STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525588	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Manor	4545 N 92nd St Milwaukee, WI 53225

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 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** 38829 Based on record review and staff interviews, the facility did not ensure that an allegation of abuse involving 1 (R3) of 2 residents reviewed for allegations of abuse were reported immediately to the State Survey Agency. *On 4/17/24 an allegation of R3 being choked by a certified nursing assistant(CNA) was not reported to the state survey agency within 2 hours and local law enforcement was not notified of the allegation immediately. Findings Include: Surveyor reviewed the facility's Alleged Incidents of Abuse, Neglect, Exploitation and Mistreatment-Reporting and Investigation policy and procedure last revised 2/2020 and notes the following in regards to reporting: .Purpose .Facility is in compliance with the reporting and investigation guidelines specific to each program area governed by the State Survey and Compliance Agencies(Division of Quality Assurance(DQA)/Office of Caregiver Quality(OCQ)). .All alleged incidents of abuse, neglect, exploitation, and misappropriation must be reported and investigated in a timely manner per program code requirements. Special Key Points 2. An initial review of the allegation prior to reporting to DQA/OCQ may be conducted to determine whether or not the incident needs to be reported to DQA/OCQ. All alleged violations involving mistreatment(including abuse, neglect, exploitation, injuries of unknown source, misappropriation of property, resident-to-resident abuse, and mistreatment by family members, visitors, volunteers or other individuals) must be reported to the DQA/OCQ as soon as possible, but not to exceed 24 hours from the discovery. The initial report is not to exceed 2 hours from discovery if serious bodily injury has occurred. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. If the injury/incident was a result of a suspected crime, law enforcement must also be notified. 2. Assess the Effect on the Resident a. The Resident(s) must be interviewed and a body assessment completed as necessary. b. An assessment for psychosocial changes will be completed and document findings. c. Physician is made aware, as needed. Family is made aware if appropriate. Case management organizations notified as needed. d. Follow-up Resident interviews should be conducted. 1.) R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Dementia with Psychotic Disturbance, Generalized Anxiety Disorder, Essential Hypertension, Type 2 Diabetes, Pulmonary Fibrosis, and Type 2 Diabetes Mellitus. R3's Quarterly Minimum Data Set(MDS) dated [DATE] documents that a Brief Interview for Mental Status(BIMS) could not be assessed as well as the Patient Health Questionnaire(PHQ-9). R3's delusions and hallucinations are not documented. R3's MDS documents that R3 has physical and verbal symptoms which occurred 1-3 days, wandering 1-3 days, and rejection of care 4-6 days during the assessment period. R3 has no range of motion issues. R3 utilizes a walker and a wheelchair. The MDS also documents that R3 requires supervision for upper and lower dressing and chair/bed-to-chair transfer. R3 is independent with mobility. R4 reported an allegation that R4 overheard verbal and physical abuse between R3 and a CNA at about 3:00 AM on 4/17/24. R4 reported that R4 heard R3 choking and then R3 was overheard to be going up and down the hallway yelling she choked me. The facility submitted to the State Survey Agency an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report on 4/17/24 at 4:30:58 PM. Surveyor notes the report does not document what time the facility was made aware of the incident or what time the administrator was notified of the allegation. The report was not submitted with-in the 2 hour required reporting time-frame for allegations of serious bodily injury. The facility submitted the Misconduct Incident Report on 4/24/24 at 8:06:45 PM. The report does not document that the local law enforcement was notified of the allegation that R3 was choked by a CNA. Surveyor notes this report is 1 day past the 5 day required reporting time-frame. On 6/3/24 at 11:35 AM, Surveyor interviewed R4 regarding the allegation that R4 overheard verbal and physical abuse between R3 and a CNA at about 3:00 AM on 4/17/24. R4 also reported that R4 heard R3 choking and then R3 was overheard to be going up and down the hallway yelling she choked me. R4 stated that R4 put R4's call light on immediately to report it, however, R4 stated that R4's call light was not answered until about 5 to 7:00 AM, by the next shift. R4 stated R4 informed a CNA whom no longer is employed at the facility. R4 informed Surveyor that R4 heard a nurse tell R4 she says she didn't choke you, but R4 does not know who that nurse was. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 7:44 AM, Surveyor interviewed Social Worker (SW-C) regarding the submitted reports to the State Survey Agency. SW-C confirmed that SW-C prepared, completed, and submitted the Facility Reported Incident(FRI) involving R3 and the allegation that R3 was verbally and physically abused including an allegation of R3 being choked. SW-C does not recall why SW-C did not report within 2 hours, why the local law enforcement was not notified, and why the Misconduct Incident Report was not submitted within the 5 day reporting time-frame. SW-C stated SW-C would need to look into the details and get back to Surveyor. On 6/5/24 at 8:37 AM, SW-C informed Surveyor that SW-C did not notify the local law enforcement because R3 could not say what happened. SW-C was not able to provide information as to why SW-C did not report within 2 hours and why the FRI was not submitted within the required time-frame. On 6/5/24 at 8:45 AM, Surveyor shared with Nursing Home Adminstrator (NHA-A)of the allegation of verbal and physical abuse including an allegation of R3 being choked was not reported with-in 2 hours, was not submitted with-in the 5 days required reporting time frame, and that the local law enforcement was not notified. NHA-A acknowledged the concern and was not able to provide any additional information at this time.

