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	12/10/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 residents (R) of the 61 residents residing in the facility. The facility did not ensure transmission-based precautions (TBP) were implemented for R53 for Norovirus (The most common cause of gastroenteritis, characterized by non-bloody diarrhea, vomiting, and stomach pain. The virus is highly contagious and spread through contaminated food or water or person-to-person contact, contaminated surfaces, or through air from the vomit of an infected person.) Licensed Practical Nurse (LPN)-K did not complete appropriate hand hygiene during medication administration.Housekeeper (HK)-G did not use appropriate disinfecting solution to mop residents' floors on a unit with a Norovirus outbreak. In addition, the housekeeping department did not have a policy or procedure to ensure appropriate cleaning and disinfection was completed. Findings include: The facility's Infection Control Precautions policy, revised 6/4/19, indicates: Both standard and transmission-based precautions (TBP) are used as appropriate to prevent the spread of communicable disease .Standard Precautions: Use standard precautions when giving care to all residents regardless of diagnosis or presumed infection status. This includes personal protective equipment (PPE) such as gloves, gowns, masks, and goggles when exposure to blood or body fluids, secretions and excretions, non-intact skin, or mucous membranes is anticipated. The type of PPE used depends on the type of exposure anticipated. Hand hygiene is always required following any patient contact and after a dirty task, following removal of gloves, and before proceeding to a clean task. Wash hands for 20 seconds with soap and warm water, if visibly soiled. (NOTE: Soap and water must always be used after using the bathroom yourself and when assisting a resident who has a Clostridioides difficile (C. diff) diagnosis or Norovirus). Transmission-Based Precautions: Based on the mode and risk of transmission, TBP add an additional layer of protection in addition to standard precautions when factors indicate increased risk of transmission .Contact Precautions: Use for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident care items .instances for adding contact precautions may include highly transmissible organisms such as C. diff, herpes, and other transmissible conditions such as impetigo, lice, scabies, rash of unknown origin, conductivities, heavily draining wounds, etc . The facility's Infection Prevention and Control Program policy, revised 5/31/19, indicates: It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection .Hand Hygiene Protocol: All staff shall wash their (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hands when coming on duty, between resident contact, after handling contaminated objects, after personal protective equipment (PPE) removal, before/after eating, before/after toileting, and before going off duty. Staff shall wash their hands before and after performing resident care procedures. Hands shall be washed in accordance with the facility's established hand washing procedure. Isolation Protocol: Standard precautions shall be observed for all residents. A resident with an infection or communicable disease shall be placed on isolation precautions as recommended by current Centers for Disease Prevention and Control (CDC) guidelines for isolation precautions. A copy of these guidelines are available at each nurses' station . The facility's Hand Hygiene/Glove Use policy, revised June 2018, indicates: Proper hand hygiene technique is used to prevent transmission of infectious disease .All employees are required to perform hand hygiene before and after resident contact, before and after performing any procedure, between tasks that are dirty and clean, after sneezing or blowing their nose, after using the toilet, before handling food, and when hands become obviously soiled .1) Antiseptic Gel Use: When appropriate to use antiseptic hand gel, thoroughly distribute enough hand gel to cover both hands and vigorously rub hands together covering all surfaces of the hands and fingers. Rub hands until dry .Hand gel is the preferred method of hand hygiene. With the exceptions listed below for soap and water handwashing. Handwashing: 1. Turn on water to a warm temperature; 2) Wet hands with water; 3) Using a liquid soap from a dispenser, rub hands together vigorously for at least 15 seconds. Be sure to wash all surfaces, including backs of hands, wrists, between fingers, and under fingernails; 4) Rinse hands well under warm running water; 5) Dry hands with paper towels .Turn faucet off with a clean, dry paper towel .Hands must be washed with soap and water: a) When hands are visibly soiled; b) After using the bathroom; c) When working with a resident who has Clostridioides difficile (C. diff) or suspected C. diff or Norovirus. The facility's Routine Cleaning and Disinfection policy, revised February 2020, indicates: It is the policy of [NAME] Home to ensure the provision of routing cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infection to the extent possible .9. Disinfectant solution will be prepared fresh daily and changed frequently in order to ensure effectiveness. a. Follow manufacturer recommendations for dilution and frequency of changing disinfectant solution. b. Follow manufacturer recommendations regarding appropriate contact time to ensure adequate disinfection. c. Change solution after cleaning a room under transmission-based precautions (TBP). Clean and disinfect any equipment that enters the room before use in other locations. d. Verify products used to clean and disinfect surfaces in rooms under TBP are effective against the pathogen of concern. 