include: Review of the facility's policy titled Abuse, Neglect and Exploitation Prevention and Reporting Policies and Procedures, reviewed September 2024, revealed: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .Causes could reasonably be expected to cause mental or emotional damage to a client, including harm to client's psychologic or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or fear of harm or death, or a combination of these behaviors. Review of the Face Sheet tab located in the electronic medical record (EMR) revealed R4 was admitted to the facility on [DATE] with diagnoses that included dementia and bipolar disorder. Review of a Significant Change Assessment, located in the Minimum Data Set (MDS) tab of the EMR with an Assessment Reference Date (ARD) of 3/16/26, revealed R4 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R4 had severely impaired cognition. In addition, R4 was able to make themself understood and was able to understand others. Review of the 4/20/26 Facility Investigation provided by the Director of Nursing (DON) revealed a witness stated CNA2 spoke to R4 in a loud and harsh manner after R4 requested to be put into bed. Review of the 4/20/26 written statement by the Health Information Manager (HIM) revealed they were on the unit writing in orders when they heard CNA2 being verbally abusive and yelling at R4 to stop sliding down in their wheelchair on three separate occasions. CNA2 got in R4's face and told them to knock it off. CNA2's partner (CNA1) and Licensed Practical Nurse (LPN)2 were present. CNA2 was not directed to stop yelling at R4 by CNA1 or the charge nurse. The second occurrence was with CNA2 yelling at R4. CNA2 told LPN2 to lay R4 down and CNA2 would pass lunch trays. The charge nurse told CNA2 that laying R4 down was an urgent matter so R4 would not fall out of their chair. CNA2 proceeded to pass lunch trays and said R4 was just playing games if everyone just understood that. R4 was put into bed by CNA1 and LPN2. Review of the 4/20/26 written statement by CNA1 revealed CNA2 stated they didn't want to do too much and didn't want to be there approximately 15 minutes into the shift. CNA1 witnessed CNA2 yell at R4. When R4 got back to the common area with a coloring supplies, R4 was yelling that they wanted to lay down. CNA2 got next to R4 on the side closest to their face and started to yell that R4 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to stop yelling and needed to stay there. CNA2 stated staff would not bring R4 back to their room or lay them down and CNA2 was not playing their games. When R4 started to scoot to the edge of the wheelchair, CNA2 yelled that they would not boost R4 back up either. CNA2 ripped out a pillow that Hospice had placed underneath R4's legs due to leg pain and said the pillow did not need to be there. LPN2 asked staff to put R4 to bed as that was the safest place, however, CNA2 refused to help and said they couldn't do anything with R4 due to no male caregivers. CNA1's statement indicated CNA2 always used that excuse so they didn't have to do anything, however, CNA2 could help transfer if it did not have to do with cares or toileting. The statement indicated CNA1 was going to transfer R4 alone, which they knew they shouldn't, but LPN2 helped put R4 into bed. The Facility Investigation did not indicate LPN2 was interviewed as a potential witness. Review of an undated written statement by CNA2 revealed CNA2 believed the allegations against them were false but was deeply saddened and sorry if anybody believed they abused a resident. CNA2 did not want anyone to think or feel that way and stated they would take full responsibility for their actions. Review of the Conclusion to the 4/20/26 Facility Investigation revealed the Administrator documented, We believe the statements of the witnesses (HIM) and (CNA1) are credible and that (CNA2) did not treat (R4) with kindness and respect .Appropriate disciplinary action was taken with (CNA2). During an observation on 6/29/26 at 9:03 AM, R4 was seated in a Broda chair at the dining table. Staff were talking to residents at the table. R4 did not show any fear of the staff. No behaviors were noted. During an interview on 6/29/26 at 2:12 PM, CNA1 verified they were part of the investigation with CNA2 and indicated CNA2 stated they would not help CNA1. CNA1 stated R4 had an intervention for no male caregivers, however, if it was a female and no cares were involved, they could help. CNA1 indicated CNA2 said shut up and I don't care if you fall to R4. CNA1 did not report the abuse to administration and stated, That was my fault. CNA1 stated CNA2 was suspended shortly after the incident and did not return. When asked if R4 had crying or increased behaviors after the incident, CNA1 stated, No, not really but (R4) just sat there and became very quiet. During an initial interview on 6/30/26 at 8:17 AM, the Administrator stated, (CNA2) was a good aide but we had to let (them) go. It was (CNA2's) tone of voice and how (they) addressed people. I don't think (CNA2) meant any harm. When asked if staff were educated on abuse during or after the investigation, the Administrator stated, I don't think there was any staff education. When asked if the Social Services Designee (SSD) had addressed the issue of possible trauma with R4, the Administrator stated, No, I don't think so. During an interview on 6/30/26 at 10:47 AM, LPN2 was asked if the Administrator had interviewed them during the investigation. LPN2 stated, No. (The Administrator) did not interview me. It surprised me that (they) didn't. I worked the next day and was waiting to talk to the Administrator, but (they) did not come and see me. When asked if LPN2 was a mandatory reporter if they heard or witnessed abuse, LPN2 stated, I am not sure whether I am a mandatory reporter or not. During an interview on 7/1/26 at 10:10 AM, the SSD was asked about their role during an abuse investigation and stated, I usually hear about (allegations of abuse) from the Administrator and then (they) tell me to go and interview residents. When asked if they were involved in the investigation of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbal abuse toward R4, the SSD said, I do not think I was involved other than taking statements from residents. In a follow-up interview on 7/1/26 at 10:55 AM, the Administrator was asked why LPN2 was not interviewed during the investigation and stated, I hand those (interviews) off to HR (Human Resources), so I don't have an answer to this question. When asked if law enforcement was notified of the abuse investigation, the Administrator stated, No. When asked why R4's care plan was not updated with any new interventions, the Administrator stated, We had talked about doing this as a team. I always ask if something needs to be changed (on the care plan). I have a check list for any investigation, however, updating the care plan was not on my check list nor was notifying law enforcement.