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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** 38829 Based on record review and staff interview, the facility did not ensure all allegations involving potential abuse, neglect and misappropriation of Resident property were thoroughly investigated for 2 (R3 and R4) of 2 sampled residents. *R3's Facility Reported Incident(FRI) dated 4/17/24 documents an allegation of R3 being choked. The FRI does not contain other Resident statements, all staff statements, the reasoning for why the local law enforcement was not notified and a root cause analysis of the circumstances of the allegation. *R4's Facility Reported Incident(FRI) dated 4/1/24 documents an allegation of R3 being choked. The FRI does not contain other Resident statements, all staff statements, and a root cause analysis of the circumstances of the allegation. Surveyor reviewed the facility's Alleged Incidents of Abuse, Neglect, Exploitation and Mistreatment-Reporting and Investigation policy and procedure last revised 2/2020 and notes the following in regards to a thorough investigation: Thorough investigation and corrective action ensures that the safety of the Resident has not been jeopardized. Guidelines 2. Assess the Effect on the Resident a. The Resident(s) must be interviewed and a body assessment completed as necessary. b. An assessment for psychosocial changes will be completed and document findings. c. Physician is made aware, as needed. Family is made aware if appropriate. Case management organizations notified as needed. d. Follow-up Resident interviews should be conducted. 2. Investigate the Allegation a. Contact law enforcement or other regulatory authority if appropriate. b. Obtain written, signed statements from all witnesses or persons with information. c. Obtain a written, signed statement from the accused individual. 4. Conclude the Investigation a. Review all components of the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Inform accused caregiver that a report to another agency has been submitted. If the accused is a Resident, inform Resident and responsible party of the report to DQA has occurred. c. The conclusion must be written on the Investigation Summary form once employee interviews and a chart review have been completed. 5. Follow-up a. All the completed forms must be submitted to the Director of Nursing/designee. b. Contact the person who reported the incident. c. Reassure the Resident and family if the caregiver. R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Dementia with Psychotic Disturbance, Generalized Anxiety Disorder, Essential Hypertension, Type 2 Diabetes, Pulmonary Fibrosis, and Type 2 Diabetes Mellitus. R3's Quarterly Minimum Data Set(MDS) dated [DATE] documents that R3's Brief Interview for Mental Status(BIMS) could not be assessed as well as the Patient Health Questionnaire(PHQ-9). R3's delusions and hallucinations are not documented. R3's MDS documents that R3 has physical and verbal symptoms which occurred 1-3 days, wandering 1-3 days, and rejection of care 4-6 days during the assessment period. R3 has no range of motion issues. R3 utilizes a walker and a wheelchair. The MDS also documents that R3 requires supervision for upper and lower dressing and chair/bed-to-chair transfer. R3 is independent with mobility. R4 reported an allegation that R4 overheard verbal and physical abuse between R3 and a CNA at about 3:00 AM on 4/17/24. R4 reported that R4 heard R3 choking and then R3 was overheard to be going up and down the hallway yelling she choked me. The facility submitted to the State Survey Agency an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report on 4/17/24 at 4:30:58 PM. The facility submitted the Misconduct Incident Report(FRI) on 4/24/24 at 8:06:45 PM to the State Survey Agency. Surveyor reviewed all of the documentation describing the allegation, and statements. The facility obtained only 4 staff statements. There are 4 additional staff statements that are blank. The facility obtained R4's statement and another Resident's statement that overheard the commotion. No other Resident statements were obtained to determine if any other Resident had been affected by the CNA. The local enforcement were not notified of the allegation of R3 being choked. The summary written by Social Worker(SW-C) states that R4 reported that R4 did not see any staff before or after the alleged incident but R4 could hear the sound of someone being hit and then the CNA was overheard to say to R3 don't put your m f . hands on me. R4 then heard R3 choking and the CNA was heard to say I told you not to touch me. R4 reported that R3 then yelled she choked me and repeatedly said this as R3 went up and down the hallway. Another Resident statement reported they heard R3 in the hallway going back and forth stating that R3 was calling the police and stating you had me by my throat. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The summary identifies CNA-F as the CNA that provided cares to R3. CNA-F statement consists of answering no to the following questions: 1. Did you provide cares to R3 on 4/17/24? 2. Are you aware of an altercation between R3 and a staff member? 3. R3 report any abuse allegations to you? 4. Did you witness any physical or verbal abuse towards R3? The summary also documents the nurse assigned to R3 was unable to be reached to obtain a statement. On 6/3/24 at 11:35 AM, Surveyor interviewed R4 regarding R4 reporting that R4 heard sounds of someone being hit, verbal abuse from CNA-F, and hearing R3 stating that R3 had been choked by CNA-F. R4 stated R4 never saw the staff member because CNA-F never came into R4's room on that shift. R4 stated that R3 was going up and down the hallway yelling R3 had been choked by CNA-F. R4 stated R4 overheard the nurse tell R3 she said she didn't choke you. R4 was not able to identify the nurse. R4 put R4's call light on and informed Surveyor that the call light was not answered until around 5 to 7:00 AM by the first shift CNA who no longer works at the facility. R4 informed that CNA of what R4 had overheard and asked the CNA to check R3. According to R4, that CNA checked R3's neck and reported to R4 there were red marks on R3's neck. Surveyor notes that R4's statement that R4 reported the allegation to that CNA, and the CNA had checked out R3's neck is not included in the documentation in the facility's FRI. Surveyor notes there is no documentation of a head to toe physical assessment of R3 included in the facility's FRI. There is no nurse statement that according to R4, R4 overheard the nurse speaking to R3 about the allegation of R3 being choked. On 6/5/24 at 7:44 AM, Surveyor interviewed SW-C regarding the 4/17/24 FRI. SW-C confirmed that SW-C completed the investigation for the allegation that R3 was choked. SW-C stated SW-C follows the same method of investigating a grievance but administration is notified and written staff statements are obtained. The accused employee is suspended pending the investigation. Sometimes SW-C will have to take verbal over the phone from staff. SW-C also obtains Resident statements. SW-C completes a BIMS and PHQ-9 on the affected Resident. SW-C pulls reports from the unit. SW-C consults with the Administrator if the local law enforcement should be notified. SW-C is not able to recall why local law enforcement was not notified of R3's allegation of being choked, why only 4 staff statements were obtained, no other Resident statements were obtained, and why a BIMS and PHQ-9 were not completed on R3. SW-C will get back to Surveyor. On 6/5/24 at 8:37 AM, SW-C informed Surveyor that a BIMS and PHQ-9 was not completed on R3 because R3 would have gotten agitated with all the questions. SW-C stated the police were not notified because R3 could not remember the incident. SW-C is not able to provide any additional information as to why CNA-F's statement was not obtained, the CNA that the allegation was reported to by R4, or the nurse's statement as well as other staff statements and Resident statements not being obtained. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 8:45 AM, Surveyor informed Nursing Home Adminstrator (NHA-A) that a thorough investigation had not been completed in regards to R3's FRI dated 4/17/24. Surveyor shared there is no documentation that a head to toe physical assessment had been completed on R3. Surveyor also shared there are no Resident statements documenting if there was any issues with abuse, and the FRI is missing several staff statements, and the FRI is missing documentation that the local law enforcement had been notified. NHA-A acknowledged the concern and provided no additional information at this time. 20483 2.) R4's diagnoses includes hypertension, atrial fibrillation, morbid obesity, and left above knee amputation. The quarterly MDS (minimum data set) with an assessment reference date of 2/24/24 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. R4 is assessed as being dependent for chair/bed to chair transfers. On 6/3/24 at 1:35 p.m., Surveyor spoke with R4 and asked how staff treats her. R4 replied ok because I advocate for myself. R4 explained she does a lot for herself and doesn't have staff do something she could do for herself. R4 informed Surveyor she has had problems in the past and explained to Surveyor she needed to get up at 5:00 a.m. as she was going to [name of hospital] for her leg. R4 explained the ride was picking her up at 8:00 a.m. and wanted to get up early to get washed and dressed. R4 informed Surveyor first shift gets here at 7:00 a.m., sometimes they don't know which area they are assigned and may not be starting until 7:10 or 7:15 a.m. R4 informed Surveyor she ask nurse to get CNA (Certified Nursing Assistant)-E. R4 informed Surveyor CNA-E was cursing in the hallway, just going off saying she was sick of this place, they are short, sick of R4 and has to get R4 up. R4 informed Surveyor she's not sure why CNA-E said she was sick of her as all she asks CNA-E for is ice. R4 informed Surveyor LPN (Licensed Practical Nurse)-D came in and told her she didn't think there was time to get her up as they were very short & very busy. R4 informed Surveyor she told LPN-D its their job to help her. R4 informed Surveyor at 5:00 a.m. she placed her call light on. R4 informed Surveyor CNA-E answered her light, came in and stated what do you want then told her she was busy. R4 indicated CNA-E did come back and helped her into her chair. R4 informed Surveyor she told CNA-E she was going to report her. R4 informed Surveyor she reported it to name of NHA (Nursing Home Administrator)-A and name of DON (Director of Nursing)-B. R4 informed Surveyor SW (Social Worker)-C spoke with her. R4 informed Surveyor CNA-E does not take care of her anymore. LPN-D is still working on the unit and she's alright with this. R4 informed Surveyor she thinks they handled it pretty well. On 6/4/24 at 1:52 p.m., Surveyor reviewed the Facility's reported Incident for date of incident 4/1/24 involving R4 and CNA-E. Surveyor noted R4's concern was written up as a grievance/concern but was escalated to a self report. Surveyor noted the Facility protected R4 & other Residents as CNA-E was suspended during the investigation. The Facility interviewed CNA-E, LPN-D, and two other staff members who were not aware of the incident. Surveyor noted on the staff interview form for incident date of 4/1/24 there is a note with handwritten notation of no answer no call back for five staff. There is no indication as to when calls were placed, whether the Facility attempted to call these five employees back or have staff come to the Facility to be interviewed. Surveyor also noted there are no Resident statements or which Residents were interviewed to determine if there were concerns with CNA-E prior. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 2:36 p.m., during the daily exit meeting, Surveyor informed NHA-A and DON-B Surveyor would like to speak with SW (Social Worker)-C the next morning. On 6/5/24 at 7:44 a.m., Surveyor met with SW-C to inquire about investigation process for Resident's concerns. SW-C informed Surveyor for grievances she takes the statement & completes the grievance form. After completing this she starts to investigate by using who, what, where method. SW-C informed Surveyor she also informs NHA-A and DON-B. Surveyor inquired what happens when it's a concern that is self reported. SW-C informed Surveyor she follows the steps she explained in the grievance process and expedites it so that it's reported in the 2 hour window and the accused employee is suspended during the investigation. SW-C indicated she takes staff statements which are written unless it's third shift staff then takes verbal statements over the phone. Surveyor asked SW-C if she calls an employee & they don't answer does she call them back. SW-C indicated she does. Surveyor inquired if she speaks with Residents. SW-C replied yes. SW-C informed Surveyor she also will do a Resident's BIMS (brief interview mental status) & PHQ (patient health questionnaire) and update the family. Surveyor informed SW-C Surveyor did not note any Resident statements in the Facility's investigation regarding R4 & CNA-E on 4/1/24. SW-C informed Surveyor she doesn't recall and would have to look. Surveyor inquired for staff that didn't call back, could SW-C show Surveyor when she called staff back. SW-C informed Surveyor she could look in the file to see if there is any information and get back to Surveyor. On 6/5/24 at 8:26 a.m., SW-C informed Surveyor she doesn't have any information to provide Surveyor regarding staff. SW-C informed Surveyor and stated [name of resident] heard but couldn't make out who was taking but heard R4's name. SW-C informed Surveyor she doesn't have a list of residents who she spoke to and what they said. On 6/5/24 at 11:20 a.m., Surveyor informed NHA-A and DON-B the Facility's reported incident regarding R4 and CNA-E was not thoroughly investigated as there were five staff who were initially called, did not call back and there is no evidence the Facility attempted to contact them again to obtain their statements. In addition there are no Resident's statements. NHA-A informed Surveyor she went back & interviewed staff. Surveyor asked NHA-A to provide Surveyor with any additional information she may have to show the Facility completed a thorough investigation of the incident on 4/1/24. Surveyor was not provided with any additional information regarding the incident on 4/1/24 involving R4 & CNA-E.

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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** 38829 Based on interview and record review the facility did not ensure that 1 (R3) of 1 residents reviewed received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. *R3's hospital discharge paperwork dated 12/20/23 has instructions for R3 to follow-up for an orthopaedic consult to be scheduled within 6 weeks after discharge. R3 did not have a consult until 3/11/24. The consult documented that R3 was to return in 1 month for repeat x-rays. R3 did not have that appointment. R3 was scheduled for an orthopaedic appointment on 5/7/24 which R3 did not attend. Findings Include: 1.) On 6/5/24 at 11:54 AM, Administrator(NHA-A) informed Surveyor the facility does not have a policy and procedure for Resident appointments. R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Dementia with Psychotic Disturbance, Generalized Anxiety Disorder, Essential Hypertension, Type 2 Diabetes, Pulmonary Fibrosis, and Type 2 Diabetes Mellitus. R3's Quarterly Minimum Data Set(MDS) dated [DATE] documents that R3's Brief Interview for Mental Status(BIMS) could not be assessed as well as the Patient Health Questionnaire(PHQ-9). R3's delusions and hallucinations are not documented. R3's MDS documents that R3 has physical and verbal symptoms which occurred 1-3 days, wandering 1-3 days, and rejection of care 4-6 days during the assessment period. R3 has no range of motion issues. R3 utilizes a walker and wheelchair. The MDS also documents that R3 requires supervision for upper and lower dressing and chair/bed-to-chair transfer. R3 is independent with mobility and transfers. Surveyor reviewed an investigation dated 12/16/23 which documents R3 was found at 3:30 PM by a certified nursing assistant(CNA) laying on left side, screaming of pain pointed to right hip. Reluctant to move or wiggle right foot due to pain. Observed R3's right foot wearing left shoe and left foot wearing right shoe. Floor notes no debris, dry, small bag full of own personal things on floor next to R3. R3 was transported to the emergency room for evaluation. Surveyor notes that both physician and guardian were notified. Surveyor reviewed R3's hospital discharge summary dated 12/20/23 which documents that R3 had a right intertrochanteric femur fracture