1.On 12/8/25, Surveyor reviewed R53's medical record. R53 had diagnoses including diabetes type 2, presence of indwelling catheter, and renal disease and was on contact precautions due to Norovirus. R53's Minimum Data Set (MDS) assessment, dated 12/2/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R53 had intact cognition. On 12/8/25 at 8:10 AM, Director of Nursing (DON)-B confirmed the D wing was in a Norovirus outbreak. On 12/8/25 at 8:55 AM, Surveyor observed R53 in a recliner. R53's door contained a sign that indicated R53 was on contact precautions. The sign indicated staff should don a gown, gloves, and a mask before entering the room. The sign also indicated staff should complete hand hygiene and remove personal protective equipment (PPE) prior to exiting the room. Surveyor interviewed R53 who confirmed R53 was on contact precautions for Norovirus and indicated many residents were ill. R53's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	call light was activated at the time. On 12/8/25 at 8:59 AM, Surveyor observed Certified Nursing Assistant (CNA)-D enter R53's room wearing a mask but no other PPE. CNA-D obtained items in the room for R53, touched surfaces, emptied a basin, and removed items from the room per R53's request. Surveyor observed CNA-D exit the room and sanitize hands. Surveyor interviewed CNA-D who indicated CNA-D should have worn the appropriate PPE and followed standard and contact precautions prior to and after exiting the room. CNA-D indicated CNA-D did not so do because CNA-D was in a rush. On 12/8/25, Surveyor noted five additional residents on the D wing were on contact precautions due to Norovirus. On 12/9/25 at 9:00 AM, Surveyor noted contact precautions were initiated for two residents on the B wing due to Norovirus. On 12/10/25 at 8:05 AM, Surveyor noted contact precautions were initiated for three additional residents on the B wing due to Norovirus. On 12/10/25 at 12:05 PM, Surveyor interviewed DON-B who verified the Norovirus outbreak began on 12/6/25 on the D wing and confirmed the outbreak spread to the B wing. DON-B indicated staff should adhere to the facility's policy and procedure for donning and doffing PPE for residents on TBP to prevent the spread of illness. 2. On 12/9/25 at 8:21 AM, Surveyor observed LPN-K prepare and administer medication to R22. After administering R22's medication, LPN-K washed hands with soap and water for five seconds in R22's room. (Surveyor counted from the beginning to the end of the water running.) On 12/9/25 at 8:45 AM, Surveyor observed LPN-K prepare and administer medication to R8. After administering R8's medications, LPN-K washed hands for five seconds with soap and water in R8's room. (Surveyor counted from the beginning to the end of the water running.) Immediately after the observations, Surveyor interviewed LPN-K who verified LPN-K did not wash hands for the recommended twenty seconds to ensure LPN-K's hands were adequately cleaned to prevent the spread of infectious agents, especially during the facility's Norovirus outbreak. On 12/10/25 at 12:07 PM, Surveyor interviewed DON-B related to hand washing during acute gastroenteritis outbreaks such as Norovirus. DON-B stated hand sanitizer is the best thing to use if hands are not visibly soiled; however, staff should use soap and water during a suspected Norovirus outbreak. Immediately after the interview, Surveyor requested the facility's policy pertaining to disinfection procedures from Nursing Home Administrator (NHA)-A. 3. On 12/9/25 at 9:15 AM, Surveyor observed Housekeeper (HK)-G clean R20's room on the D wing which contained four halls. Surveyor observed one housekeeping cart on the unit that contained one mop bucket and a mop with a reusable head. Immediately after observing HK-G clean R20's room, Surveyor interviewed HK-G who stated bathrooms are shared between two rooms and HK-G had already cleaned the room's shared bathroom which was the last room on the D wing. HK-G stated R20 did not want the floor mopped. HK-G swept the room after cleaning and disinfecting other areas. R20 was not on TBP at the time of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation. When Surveyor asked if HK-G had a specific cleaning order for resident rooms, HK-G stated no; however, HK-G tried to clean rooms that residents were not in first. HK-G stated R20's was the last room to clean in that hall of the four halls on the D wing. When Surveyor asked about the solution in the mop bucket, HK-G indicated there was a virus going around the D wing and stated the bucket contained one capful of bleach and cold water. HK-G was not aware of a policy or directions to refer to regarding which disinfectant products to use or how to mix the bleach and water. HK-G used a pre-mixed Virex solution for a smaller bucket that was on top of the housekeeping cart. HK-G filled the bucket and put multiple cloths in the bucket to use for surfaces. HK-G stated HK-G only changed the bleach water if the water became cloudy. HK-G stated there was only one housekeeper and one cart on the D wing so HK-G may change the water once; however, there were usually two housekeepers and two carts on the D wing and the water usually lasted through all of the rooms. On 12/10/25 at 12:37 PM, Surveyor interviewed Housekeeping Supervisor (HS)-H on the D wing. Surveyor informed HS-H of the observation with HK-G and asked for the facility's policy and procedure for the disinfectant used for mopping residents' rooms during a gastrointestinal outbreak. HS-H stated if bleach is used, staff should use one cup of bleach per one bucket of water. HS-H was unsure why HK-G used bleach when the facility has Virex which is effective against all viruses. HS-H indicated HK-G should not have used one capful of bleach per one bucket and stated mop heads should be changed every three to four rooms. When Surveyor requested the facility's policy for disinfecting, HS-H was not aware of a policy or procedure and stated Surveyor should ask Nursing Home Administrator (NHA)-A. On 12/10/25 at 12:58 PM, NHA-A provided Surveyor with the facility's Routine Cleaning and Disinfection policy. The policy did not contain specifics for outbreaks or products that staff should use to clean and disinfect.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 1 resident (R) (R8) of 1 sampled resident with a Guardian was protectively placed at the facility. R8 had a legal Guardian at the time of admission on [DATE]. R8's medical record included an order for Guardianship of person and estate dated 9/21/22. R8's medial record did not contain an order for protective placement.Findings include:State Statute Chapter 55.03(4) indicates: The law requires a court-ordered protective placement for any resident admitted to a nursing home who has a legal Guardian and whose nursing home stay exceeds sixty days, only to be extended with court approval (State Statute Chapter 55.05(b)). Protective placement is reviewed annually (State Statute Chapter 55.18) to determine if placement continues to be least restrictive and in the best interest of the individual.On 12/8/25, Surveyor reviewed R8's medical record. R8 had diagnoses including schizophrenia, seizure disorder, and anxiety disorder. R8's Minimum Data Set (MDS) assessment, dated 12/2/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R8 had severely impaired cognition. R8 had a court-ordered Guardian for health and financial decisions. R8's medical record did not contain a protective placement order. On 12/9/25 at 2:25 PM, Surveyor interviewed R8's Guardian ((GD)-E) who confirmed R8 had been under court-ordered Guardianship since 2022. GD-E confirmed R8 did not have a protective placement order and was not aware that a protective placement order was required for R8 to reside in the facility. GD-E stated R8's managed care organization (MCO) case worker informed GD-E that R8 did not require a protective placement order. GD-E also stated the facility had not informed GD-E that a protective placement order was needed. On 12/9/25 at 12:18 PM and 1:25 PM, Surveyor interviewed Social Worker (SW)-C who could not locate a protective placement order for R8. SW-C indicated SW-C started at the facility in June of 2025 and did not complete an audit for missing resident documentation. SW-C stated SW-C did not receive training on protective placement and did not know protective placement requirements. SW-C confirmed R8 was not protectively placed at the facility and stated SW-C would work with GD-E and the county to obtain protective placement for R8.