status post insertion of trochanteric femoral nail. The discharge summary has instructions for R3 to follow-up with orthopaedic trauma surgery in 6 weeks after discharge. R3 did not have a follow-up examination until 3/11/23 according to an after visit summary dated 3/11/24. Instructions were for R3 to return in one month for an x-ray. There is no documentation that R3 returned in one month for the repeat x-ray at the orthopaedic clinic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The after visit summary dated 4/29/24 where R3 was evaluated at the heart and vascular center documents that R3 has an appointment scheduled on 5/7/24 at the orthopaedic clinic. There is no documentation that R3 went to the 5/7/24 appointment. On 6/5/24 at 10:29 AM, Surveyor spoke with Health Information Manager(HIM-X) in regards to R3's missed appointments. Surveyor asked why the delay in and missed appointments for R3. HIM-X suggested there was an issue with openings or the facility being able to provide an escort. HIM-X will get back to Surveyor. On 6/5/24 at 11:41 AM, HIM-X stated to Surveyor that HIM-X found discrepancies with R3's appointments. HIM-X explained that it was discovered that appointments were not being followed up in a timely manner and Health Unit Secretory(HUC-Y) was disciplined. HIM-X stated there was a training in March of 2024 in regards to not scheduling appointments in a timely manner. HIM-X suggested that R3 refused the appointment in April, but agreed there is no documentation that R3 actually refused the appointment. On 6/5/24 at 11:54 AM, Nursing Home Adminstrator (NHA-A) was made aware of R3's missed appointments for the follow-up to R3's fracture. No additional information was provided as to why the facility did not ensure that R3 received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525588	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Manor	4545 N 92nd St Milwaukee, WI 53225

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20483 Based on observation, interview, and record review, the facility did not ensure that residents with a pressure injury or at risk for pressure injuries received necessary treatment and services, consistent with professional standards of practice, to prevent the development of pressure injuries and to promote healing for 3 (R7, R2, and R5) of 3 residents reviewed for pressure injuries. * On 5/14/24, R7 was identified as having a DTI (deep tissue injury) pressure injury to the right gluteal fold measuring 6 cm (centimeters) by 5 cm. A treatment of soap and water followed by Allevyn dressing every 72 hours continued through 6/2/24. On 5/15/24, APNP (Advance Practice Nurse Prescriber)-R assessed R7 to have an open area to the left ischial with necrotic tissue, odor, and drainage. APNP-R ordered CBC (complete blood count), CMP (comprehensive metabolic panel), CRP (C reactive protein), ESR (erythrocyte sedimentation rate), X-ray of pelvis/Left hip, and to start Doxycycline 100 mg (milligrams) twice daily for 7 days. R7's labs were not drawn until 5/21/24, the x-ray of pelvis/left hip was not done, and the antibiotic was administered for 5 days not 7 days. On 5/17/24, Wound Physician-U assessed R7 with an unstageable left ischium pressure injury and a Stage 1 sacrum pressure injury. Treatments were ordered. The facility implemented the left ischium treatment but did not implement the treatment to R7's sacrum. On 5/22/24, Wound Physician-I assessed R7 with a Stage 4 left ischium pressure injury and a Stage 2 sacrum pressure injury. The facility did not revise the potential skin integrity care plan or develop an actual pressure injury care plan until 5/28/24, 14 days after R7's pressure injury was identified. * R2 was admitted to the facility and found to be at risk for pressure injuries. R2 developed multiple facility acquired pressure injuries including an unstageable right heel pressure injury. R2's unstageable right heel pressure injury deteriorated and became infected while residing at the facility. R2 was hospitalized due to infection of unstageable right heel pressure injury which led to an above the knee amputation of their right lower extremity. The facility's failure to provide care to prevent the development of pressure injuries and promote the healing of pressure injuries R7 & R2, the failure to develop and/or update residents' pressure injury care plans, and the failure to implement and carry out treatments in accordance with doctors' orders created a finding of Immediate Jeopardy (IJ) which began on 5/15/24. Surveyor notified NHA (Nursing Home Administrator)-A & DON (Director of Nursing)-B of the immediate jeopardy on 6/5/24 at 2:56 p.m. The immediate jeopardy was removed on 6/7/24. The deficient practice continues at a scope and severity of G (harm/isolated) related to the example involving R5 and as the facility continues to implement its action plan. * R5 developed a Stage 2 pressure injury on 4/30/24 that was not comprehensively assessed until 5/22/24 when R5 was seen by the wound physician. The wound physician's assessment of the wound indicated the wound had declined to Unstageable with slough in the wound bed and had doubled in size from when it was initially discovered. R5's Skin Integrity Care Plan was not revised with the development of the pressure injury. The dietician was not involved with R5 when the new pressure injury developed. R5 was observed to not have incontinence care or repositioning every two hours as care planned. Findings include: (continued on next page)

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	525588	A. Building B. Wing	06/11/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Treatment/SVS to Prevent/Heal Pressure Ulcer Policy & Procedure revised 3/4/24 under purpose documents: The facility's policy is to ensure it identifies and provides needed care -and services that are resident-centered, per the resident's preferences, goals for care, and professional standards of practice that will meet each resident's physical, mental and psychosocial needs. Under procedure documents: 1. Upon admission, the resident will receive a head-to-toe skin check as soon as possible to identify any skin issues. 2. All residents will have a Braden Scale evaluation completed at the time of admission, in conjunction with each quarterly and annual assessment, with any significant change assessment and as deemed necessary by the Interdisciplinary Team. 3. Interventions will be implemented in the resident's plan of care to prevent pressure injury development. 4. When the resident is admitted with a pressure ulcer(s), the admitting nurse will document the size, location, odor (if any), drainage (if any). 5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure injury. 6. The admitting nurse will notify the attending physician or wound physician to obtain a treatment order. 7. The pressure ulcer(s) will be evaluated weekly by a Registered Nurse or Wound Physician, and the following will be documented in the resident's electronic medical record: the size, location, odor (if any), drainage (if any), and current treatment ordered. 8. The nurse will notify the physician any time the pressure injury shows signs of non-healing or infection and request treatment order changes. 9. The resident and or the resident's representative will be notified of any changes related to the improvement, deterioration, and/or treatment changes on an ongoing basis. Surveyor noted the facility's policy & procedure does not include for evaluation of pressure injuries the stage or description of the wound bed. On 6/5/24 at 3:05 p.m., Surveyor asked NHA (Nursing Home Administrator)-A what standard of practice the facility's pressure injuries policy & procedures is based on. NHA-A informed Surveyor National Pressure Ulcer Association. 1.) R7 was admitted to the facility on [DATE]. R7's POA (Power of Attorney) for health care was activated on 5/30/24. R7's diagnoses includes hemiplegia & hemiparesis following cerebral infarction, vascular dementia, hypertension, and diabetes mellitus. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident has potential for impairment to skin integrity r/t (related to) decreased mobility, residual L (left) sided hemiparesis with L hand contracture, incontinence, and terminal condition - on hospice care initiated 6/4/21 & revised 5/28/24 documents the following approaches/tasks: * Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Initiated 3/13/18. * Encourage good nutrition and hydration in order to promote healthier skin. Initiated 3/13/18. * Use a draw sheet or lifting device to move resident. Initiated 3/13/18. * Please provide INC (incontinent) cares for resident at midnight and 0600 (6:00 a.m.). Initiated 9/27/18 & revised 11/16/21. * Heels Up pad when in bed or heel lift boot on at HS (hour sleep) as tolerated. Initiated 8/20/21 & revised 1/4/22. * The resident has pressure relieving mattress, Equa gel cushion on wheelchair and reposition Q (every) 2 hours or PRN when on [sic] (in) bed as tolerated. Initiated & revised 1/4/22. The Quarterly MDS (minimum data set) with an assessment reference date of 3/15/24 has a BIMS (brief interview mental status) score of 5 which indicates severe impairment. R7 is assessed as not having any behaviors, including refusal of cares. R7 is assessed as requiring set up or clean up assistance for eating and toileting, hygiene is dependent, and chair/bed to chair transfer and toilet transfer is assessed as substantial/maximal assistance. R7 uses a wheelchair and is dependent for wheeling. R7 is assessed as always incontinent of urine and frequently incontinent of bowel. R7 is at risk for pressure injury development and is assessed as not having any pressure injuries. Under skin & ulcer treatment, the following approaches are checked: pressure reducing device for bed, pressure reducing device for chair, and applications of ointments/medications other than to feet. The COMS skin only evaluation dated 3/18/24 answers no for current skin issues. For general notes documents skin intact. The Braden assessment dated [DATE] has a score of 18 which indicates at risk for pressure injury development. The May 2024 TAR (treatment administration record) includes weekly shower and skin check Tuesday AM (morning) before 10:00am, if refused shower update resident son. every day shift every Tue (Tuesday) with a start date of 9/26/23. Surveyor noted 5/7 is blank and not checked with initials as being completed. There are no nurses initials on 5/7/24 for refusal of shower/skin check. Surveyor reviewed R7's amount eaten from 5/7/24 to 5/14/24 and noted under the task section documents the following: On 5/7/24 & 5/8/24 all three entries are 76-100%. 5/9/24 all three entries are 51-75% (continued on next page)

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	525588	A. Building B. Wing	06/11/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/10/24 51-75%, 76-100% & 26-50% 5/11/24 25-50%, 51-75% & 76-100% 5/12/24 26-50%, 51-75%, & 26-50% 5/13/24 51-75%, 51-75%, & 76-100% 5/14/24 all three entries are 51-75%. The nurses note dated 5/14/24 at 1350 (1:50 p.m.) documents Res (Resident) with DTI (deep tissue injury) to R (right) gluteal fold purple in color measuring 6 cm (centimeters) L (length) X (times) 5 W (width) unstageable. Area cleansed and dressed. Scheduled pain meds given [Name] NP (Nurse Practitioner) [Name] here and updated. N.O.R. TX (new order received treatment). This nurses note was written by RN (Registered Nurse)-P. R7's potential for skin integrity was not revised until 5/28/24, 14 days later. The revision on 5/28/24 does not have any changes for R7's approaches/tasks. The actual pressure injury care plan was not developed until 5/28/24, 14 days later. Surveyor was unable to interview RN-P as RN-P is no longer employed at the facility. The physician orders dated 5/14/24 document: Soap & water wash follow by Allevyn dressing to DTI (R) gluteal fold change every 3 days and PRN (as needed) in the morning. The COMS skin only evaluation dated 5/14/24 at 14:01 (2:01 p.m.) documents Skin: Skin warm & dry, skin color WNL (within normal limits), mucous membranes moist, turgor normal. Resident has current skin issues. Skin Issue: Deep Tissue Pressure Injury (DTPI). Skin Issue Location: R-gluteal fold Pressure Ulcer/Injury Stage: Unstageable. Length: 6 Width (cm): 5 DTI noted to R-gluteal fold. Area cleansed & dressed. Clinical Suggestions: Evaluated for pain, discomfort. Dressing changes/treatments performed as ordered. This evaluation was completed by RN-P. The nurses note dated 5/14/24 at 14:38 (2:38 p.m.) documents: Son [Name] updated on DTI and TX order. This nurses note was written by RN-P. The nurses note dated 5/14/24 at 22:04 (10:04 p.m.) documents Res rt (right) gluteal fold tx ongoing f/u (follow up) wound team. This nurses note was written by LPN (Licensed Practical Nurse)-Q. The nurses note dated 5/15/24 at 10:23 (10:23 a.m.) documents: F/U (follow up) DTI to R-gluteal fold: Dressing CDI (clean dry intact). Denies pain/discomfort. This nurses note was written by RN-P. (continued on next page)

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	525588	A. Building B. Wing	06/11/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	APNP (Advanced Practice Nurse Prescriber)-R's progress note dated 5/15/24 under history of present illness documents: [R7's name] 97 Y (year) female at [Facility's name]. History significant for CVA (cerebral vascular accident) with left side hemiplegia, dysphagia, subdural hemorrhage, hypertension, aortic stenosis, type 2 diabetes L (left) urethral stone (stent removed 9/28), shingles with postherpetic neuralgia, chronic leukocytosis, anemia. Resident is seen today for review of chronic conditions and follow up of functional deficits in mobility, safety and ADLs (activities daily living). Under Interval History documents: Approached by son [Name] in hall. Informed of possible open area to left side of buttocks. Discussed with facility staff, noted 5/14 treatment initiated. Patient with complaints of pain to left side of bottom. On Tramadol PRN. Left sided hemiplegia at baseline. Was previously ambulatory with restorative, functional decline recently due to complaints of left ankle pain. Wheelchair dependent at baseline. Appetite and weight stable. No recent ER (emergency room) visits or hospitalization over the past quarter. Under Physical Exam for skin documents open area to left ischial with necrotic tissue present to wound bed. + (positive) odor and drainage. Wound of left buttock, initial encounter Rapid progress of wound noted by staff. Indicator of decline. CBC (complete blood count), BMP (basic metabolic panel), CRP (C reactive protein), ESR (erythrocyte sedimentation rate). XR (x-ray) pelvis/L hip Start Doxycycline Offload pressure Air mattress Broda chair Wound treatment: dakins kerlix, cover with ABD (abdominal) pad change BID (twice daily) and PRN Wound MD (medical doctor) at facility to follow up Comfort focused care Paint management: scheduled Tylenol. Schedule Tramadol TID (three times daily), continue PRN Tramadol. Under advance care planning documents: Goals of care discussion had at bedside with patient and son [Name]. Rapid decline in wound to left ischium with necrotic tissue, likely to bone. Discussed skin failure as an indicator of decline. Unfortunately patient with functional decline complicated by left sided hemiplegia. Due to multiple co-morbidities, favor comfort focused plan of care. Does not want aggressive interventions or work up outside of facility. Plan as above. Hospice consult. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The physician orders dated 5/15/24 documents: Doxycycline Hyclate 100 mg (milligrams) give 1 tablet by mouth every 12 hours for infection for 7 days. Surveyor noted according to R7's May 2024 MAR (medication administration record) R7 started receiving Doxycycline Hyclate 100 mg on the PM (evening shift) on 5/15/24 with the last dose being administered on 5/19/24 on the AM (morning) shift. Surveyor noted this medication was not administered for 7 days according to physician orders. The physician order dated 5/15/24 documents: May have air mattress to promote wound healing. On 6/4/24 at 9:01 a.m., Surveyor asked Maintenance Director-DD if he could tell Surveyor when the air mattress was placed on R7's bed. At 9:09 a.m. Maintenance Director-DD informed Surveyor the air mattress was placed on R7's bed on May 15th. Surveyor asked Maintenance Director-DD if he could find out what type of mattress was on R7's bed prior to the air mattress. At 9:11 a.m., Maintenance Director-DD informed Surveyor he doesn't know what type of mattress was on prior. The nurses note dated 5/15/24 at 22:08 (10:08 p.m.) documents: Res rt gluteal fold DTI necrosis foul smelling started ABT (antibiotic) therapy f/u wound team. This nurses note