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on staff interview and record review, the facility did not ensure 2 residents (R) (R2 and R22) of 2 sampled residents were provided a Skilled Nursing Facility Advanced Beneficiary Notice (ABN) form which is used to inform residents of the potential liability for payment (daily cost of care and services at the facility).The facility did not provide an ABN form to R2 when R2's Medicare Part A benefits ended on 10/10/25 and R2 remained in the facility. The facility did not provide an ABN form to R22 and when R22's Medicare Part A benefits ended on 11/25/25 and R22 remained in the facility. Findings include:The Centers for Medicare & Medicaid Services (CMS)-10055 Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (ABN) form indicates: The ABN provides information to the beneficiary so the beneficiary can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility .The ABN is only issued if the beneficiary intends to continue services and the skilled nursing facility believes the services may not be covered under Medicare.The facility's Advance Beneficiary Notices policy, dated March 2025, indicates: If services are being terminated and the beneficiary wants to continue receiving care that is no longer considered medically reasonable and necessary, the facility shall issue an ABN prior to furnishing non-covered care.1. From 12/8/25 to 12/10/25, Surveyor reviewed R2's medical record. R2's Medicare Part A services ended with a last covered day of 10/10/25. The facility issued a Notice of Medicare Non-coverage (NOMNC) form to R2 with a signature date of 10/8/25. R2 remained in the facility. The facility did not provide R2 or R2's representative with an ABN form or provide evidence that R2 or R2's representative were aware of the facility's private pay cost. 2. From 12/8/25 to 12/10/25, Surveyor reviewed R22's medical record. R22's Medicare Part A services ended with a last covered day of 11/25/25. The facility issued a NOMNC form to R22 with a signature date of 11/20/25. R22 remained in the facility. The facility did not provide R22 or R22's representative with an ABN form or provide evidence that R22 or R22's representative were aware of the facility's private pay cost.On 12/10/25 at 8:23 AM, Surveyor interviewed Social Worker (SW)-C who verified SW-C did not provide ABN forms to R2 and R22 and indicated SW-C was not familiar with the form. SW-C indicated SW-C verbally informed R2 and R22 of the per day cost to remain in the facility.On 12/10/25 at approximately 5:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility did not have a signed ABN form for R2 or R22; however, SW-C was provided education to ensure ABN forms are provided to residents who choose to remain in the facility after discharge from Medicare Part A services.

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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. Based on observation, staff interview, and record review, the facility did not ensure 1 resident (R) (R2) of 3 sampled residents was free from abuse.The facility was aware of verbal abuse directed at R2 by R2's activated Power of Attorney for Healthcare (POAHC) on 10/16/25. An investigation was not completed and the facility did not implement measures to protect R2 from future abuse. A second occurrence of verbal abuse directed at R2 by POAHC-M occurred on 12/8/25. Findings include: The facility's Abuse, Neglect and Exploitation Prevention and Reporting Policies and Procedures, revised June 2025, indicates: .You as an individual employee have a moral and legal responsibility to make sure each resident is free from abuse. The Administration of this facility takes very serious this duty. Abuse, in general, is any act that inflicts physical, emotional, or mental harm upon a resident .abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish From 12/8/25 to 12/10/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility in May of 2021 and had diagnoses including Alzheimer's disease, dementia, diabetes mellitus type 2, and depression. R2's most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated Power of Attorney for Healthcare ((POAHC)-M). On 12/8/25 at approximately 3:11 PM, Surveyor was in the C wing nurses' station and heard someone yelling down the hall. The individual said, .I'm going to leave. I'm going to walk out . in a loud and aggressive tone. Surveyor also heard, .Get .from there or I'm going to beat your head in! When Surveyor asked Registered Nurse (RN)-I (who was also in the nurses' station) if RN-I heard the yelling, RN-I stated RN-I was not sure. Surveyor informed RN-I of the statements Surveyor heard coming from down the hall. RN-I stated POAHC-M was visiting R2. RN-I walked to R2's room and then returned to the nurses' station and made a phone call. RN-I informed the person on the other end that POAHC-M was loud and aggressive and asked if it was something RN-I needed to worry about. On 12/8/25 at 3:40 PM, Surveyor interviewed Director of Nursing (DON)-B and asked if RN-I had informed DON-B of what Surveyor reported. DON-B stated yes and indicated the facility completed an investigation a couple weeks prior because POAHC-M was loud according to staff. DON-B stated Social Worker (SW)-C was notified of what occurred earlier and went to R2's room. On 12/9/25 at 12:28 PM, Surveyor interviewed SW-C who stated SW-C spoke with R2 and POAHC-M on 12/8/25 but did not document the conversation. SW-C stated SW-C received an e-mail from RN-I on 12/8/25 that stated POAHC-M was hollering in R2's room. At approximately the same time, Assistant Director of Nursing (ADON)-L called SW-C regarding the yelling. SW-C went to R2's room and asked if POAHC-M needed help. POAHC-M stated POAHC-M was scolding R2 because the Certified Nursing Assistants (CNAs) stated R2 was being uncooperative. SW-C stated R2 let out a nervous chuckle during the conversation like R2 may be