was written by LPN-Q. The nurses note dated 5/16/24 at 12:03 (12:03 p.m.) documents: Dressing CDI to wound R-gluteal. Doxycycline 100 mg started DX (diagnosis) wound infection without adverse reactions. T (temperature) 97.8 P (pulse) 70 R (respirations)-16 B/P (blood pressure) 122/70 O2 94%. Intervention in place R/T (related to) wound. Hospice eval (evaluation) pending. This nurses note was written by RN-P. The nurses note dated 5/17/24 at 09:44 (9:44 a.m.) documents: Resident alert and resting in bed. Dressing changed to Glut (gluteal) area as ordered. Remains on ABT (antibiotic) for wound with no adverse reactions noted or reported. Temp 97.8 Small amount of drainage and odor noted. Writer noted that resident appears comfortable while resting and does call out with cares and dressing changes. Resident receives scheduled/PRN pain medication. This nurses note was written by LPN-S. The nurses note dated 5/17/24 at 18:02 (6:02 p.m.) documents: Resident seen by wound MD (medical doctor). New tx order placed for left ischium. See MD notes. This nurses note was written by LPN-T. Wound Physician-U initial wound evaluation & management summary dated 5/17/24 under Focused Wound Exam (Site 1) documents: Unstageable (due to necrosis) of the left ischium full thickness. Etiology is Pressure, MDS 3.0 Stage Unstageable Necrosis, Wound Size (L x W x D) (length times width times depth) 5 x 5 x 0.1 cm (centimeters), exudate moderate serous, and thick adherent devitalized necrotic tissue 100%. Under additional wound detail documents: Unavoidable secondary to general decline, possible Kennedy ulcer (secondary to rapid progression). Possible skin failure with multiple new wounds. Under procedure note documents: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade was used to surgically excise 12.5 cm2 of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 3 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 50 percent. Hemostasis was achieved and a clean dressing was applied. (continued on next page)

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	525588	A. Building B. Wing	06/11/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Focused Wound Exam (Site) 2 documents: Stage 1 pressure wound sacrum. Etiology is Pressure, MDS 3.0 Stage 1, Wound size (L x W x D) 1 x 1 x Not measurable cm, Exudate none and skin Intact with non-blanching redness. Under treatment plan documents: Border foam apply three times per week for 30 days. The facility did not implement this dressing for R7's stage 1 sacrum pressure injury. The facility still has not revised R7's potential for skin integrity care plan or developed an actual skin integrity care plan after Wound Physician-U's evaluation on 5/17/24. The nurses note dated 5/19/24 at 21:41 (9:41 p.m.) documents: Resident is lethargic. Decreased appetite. Able to make needs known. Denies pain or discomfort. Hospice team notified. Comfort cares per NP order. Tx to left ischium done per MD orders. Necrotic tissue, drainage with odor observed. Resident is resting in bed at the moment. This nurses note was written by LPN-W. The Braden assessment dated [DATE] has a score of 10 which indicates high risk for pressure injury development. The doctors order dated 5/20/24 documents: Admit to hospice. The nurses note dated 5/22/24 at 08:50 (8:50 a.m.) documents: Alert orientated X 2 with forgetfulness. Recent decline in condition with hospice care & comfort measures in place. Appetite & fluid intake remains poor. Supplements encouraged. Open area to L gluteal fold with Tx & interventions in place. POA [Name] involved and kept updated on changes in TX & care. Total care with all cares. Difficulty sitting in Broda chair R/T (related to) pain from L-ischium. Incontinent of B & B (bowel and bladder). This nurses note was written by RN-P. Wound Physician-I's wound evaluation & management summary dated 5/22/24 under Focused Wound Exam (Site 1) documents: Stage 4 Pressure Wound of the left ischium full thickness. Etiology is Pressure, MDS 3.0 Stage 4, Wound Size (L x W x D) (length times width times depth) 4.5 x 6 x 2 cm (centimeters), exudate moderate Sero-sanguineous, and thick adherent devitalized necrotic tissue 100%. Under expanded evaluation performed documents: The progress of this wound and the context surrounding the progress were considered in greater depth today. Patient requiring an increase in the level of care. The patient needs debridement under GA (general anesthesia) for Necrotizing Fasciitis. The discussion done with the hospice nurse to discuss the plan of sending the patient out to the hospital with the family. Under procedure note documents: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick ups were used to surgically excise 8.10cm2 of devitalized tissue and necrotic muscle level tissues were removed at a depth of 2.7 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 70 percent. Hemostasis was achieved and a clean dressing was applied. Focused Wound Exam (Site) 2 documents: Stage 2 pressure wound sacrum partial thickness. Etiology is Pressure, MDS 3.0 Stage 2, Wound size (L x W x D) 1 x 1 x 0.1 cm, Exudate none and dermis: open areas with exposed dermis. (continued on next page)

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	525588	A. Building B. Wing	06/11/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Under treatment plan documents: Primary dressing(s) Leptospermum honey apply once daily for 30 days Secondary dressing(s) Gauze island w/ (with) bdr (border) apply once daily for 30 days. Under recommendations documents: Antibiotic choice: Doxycycline 100 mg BID for 10 days; off-load wound; reposition per facility protocol. The facility still has not revised R7's potential for skin integrity care plan or developed an actual skin integrity care plan after Wound Physician-U's evaluation on 5/22/24 documents R7's left ischium declined to Stage 4 and sacrum to a Stage 2. The nurses note dated 5/22/24 at 17:40 (5:40 p.m.) documents: [Wound Physician-I's name] per wound round assessment suggest that resident goes to hospital for further wound evaluation. Hospice contacted; hospice verified that resident and family doesn't want hospitalization for wound care per hospice/code status agreement. [RN Manager-J's first name], (unit nurse) hospice nurse, wound support nurse and Wound Physician-I made aware. This nurses note was written by RN-G. The nurses note dated 5/22/24 at 17:58 (5:58 p.m.) documents: Resident seen by wound MD. See MD notes for additional information. New order for Tx for unstageable (due to necrosis) of the left ischium full thickness: skin prep surrounding area. Dakins half strength dampened kerlix Pack cavity with wet kerlix. Cover w/ border gauze. New order for Tx for stage 2 pressure wound to sacrum: Medihoney with border gauze. New order for Doxycycline 100mg po BID x 10 days. Wound MD recommended communication with hospice regarding left ischium wound being necrotizing fasciitis and recommending resident be sent to ER for debridement and IV (intravenous) abx. This note was written by RN Manager-J. The nurses note dated 5/22/24 at 18:12 (6:12 p.m.) documents: Writer contacted Hospice per wound MD recommendation to discuss left ischium wound being early necrotizing fasciitis and recommendation to be sent to ER for debridement and IV abx. Hospice stated that when resident was admitted to hospice they had extensive conversation with resident's son/POA who expressed at that time that he did not want resident to be sent to the hospital for treatments. Hospice stated that they would follow up with resident's son/PA regarding the wound MD's recommendation and goals of care. This nurses note was written by RN Manager-J. The significant change MDS with an assessment reference date of 5/23/24 has a BIMS of 00 which indicates severe cognitive impairment. R7 is assessed as not having any behaviors including refusal of care. R7 is assessed as being dependent with eating, toileting, hygiene, roll left and right, and chair/bed to chair transfers. R7 is always incontinent of urine and bowel, is at risk for pressure injuries, and is assessed as having one Stage 2 and one Stage 4 pressure injury. (continued on next page)

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	525588	A. Building B. Wing	06/11/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The pressure ulcer/injury CAA (care area assessment) dated 5/28/24 for analysis of findings under nature of the problem/condition documents: [R7's first name] has a Stage 4 pressure injury to L ischium with current infection and on oral antibiotic treatment, and Stage 2 PI to sacrum. Has daily ordered treatment/dressing change and is being followed by visiting wound MD (medical doctor). She requires total assistance with most of her ADLs (activities of daily living). See ADL CAA. Also is totally incontinent of urine and bowel. Poor oral intake, taking 0-25% during meals. Recently enrolled to hospice care. Diagnosis includes hemiplegia/hemiparesis following cerebral infarction affecting L non-dominate side, vascular dementia without behavioral nor psychotic nor mood disturbances nor anxiety, HTN (hypertension), nonrheumatic aortic valve stenosis, hyperlipidemia, anemia, Type 2 DM (diabetes mellitus), Vit (vitamin) D deficiency, osteoarthritis, slow transit constipation, glaucoma, and other age related cataract. Receives oral and topical analgesics including narcotic analgesic, and antibiotic, otherwise most of her medication has been discontinued. Braden Score = 10 (high risk). The nurses note dated 5/24/24 at 13:05 (1:05 p.m.) documents: F/U open area L-gluteal fold & sacral; Alert & responsive. Comfort measures in place. TX completed per MD order. ABT without adverse reactions. This nurses note was written by RN-P. The resident has Stage 4 pressure injury to L (left) ischium and Stage 2 to Sacrum r/t (related to) Terminal Condition, poor oral intake, and immobility initiated & revised on 5/28/24 documents the following approaches/tasks: * Administer medications as ordered. Monitor/document for side effects and effectiveness. Initiated 5/28/24. * Administer treatments as ordered and monitor for effectiveness. Initiated & revised 5/28/24. * Assess/record/monitor wound healing weekly. Wound consult/follow up as needed. Initiated & revised 5/28/24. * Inform the resident/family of any new area of skin breakdown. Initiated and revised 5/28/24. * Monitor dressing each shift to ensure it is intact and adhering. Initiated & revised 5/28/24. * Monitor nutritional status. Serve diet as ordered, monitor intake and record. Initiated & revised 5/28/24. * Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length X (times) width X depth), stage. Initiated & revised 5/28/24. * Pressure relieving/reducing device on bed and chair. Initiated & revised 5/28/24. * The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. Initiated & revised on 5/28/24. * The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. Initiated 5/28/24. (continued on next page)

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	525588	A. Building B. Wing	06/11/2024

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* Treat pain as per orders prior to treatment/turning etc. to ensure the Resident's comfort. Initiated 5/28/24. * Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. Initiated 1/4/22. * Turn & reposition q 2 hours and PRN while in bed. Initiated 11/25/22. * Apply house barrier cream every shift and/or with incontinence episode(s). Initiated 2/1/23. Wound Physician-I's wound evaluation & management summary dated 5/29/24 under Focused Wound Exam (Site 1) documents: Stage 4 Pressure Wound of the left ischium full thickness. Etiology is Pressure, MDS 3.0 Stage 4, Wound Size (L x W x D) (length times width times depth) 4.1 x 5.4 x 2.9 cm (centimeters), exudate light Sero-sanguineous, thick adherent devitalized necrotic tissue 100% wound progress: Improved evidenced by decreased surface area. Under procedure note documents: The wound was cleansed with normal saline and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, 15 blade, pick ups were used to surgically excise 15.50cm2 of devitalized tissue and necrotic muscle level tissues were removed at a depth of 3.8 cm and healthy bleeding tissue was observed. As a result of this procedure, the nonviable tissue in the wound bed decreased from 100 percent to 30 percent. Hemostasis was achieved and a clean dressing was applied. Focused Wound Exam (Site) 2 documents: Stage 2 pressure wound sacrum partial thickness. Etiology is Pressure, MDS 3.0 Stage 2, Wound size (L x W x D) 0.7 x 0.6 x 0.1 cm, Exudate light serous and dermis: open areas with exposed dermis. Wound progress: Improved by decreased surface area. The nurses note dated 5/31/24 at 12:49 (12:49 p.m.) documents: F/U ABT for Wd (wound) infection. Resident is alert and responsive. Resident cont. (continues) on abt for wound infection temp (temperature) was 97.1. No adverse reaction noted at this time. Tx was done as ordered some odor noted to area. Some depth and tunneling noted to wound. Drsng (dressing) C/D/I to area. Resident cont. to be turn q (every) 2 hours and as needed. Resident gets up in chair as much as tolerated. Will cont. to monitor. This nurses note was written by LPN-Z. On 6/3/24 at 1:23 p.m., Surveyor spoke with POA-AA regarding R7. POA-AA informed Surveyor R7 started to complain of pain in her bottom about a week or two before the pressure sore developed. POA-AA informed Surveyor the pressure sore wasn't open and then it was terrible. Surveyor asked POA-AA if he knew how the pressure injury developed. POA-AA replied no. POA-AA informed Surveyor the wound doctor recommended R7 go to the hospital. POA-AA informed Surveyor he said no stating they can't do anything in the hospital and no anesthesia because of her age. POA-AA informed Surveyor R7 could walk and then when she complained of pain couldn't walk, was sitting in a wet diaper all the time, supposed to be changed every two hours but didn't think that happened. Surveyor observed R7 in bed on her back with a heel lift pad under R7's lower legs and R7 was wearing pressure relieving boots. R7 is on an air mattress which is on. On 6/4/24 at 7:14 a.m., Surveyor observed R7 awake in bed on her back with the head of the bed elevated, there is a heel lift pad under R7's lower legs but R7's heels are resting directly on the mattress. R7's air mattress is on. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/4/24 at 7:22 a.m., Surveyor observed CNA (Certified Nursing Assistant)-BB & CNA-CC enter R7's room. Staff informed Surveyor they were going to reposition R7. Surveyor asked R7 if it was alright that Surveyor was in the room with CNA-BB & CNA-CC. R7 shook her head no and Surveyor left R7's room. On 6/4/24 at 7:39 a.m., Surveyor asked CNA-CC what they did for R7. CNA-CC explained they repositioned & provided oral care. Surveyor asked CNA-CC if they did incontinence care. CNA-CC replied yes, had a small BM (bowel movement). On 6/4/24 at 9:29 a.m., Surveyor observed R7 in bed on her right side. Surveyor observed R7 is not wearing pressure relieving boots and R7's heels are resting on the heel lift pad. On 6/4/24 at 9:31 a.m., Surveyor observed CNA-CC enter R7's room informing R7 she is going to lower her head and reposition her. On 6/4/24 at 10:27 a.m., Surveyor observed R7 in bed position on the left side. R7's son is sitting next to R7's bed holding her hand. Surveyor observed R7 is not wearing pressure relieving boots and has the heel lift pad under R7's lower legs. On 6/4/24 at 1:01 p.m., Surveyor entered R7's room with RN-EE & CNA-CC. R7's son was in the room. R7's son and R7 gave Surveyor permission to observe R7's pressure injury treatments. RN-EE & CNA-CC placed gloves on. The sheet was removed and Surveyor observed R7 is not wearing pressure relieving boots and R7's heels are resting on the edge of the heel lift pad. R7's bed was moved away from the wall & the bed was raised up. CNA-CC removed the pillow from under R7's left side, R7 was moved to the right, the incontinence product was unfastened and R7 was positioned on the left side. RN-EE wiped the stool off R7's buttocks using the incontinence product, removed her gloves and placed new gloves on. Surveyor noted while RN-EE was wiping off the stool R7's dressing on the left ischium was also removed. Surveyor noted there is foam dressing on the sacrum which is not dated. Using multiple disposable wipes, RN-EE wiped off BM from R7's buttocks & rectal area. RN-EE removed her gloves, washed her hands, and placed gloves on. RN-EE removed the packing from R7's left ischium pressure injury which also contained stool on the packing. RN-EE removed her gloves, washed her hands, and placed gloves on. RN-EE stated she sees some fascia and tendon. RN-EE opened a new bottle of dakins, poured the dakins on four by four gauze, removed