used to (POAHC-M) yelling at (R2) and POAHC-M looked down in a shameful manner. SW-C stated POAHC-M acknowledged that POAHC-M should talk nicer to R2. SW-C confirmed SW-C heard POAHC-M speak loudly to R2 in the past which is how POAHC-M communicates. When Surveyor asked what RN-I and ADON-L told SW-C on 12/8/25, SW-C printed an e-mail from RN-I that stated, .I don't know if you are aware of the situation with (R2) and (POAHC-M), regarding how (POAHC-M) speaks loudly and aggressively with (R2). (POAHC-M) is here right now and we could hear (POAHC-M) down the hall. I went in there and asked if all was well and (POAHC-M) said it is. Not sure if this is how they are or what. Could you just come speak with (POAHC-M), if possible. (POAHC-M) is here right now. Thanks Surveyor informed SW-C of what Surveyor heard POAHC-M yell on 12/8/25. SW-C was not aware of what POACH-M yelled and just knew there was yelling. SW-C stated the words made the hair on the back of SW-C's neck stand up and it should have been looked into. On 12/9/25 at 12:50 PM, Surveyor interviewed DON-B who was aware that POAHC-M was loud. DON-B stated DON-B was in ADON-L's office when RN-I called (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON-L on 12/8/25. DON-B stated ADON-L then called SW-C who went to R2's room. DON-B confirmed the facility had not began an investigation yet. When Surveyor asked if RN-I told DON-B exactly what Surveyor heard and reported, DON-B was not aware. Surveyor informed DON-B of what Surveyor heard coming from R2's room and requested the facility's investigation for the previous incident between R2 and POAHC-M that DON-B mentioned on 12/8/25. On 12/9/25 at 1:02 PM, DON-B provided Surveyor with two witness statements from an incident between R2 and POAHC-M on 10/16/25. DON-B stated Nursing Home Administrator (NHA)-A had the statements and informed Surveyor that NHA-A requested a witness statement from Surveyor regarding the incident on 12/8/25. DON-B indicated the incident on 10/16/25 occurred when POAHC-M was upset with staff for not making R2 use a repositioning wedge. Surveyor reviewed the witness statements from staff who heard R2 cough and heard POAHC-M say, I hope you choke. One of the statements indicated POAHC-M became angry with R2 when R2 refused to reposition with a pillow under R2's side because it made R2 hurt worse. POAHC-M yelled and swore loudly at R2 and said R2 was going to die. On 12/9/25 at 4:40 pm, Surveyor interviewed DON-B regarding the 10/16/25 incident between R2 and POAHC-M. DON-B stated DON-B did not know exactly what happened and indicated it was a long time ago. DON-B stated when someone has to report an incident they report to DON-B or someone else; however, NHA-A decides what is investigated. On 12/9/25 at 1:28 PM, Surveyor interviewed NHA-A about the 10/16/25 incident between R2 and POAHC-M. NHA-A was informed of the incident during morning report. NHA-A stated POAHC-M was upset that staff did not make R2 use a repositioning wedge but was not necessarily abusive to R2. NHA-A stated NHA-A was not aware of the choking comment until DON-B provided the two employee statements on approximately 10/18/25. NHA-A stated the two statement were the extent of the facility's investigation. The facility did not take further steps to ensure POAHC-M did not abuse R2 again.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an allegation of verbal abuse was reported to the State Agency (SA) for 1 resident (R) (R2) of 3 sampled residents. On 10/16/25, the facility was informed of an allegation of verbal abuse toward R2 by R2's activated Power of Attorney for Healthcare (POAHC). The allegation of abuse was not reported to the SA. Findings include: The facility's Abuse, Neglect and Exploitation Prevention and Reporting Policies and Procedures, revised June 2025, indicates: .Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Reporting Abuse: It is the responsibility of our employees, attending physicians, family members, visitors, volunteers, contractors, etc., to immediately report any incident or suspected incident of neglect or physical or verbal resident abuse .to the Administrator or his/her designee Immediately means upon witnessing an incident or as soon as knowledge of an incident or suspected incident is obtained .1. [NAME] Home will not condone resident abuse by anyone, including staff, physicians, consultants, volunteers, or staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. 2. All staff, residents, family members, visitors, etc., must report incidents of resident abuse or suspected incidents of abuse .3. Employees .must report any suspected abuse or incidents of abuse to the Administrator .Director of Nursing . and/or a member of the Social Work staff immediately. Abuse or suspected abuse may be reported in writing using the Resident Rights-Potential Violation Report Form. This form can be used even when the initial report is made verbally. These forms are available at each nursing station, the Social Work office, and from the Administrator. When an incident of abuse or suspected abuse is received by someone other than the Administrator, the Administrator shall be notified immediately regardless of the day of the week or time of day. Immediately means upon witnessing an incident or as soon as knowledge of an incident or suspected incident is obtained .The Administrator or his/her designee will also report any allegations of abuse immediately or at least within twenty-four hours of receiving notification to the Division of Quality Assurance (DQA). The initial report will be submitted to DQA via on-line reporting .From 12/8/25 to 12/10/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility in May of 2021 and had diagnoses including Alzheimer's disease, dementia, diabetes mellitus type 2, and depression. R2's most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated Power of Attorney for Healthcare ((POAHC)-M). On 12/8/25 at 3:40 PM, Surveyor interviewed Director of Nursing (DON)-B regarding an incident between R2 and POAHC-M that occurred on 12/8/25. DON-B was aware of the incident and indicated the facility did an investigation a couple weeks ago because POAHC-M was loud (on 10/16/25) according to staff.On 12/9/25 at 1:02 PM, DON-B provided Surveyor with two witness statements related to the 10/16/25 incident between R2 and POAHC-M. DON-B stated Nursing Home Administrator (NHA)-A had the statements and that was all that was provided to DON-B. An undated statement from Certified Nursing Assistant (CNA)-N indicated CNA-N worked on R2's unit with two other staff on 10/16/25. Staff had to reposition R2 in order to set up a new air mattress. POAHC-M was in the room and agreed to how staff positioned R2; however, POAHC-M became angry and wanted a pillow under R2's side to relieve pressure from R2's buttocks. Staff tried multiple times to place the pillow under R2, however, R2 refused and stated the pillow made R2 hurt worse. Staff informed POAHC-M they could not force R2 to use the pillow. POAHC-M yelled and swore loudly at R2 and said R2 was going to die. Staff at the nurses' station on the opposite end of the hall could hear POAHC-M. When R2 coughed after staff brought R2's dinner tray, staff heard POAHC-M laugh and say, I hope you choke. The statement indicated the nurse on the unit did not address the situation so staff went to another unit to ask a (continued on next page)

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	12/10/2025

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse to talk to POAHC-M. A statement by Staff (STF)-O, dated 10/18/25, indicated STF-O walked past R2's room on 10/16/25 and heard R2 cough. STF-O then heard POAHC-M say, Good. I hope you choke. On 12/9/25 at 1:28 PM, Surveyor interviewed NHA-A regarding the 10/16/25 incident between R2 and POAHC-M. NHA-A was informed of the incident during morning report after it occurred. NHA-A stated POAHC-M was upset that staff did not make R2 use a repositioning wedge but was not necessarily abusive to R2. NHA-A was not aware of the choking comment until DON-B provided NHA-A with two employee statements on approximately 10/18/25. NHA-A verified the allegation of abuse was not reported to the SA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 1 resident (R) (R2) of 3 sampled residents. On 10/16/25, the facility became aware of an allegation of verbal abuse toward R2 by R2's activated Power of Attorney for Healthcare (POAHC). The allegation of abuse was not thoroughly investigated. Findings include: The facility's Abuse, Neglect and Exploitation Prevention and Reporting Policies and Procedures, revised June 2025, indicates: .All reports of resident abuse, neglect, and injuries of unknown source shall be immediately and thoroughly investigated .1. Should an incident or suspected incident of abuse, neglect, or injury of an unknown source be reported, the Administrator and/or his/her designee will investigate the alleged incident. 2. The individual(s) conducting the investigation will, at a minimum, and when necessary: a. Review the resident's medical record to determine events leading up to the incident; b. Interview the person(s) reporting the incident; c. Interview any witnesses to the incident; d. Interview the resident (as medically appropriate); e. Physically examine the resident for potential injuries; f. Interview the resident's physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview employees (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members .; and j. Review all events leading up to the alleged incident .4. Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports. 5. While the investigation is being conducted, accused individuals not employed by [NAME] Home will be denied unsupervised access to residents. Visits may only be made in designated areas approved by the Administrator .7. The individual in charge of the investigation will consult daily with the Administrator concerning the progress of the investigation .9. The results of the investigation will be reduced to written form. 10. The investigator will give a copy of the investigation report to the Administrator within four working days of the reported incident .12. The Administrator or his/her designee will provide a written report of all abuse allegations and appropriate action taken to the State Agency and any other state, federal, or local agency as may be required by regulation within five working days of the reported allegation . From 12/8/25 to 12/10/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility in May of 2021 and had diagnoses including Alzheimer's disease, dementia, diabetes mellitus type 2, and depression. R2's most recent Quarterly Minimum Data Set (MDS) assessment, dated 11/25/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated Power of Attorney for Healthcare ((POAHC)-M). On 12/8/25 at 3:40 PM, Surveyor interviewed Director of Nursing (DON)-B regarding an incident between R2 and POAHC-M that occurred on 12/8/25. DON-B was aware of the incident and indicated the facility did an investigation a couple weeks ago because POAHC-M was loud on 10/16/25. On 12/9/25 at 1:02 PM, DON-B provided Surveyor with two witness statements for the 10/16/25 incident between R2 and POAHC-M. DON-B stated NHA-A had the statements and that is all that was provided to DON-B. An undated statement from Certified Nursing Assistant (CNA)-N indicated CNA-N worked on R2's unit with two other staff on 10/16/25. Staff had to reposition R2 in order to set up a new air mattress. POAHC-M was in the room and agreed to how staff positioned R2; however, POAHC-M became angry and wanted a pillow under R2's side to relieve pressure from R2's buttocks. Staff tried multiple times to place the pillow under R2, however, R2 refused and stated the pillow made R2 hurt worse. Staff informed POAHC-M they could not force R2 to use the pillow. POAHC-M yelled and swore loudly at R2 and said R2 was going to die. Staff at the nurses' station on the opposite end of the hall could hear POAHC-M. When R2 coughed after staff brought R2's dinner tray, staff heard POAHC-M laugh and say, I hope you choke. The statement indicated the nurse on the unit did not address the situation so staff went to another unit to ask a nurse to talk to POAHC-M. A statement by Staff (STF)-O, dated 10/18/25, indicated STF-O walked past R2's room on 10/16/25 and heard R2 cough. STF-O then (continued on next page)

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	525476	A. Building B. Wing	12/10/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heard POAHC-M say, Good. I hope you choke. On 12/9/25 at 4:40 PM, Surveyor interviewed DON-B regarding the 10/16/25 incident between R2 and POAHC-M and the facility's process for investigating an incident. DON-B could not recall exactly what happened and indicated the incident occurred a while ago. DON-B stated when staff have to report an incident they report to DON-B or someone else; however, NHA-A decides what is investigated. On 12/9/25 at 1:28 PM, Surveyor interviewed NHA-A regarding the 10/16/25 incident between R2 and POAHC-M. NHA-A was informed during morning report after the incident occurred. NHA-A stated POAHC-M was upset that staff weren't making R2 use a repositioning wedge but was not necessarily abusive to R2. NHA-A was not aware of the choking comment until DON-B provided the two employee statements to NHA-A on approximately 10/18/25. NHA-A verified the statements were the extent of the facility's investigation.

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	525476	A. Building B. Wing	12/10/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide Preadmission Screening and Resident Review (PASRR) services for 1 resident (R) (R8) of 24 sampled residents. The facility did not contact the state mental health authority to pursue PASRR Level I or II screening for R8 who had a mental illness diagnosis.Findings include:The facility's Resident Assessment-Coordination with PASRR Program policy, revised June 2023, indicates: The facility coordinates assessments with the Preadmission Screening and Resident Review (PASRR) program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort. All individuals with a mental disorder or intellectual disability who apply for admission to the facility will be screened in accordance with the state's Medicaid rules for screening. The facility will only admit individuals with a mental disorder or intellectual disability who the state mental health or intellectual disability authority has determined as appropriate for admission .Recommendations, such as any specialized services, from a PASRR Level II determination and/or PASRR evaluation report will be incorporated into the resident's assessment, care planning, and transition of care .On 12/8/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including schizophrenia, seizure disorder, and anxiety disorder. R8's Minimum Data Set (MDS) assessment, dated 12/2/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 10 which indicated R8 had severe cognitive impairment. R8 had a court-ordered Guardian for healthcare and financial decisions. R8's medical record did not contain PASRR Level I or Level II Screen.On 12/9/25 at 12:18 PM and 1:25 PM, Surveyor interviewed Social Worker (SW)-C who verified R8's medical record did not contain a PASRR Level I or Level II Screen and confirmed PASRR Level I and Level II Screens were not completed for R8. SW-C indicated SW-C started at the facility in June of 2025 and did not receive training on PASRR requirements.

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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 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 staff interview and record review, the facility did not provide care and treatment in accordance with professional standards of practice for 1 resident (R) (R1) of 22 sampled residents. The facility did not accurately document and treat R1's injured right ankle after R1 was lowered to the ground on 11/16/25. Findings include: The facility's Falls: Prevention/Management/Documentation policy, dated January 2009, indicates: .Successful management of falls includes a variety of facility-wide and individual approaches in order to reduce the risk for falls and fall-related injuries to the residents of this facility .A fall occurs whenever unplanned movement from a higher level to a lower level occurs. This includes lowering a resident to the floor to prevent injury from an uncontrolled downward movement .5. All falls will be recorded on the 24-hour report board and follow-up assessment will continue for three shifts. Follow-up will include: vital signs, check for injury, and changes in range of motion or evidence of pain . From 12/8/25 to 12/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility in September of 2025 and had diagnoses including Alzheimer's disease unspecified, dementia without behavioral disturbance, pneumonia, sepsis, long term use of anticoagulants, and weakness. R1's most recent Minimum Data Set (MDS) assessment, dated 9/30/25, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R1 had severely impaired cognition. R1's medical record contained the following documentation regarding a fall with major injury that occurred on 11/16/25: ~ Between 4:10 AM and 4:35 AM on 11/16/25, a Certified Nursing Assistant (CNA) lowered R1 to the ground while taking R1 to the bathroom. No injuries were noted at the time of the fall. ~ An entry on 11/16/25 at 5:44 AM indicated there was no apparent injury noted and the physician was notified via the facility's electronic health record system which was also used for communication. ~ An entry on 11/16/25 at 6:36 PM indicated a message from Licensed Practical Nurse (LPN)-J to R1's provider indicated R1 was lowered to the floor and was unable to put pressure on R1's left foot/ankle. R1 reported pain, refused to walk, and had a hard time transferring to and from R1's chair. There was no bruising or swelling at that time. ~ An entry on 11/17/25 at 11:09 AM indicated the facility received a message from R1's provider to obtain an X-ray of the left foot and left tibia/fibula (lower leg bones). The provider also stated to continue Tylenol and update the provider if the X-ray was negative but pain persisted over the next week. (R1's medical record did not indicate when the X-ray of the left foot/ankle was obtained; however, the results were available on 11/19/25 at 4:30 PM.) ~ An entry on 11/19/25 at 4:30 PM indicated the facility received a message from R1's provider that there were no acute concerns. R1 had osteopenia (lower than normal bone density) which would be addressed. R1 appeared to have dementia and had an activated Power of Attorney (POA). An X-ray of the left foot was obtained with 3 + views. ~ An entry on 11/20/25 at 12:16 PM indicated Registered Nurse (RN)-I sent a message to R1's provider that indicated R1 fell on [DATE] which resulted in an ankle injury. The message indicated the provider was mistakenly told that R1's left ankle was injured; however, R1 needed an X-ray of the right ankle which was bruised, swollen, and painful. RN-I requested an order for an X-ray of R1's right foot and right tibia/fibula. ~ An entry on 11/20/25 at 12:20 PM indicated a message was sent from an LPN at the provider's office clarifying the X-ray order which originally stated foot and ankle; however, the new request only stated ankle. ~ An entry on 11/20/25 at 2:22 PM indicated a message was sent from R1's provider to the LPN that indicated the order was for a tibia/fibula and ankle or (sic) right. ~ An entry on 11/21/25 at 3:17 PM indicated an RN from the provider's office messaged the facility regarding R1's right tibia/fibula X-ray results which showed an acute distal fibular fracture. The provider sent the following orders: STAT (immediate) referral to an orthopedist; non-weight bearing to right lower extremity until evaluated with orthopedics; and update provider on R1's pain. ~ An entry on 11/21/25 at 3:18 PM indicated an RN from the provider's office messaged the facility that an ortho referral was sent to (named hospital) and asked the facility to respond to the provider's question. (The facility did (continued on next page)

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	525476	A. Building B. Wing	12/10/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not respond until 11/25/25 at 6:24 AM). ~ An entry on 11/24/25 at 6:24 AM indicated LPN-J messaged the provider and indicated R1 was in significant pain when R1 tried to use the foot. The message indicated staff used a lift for R1 and were keeping R1 non-weight bearing which helped. R1 only complained of pain with use of the foot and received scheduled Tylenol. ~ An entry on 11/24/25 at 10:21 AM indicated the provider messaged the facility and asked that R1 see an orthopedic surgeon as soon as possible. The message contained an order for tramadol 25 milligrams (mg) three times daily (TID) as needed for additional pain relief. (The facility indicated an orthopedic surgery consult was scheduled for 11/24/25 at 2:15 PM.) On 12/10/25 at 3:55 PM, Surveyor interviewed Director of Nursing (DON)-B who stated R1 received scheduled acetaminophen twice daily and R1's medical record did not indicate R1 had pain. R1 was prescribed tramadol after an orthopedic appointment but did not receive any doses of tramadol or any PRN acetaminophen. DON-B verified the original message to the provider mentioned the wrong foot which prolonged R1's treatment and healing.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R41) of 22 sampled residents.The facility did not ensure R41's Average Volume Assured Pressure Support (AVAPS) machine was in working condition and did not follow orders to apply R41's AVAPS machine while sleeping.Findings include:The [NAME] Medical (which makes R41's AVAPS model - [NAME] LM150TD) User Guide indicates: .2.1.1 c. Always keep an alternative means of ventilation available in order to avoid life threatening situations if the device fails .According to Zimnoch et al. in the Journal of Clinical Medicine an article on Non-Invasive Ventilation (NIV), published [DATE]: Non-invasive ventilation modalities such as continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP), and AVAPS are a cornerstone in the management of acute and chronic respiratory failure. Inappropriate discontinuation or lack of NIV support when indicated has been shown to increase the risk of escalation to invasive ventilation, longer hospital stays, and increased morbidity due to failure of adequate respiratory support.On [DATE], Surveyor reviewed R41's medical record. R41 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, moderate persistent asthma, acute on chronic diastolic (congestive) heart failure, morbid (severe) obesity with alveolar hypoventilation, dependence on supplemental oxygen, and obstructive sleep apnea. R41's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R41 had intact cognition.R41 had a physician order (dated [DATE]) for AVAPS to be worn daily when napping and sleeping.On [DATE] at 10:14 AM, Surveyor interviewed R41 who indicated R41 was upset that R41's AVAPS machine was not applied the night before. R41 indicated staff put water in the wrong place, didn't know what they were doing, and didn't know how to use the machine. R41 indicated the machine no longer worked due to staffs' error. R41 stated R41 was not supposed to sleep without the machine because R41 had high carbon dioxide (hypercapnia). R41 indicated R41 asked staff to have the machine looked at so R41 didn't have to go without it again. R41 stated R41 almost died in the past due to high carbon dioxide and reiterated that R41 must wear the AVAPS machine while sleeping.On [DATE], Surveyor reviewed R41's plan of care and nursing care card (which was posted in R41's room as a quick reference) and noted neither indicated that R41 used an NIV device. R41's care plan also did not mention respiratory care including oxygen or AVAPS machine use.On [DATE] at 10:44 AM, Surveyor observed R41 asleep in R41's room without the AVAPS machine. Surveyor did not enter the room as R41 had become ill and was on contact precautions.On [DATE] at 9:32 AM, Surveyor observed R41 awake in bed. Surveyor donned personal protective equipment (PPE) and entered the room to interview R41 who indicated R41 was still upset. R41 stated R41 had not worn the AVAPS machine for the past couple nights because staff had called the company to fix it. R41 again indicated R41 was told R41 must wear the AVAPS machine when sleeping because R41's doctor stated R41 had high carbon dioxide and it was dangerous not to wear it. R41 stated R41 told staff the machine needed to be fixed and R41 needed the machine to sleep. R41 indicated R41 had worn the machine to sleep before the machine broke on the evening of [DATE].On [DATE] at 9:51 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F who indicated R41 had a CPAP machine. CNA-F indicated the machine did not work and CNA-F needed to call the company to have it fixed but had not had time. CNA-F was aware R41 did not use the machine that day and the night prior, but thought it was because R41 was ill and didn't want to vomit into the mask. CNA-F indicated CNA-F was told in morning report on [DATE] that the AVAPS machine wasn't working. CNA-F didn't know the machine wasn't working on [DATE] or [DATE] and did not work those days.On [DATE], Surveyor reviewed R41's [DATE] Treatment Administration Record (TAR) which contained a physician order for R41 to use the AVAPS machine while napping or sleeping. The (continued on next page)

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	525476	A. Building B. Wing	12/10/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TAR indicated R41 used the AVAPS machine while napping/sleeping for all shifts in December to date, including the days the machine was not working (starting on the evening of [DATE]).On [DATE] at 2:45 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should have called the company for repair of the device as soon as they knew it wasn't working. DON-B indicated initials on the TAR for the AVAPS application indicated the order was completed/followed that shift. DON-B indicated staff should not indicate on the TAR that the AVAPS machine was used it it was broken. DON-B indicated AVAPS use should have been on R41's care plan and nursing care card. DON-B stated it was not on R41's care plan because R41 was a newer admission and DON-B had been on vacation the week prior. Surveyor requested the facility's CPAP/AVAPS policy.On [DATE] at 2:54 PM, Surveyor interviewed DON-B who indicated R41 wanted the facility to call R41's daughter so R41's daughter could call the company and get the AVAPS machine repaired. DON-B again indicated the facility should have contacted R41's daughter and/or the company for repair at least by the morning of [DATE].On [DATE], DON-B provided Surveyor with the facility's CPAP policy, dated [DATE]. The policy referred to cleaning CPAP devices but did not address CPAP/AVAPS orders or use. DON-B later confirmed via email that the facility did not have any other policies related to CPAP/AVAPS use.

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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 observation, staff and resident interview, and record review, the facility did not ensure the accurate and safe administration of medication for 2 residents (R) (R25 and R41) of 22 sampled residents.Medications were observed on a table in R25's room. R25 did not have a self-administration of medication assessment that indicated R25 could safely and accurately self-administer medication. In addition, R25 did not have physician orders for the medications.Medications were observed on R41's counter. R41 did not have a self-administration of medication assessment that indicated R41 could safely and accurately self-administer all of the medications. In addition, R41 did not have a physician order for 1 of the medications.Findings include: The facility's Self-Administration of Medication policy, dated 8/2008, indicates: .1. If the resident chooses to self-administer drugs, the Interdisciplinary Team (IDT) must assess the resident's cognitive, physical, and visual abilities to carry out this responsibility. 2. The IDT will determine the resident's ability to participate in self-administration of their medication and inform the resident of their decision which will be evaluated on an ongoing basis. 3. A physician's order will be obtained and recorded in the chart. The order also needs to include which specific medications can be kept at the bedside. 4. Transcribe the physician's order on the Medication Administration Record (MAR). 5. Provide equipment to facilitate self-administration. (Lock box, large print MAR, etc.) 6. Nurse to check with resident daily for appropriate medication administration. 7. Licensed nurse to monitor for medication side effects and provide ongoing education. 8. Licensed nurse to complete self-administration of medication assessment monthly as condition warrants for ongoing evaluation and technique. 9. IDT to review for appropriateness at a minimum quarterly as well as with cognitive and mobility changes and with significant change in status. 10. Place on resident care plan, review and revise as needed.1. On 12/8/25, Surveyor reviewed R25's medical record. R25 was admitted to the facility on [DATE] and had diagnoses including acquired absence of other specified parts of digestive tract (colectomy), nausea with vomiting, abdominal pain, and slow transit constipation. R25's Minimum Data Set (MDS) assessment, dated 10/27/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R25 had intact cognition.On 12/8/25 at 10:37 AM, Surveyor interviewed R25 and observed medication in R25's room. Surveyor noted a bottle of Refresh Tears eye drops and a bottle of vitamin C pills on a stand near the door. The medications were visible from the right side of the hallway and R25's door was partially open. Neither of the medications contained a pharmacy label. R25 indicated the medications belonged to R25.Surveyor reviewed R25's MAR which did not contain orders for the medications. In addition, R25's plan of care did not indicate R25 could self-administer medication or have medication at the bedside. R25's medical record contained a self-administration of medication assessment, dated 10/20/23, that indicated R25 was forgetful and not able to self-administer medication. On 12/9/25 at 10:24 AM, Surveyor noted R25's door was open. R25 had a guest in the room and was in bed. Surveyor again observed Refresh Tears eyedrops and vitamin C pills on the stand near the door and within eye sight from the hallway.On 12/10/25 at 9:40 AM, Surveyor observed Refresh Tears eyedrops and vitamin C pills on a stand near the door of R25's room and in eye sight from the hallway. Surveyor interviewed R25 who stated the eyedrops and vitamin C pills had been there a long time and were from home. R25 indicated R25's spouse visited every other day and often gave R25 the medication.2. On 12/8/25, Surveyor reviewed R41's medical record. R41 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, moderate persistent asthma, acute on chronic diastolic (congestive) heart failure, morbid (severe) obesity with alveolar hypoventilation, dependence on supplemental oxygen, and obstructive sleep apnea. R41's MDS assessment, dated 11/27/25, had a BIMS score of 14 out of 15 which indicated (continued on next page)

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	12/10/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41 had intact cognition.On 12/8/25 at 10:14 AM, Surveyor observed R41's room and noted Biofreeze gel and Cepacol throat spray on R41's counter. Neither medication contained a pharmacy label. Surveyor also observed containers of nystatin powder and nystatin cream with pharmacy labels. Surveyor observed a bottle of One A Day vitamins on a bedside tray. Surveyor interviewed R41 who indicated staff gave R41 the medications. R41 indicated R41 required a lift for transfers and needed staff assistance to get around the room.Surveyor reviewed R41's plan of care and nursing care card. The nursing care card was posted in R41's room as a quick reference for care but did not indicate that R41 could have bedside medications. R41's plan of care indicated R41's medications should be administered as ordered and staff should monitor R41 for efficacy and adverse effects. R41's plan of care did not indicate that R41 was approved to self-administer medication or keep medication at the bedside.Surveyor reviewed R41's MAR which contained the following orders: ~ Nystatin cream 100000 units/gram (gm); twice daily as needed. The order did not indicate the medication could be kept at the bedside or self-administered.~ Nystatin powder 100000 units/gm; daily as needed. The order did not indicate the medication could be kept at the bedside or self-administered.~ Menthol gel (Biofreeze); Apply twice daily to elbows and legs for pain. May keep at bedside if desired. The order did not indicate the medication could be self-administered.R41's MAR did not contain an order for Cepacol throat spray.A self-administration of medication assessment, dated 11/21/25, indicated R41 could self-administer medication.On 12/9/25 at 9:24 AM, Surveyor observed R41 asleep in R41's room. Surveyor did not enter the room because R41 had become ill and was on contact precautions.On 12/10/25 at 9:32 AM, Surveyor observed R41 awake in bed. Surveyor donned personal protective equipment (PPE) and entered the room to interview R41. Surveyor observed nystatin cream, nystatin powder, and Cepacol throat spray on the counter. R41 indicated staff applied the nystatin medications to R41 and left the medications on the counter.On 12/10/25 at 10:24 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents should not have medication in the room unless they have a physician's order for beside medication and a self-administration of medication assessment. DON-B indicated each medication should be approved for self-administration and bedside storage. DON-B stated residents who wish to keep medication at the bedside or self-administer medication should be assessed monthly. DON-B confirmed all resident medications must have a physician's order in order to be administered by staff or self-administered by the resident. DON-B stated care plans should also address bedside medication and self-administration of medication. DON-B was not sure why R25 and R41 had medications in their rooms that did not have orders. DON-B stated R25's spouse visited daily and often completed R25's cares. DON-B indicated staff should still check on R25 even though family helps daily. DON-B confirmed R25 and R41 were not able to self-administer medication.On 12/10/25 at 10:45 AM, DON-B approached Surveyor and indicated R41 had an approved self-administration of medication assessment; however, it was not for the medications that were in R41's room. DON-B indicated the medications were removed from R25 and R41's rooms.