her gloves while telling R7's son what she is going to do and placed gloves on. RN-EE then cleansed R7's left ischium pressure injury with four by four with dakins and removed her gloves. RN-EE did not perform hand hygiene. RN-EE poured dakins on kerlix, placed gloves on, cut the kerlix, had CNA-CC pull back on R7's left buttocks and packed the left ischium pressure injury with kerlix. While RN-EE was packing the pressure injury RN-EE stated she c [TRUNCATED]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38253 Based on observation, record review, and interview, the facility did not ensure care plans were implemented for residents determined to be at risk for falls and did not ensure residents were comprehensively assessed after a fall to implement preventive measures based on the assessment for 2 (R1 and R3) of 4 residents reviewed for falls. *R1 was admitted to the facility after sustaining a fractured left hip from a fall in the community. R1 was assessed to be a high risk for falls and no care plan was developed to address the fall risk. On 4/22/2024, R1 fell from bed and sustained a fracture to the right hip. *R3 fell on [DATE] and sustained a fractured to the right hip. The fall was not thoroughly investigated as to the root cause and no care plan interventions were implemented to prevent future falls. Observations were made during the survey of fall interventions not in place per care plan. Findings include: 1.) R1 was admitted to the facility on [DATE] with diagnoses of fractured neck of the left femur, post hemorrhagic anemia, encephalopathy, Alzheimer's disease, and anxiety. R1's admission Minimum Data Set (MDS) assessment dated [DATE] indicated R1 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 6 and assessed as being dependent for toileting hygiene and transferring, and maximal assistance with dressing and bathing, and moderate assistance for bed mobility. R1's Fall Care Area Assessment with the admission MDS indicated falls were to be addressed in a care plan to minimize risks. R1 had an activated Power of Attorney (POA). On 3/7/2024, R1's Admission Data Collection and Baseline Care Plan Tool was completed by Licensed Practical Nurse (LPN)-N. LPN-N documented in the Physical and Functional Status section of the form that R1 was at risk for falls. Interventions were listed as possible fall prevention measures and no fall planning interventions were selected on the form. On 3/7/2024, R1's Fall Risk Evaluation form was completed by LPN-N. LPN-N documented R1 was a t risk for falls with a score of 13. The top of the form in the computer charting system indicates any score above 10 indicates the resident is at high risk for falls. Surveyor reviewed R1's comprehensive Care Plan. The Care Plan did not include any fall risk or interventions to prevent future falls. On 3/9/2024 at 2:19 AM, in the progress notes, nursing charted R1 did not attempt to self-transfer or get out of bed. On 3/9/2024 at 11:39 PM, in the progress notes, nursing charted the call light was within reach and the bed was locked and at lowest position. On 3/10/2024 at 9:48 PM, in the progress notes, nursing charted the call light was within reach and the bed was locked and at lowest position. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/12/2024 at 7:40 AM, in the progress notes, nursing charted R1 was alert to self, confused to time and place. R1 had been removing the linen off the bed and had undressed in bed. R1 had a nervous laugh as R1 rubbed the left hip and leg. Pain medication was administered along with one-on-one and position changes. R1 denied pain when asked but showed nonverbal pain such as the nervous laugh, rubbing the hip, restlessness, and moaning. R1 had poor safety awareness. Decreased stimuli was provided. On 4/9/2024 at 4:55 AM, in the progress notes, nursing charted R1 had made several attempts to get out of bed unassisted. R1 was weight-bearing as tolerated but at that time was not ambulating. R1 calls out for help and has a laughter that resembles that of a nervous laugh. Even when nurses or Certified Nursing Assistants (CNAs) did some one-on-one with R1, that did not stop R1 from calling out help, help, oh no. R1 had been changed and is dry, fluids and a snack were provided. Diminished stimuli was provided. R1 continued with anxiety and restless ness. CNA/nurse provided a safe environment so that R1 would not fall or injure themselves. On 4/10/2024 at 5:32 AM, in the progress notes, nursing charted R1 was restless and called out help me, help me, help me. Staff in with R1 to anticipate and assist with R1. R1 made several attempts to get out of bed unassisted. R1 remained restless even after toileting. Due to safety, R1 was washed up and got ready for the morning. R1 was brought to the common area and given a magazine to look at and a sandwich and apple juice to eat. R1 continued to be anxious and restless. On 4/14/2024 at 5:50 AM, in the progress notes, nursing charted R1 called out help, help, help. The CNA went into the room and R1 was sitting at the edge of the bed. When asked what R1 was doing, R1 did not know and then had a nervous laughter. R1 asked the CNA to please help and when the CNA asked what R1 would like the CNA to do, R1 did not know. R1 had poor safety awareness at night. On third shift R1 does not walk independently; R1 is a max assist of two to transfer to the wheelchair. Safety checks were done related to R1 attempting to get out of bed. Despite being taken care of, R1 continued to demonstrate anxiety and restlessness. On 4/15/2024 at 2:59 AM, in the progress notes, nursing charted R1 had been up since the change of shift. R1 was repetitive, restless, and anxious. Decreased stimuli was provided, one-on-one was given when able, and snacks and fluids were given. All interventions provided short-term relief for restlessness, but it was not effective for the anxiety. The Nurse Practitioner was notified. On 4/22/2024 at 10:07 PM, in the progress notes, LPN-L was informed by the Supervisor that R1 was on the floor. LPN-L and the Supervisor went to R1's room and observed R1 sitting on the floor with legs straight leaning with R1's back on the recliner chair facing the bed. Range of motion was within normal limits to all extremities. Neurological checks were initiated and were negative. R1 could respond to questions but could not remember what happened as R1 has impaired memory and is forgetful. This was normal for R1 as R1 had diagnoses of dementia with anxiety. No changes in consciousness or conditions were noted. No acute distress was observed. Scheduled Tylenol was administered for complaints of pain. R1 had a skin tear with hematoma to the right arm that measured 11 cm x 6.5 cm. The area was cleansed with normal saline and a wet to dry dressing was applied followed by Kerlix. A cold pack was placed on the area. R1 was put back in bed with a Hoyer lift by two CNAs and the assigned CNA. Vital signs were stable and remained with baseline. Interventions were put in place: a bed bolster placed on the left side of R1 under the fitted sheet. The bed was at low level and call light was in place. R1 is forgetful and reminded to call for assistance. The POA, Nurse Practitioner, Director of Nursing (DON) were updated and aware of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/22/2024 at 11:01 PM, in the progress notes, the LPN Nursing Supervisor charted R1 was sitting on the floor facing the bed with the back against the recliner. R1 had gripper socks on, and the call light was on the bed. R1 had scabbing along the right lateral arm with bleeding and a bruise. The unit nurse measured the wound 11 cm x 6.5 cm and cleaned the wound and applied a dressing. A cold pack was placed on the arm and a bed booster was placed on the left side of R1 under the fitted sheet. The Supervisor notified the Nurse Practitioner and the POA of the situation. The POA requested an x-ray. (Surveyor attempted to interview the LPN Nursing Supervisor, but they were unavailable for interview.) On 4/23/2024 at 8:00 AM, in the progress notes, nursing charted the nurse was called into R1's room by the CNA at 7:45 AM. R1 was lethargic and screaming with complaints of excruciating pain in the right leg. R1 had a hematoma to the right arm. Blood pressure 96/56, temperature 98.1, pulse 95, oxygen saturation 95% on room air, and respirations 18. R1 was unable to move lower extremities per baseline. The nurse contacted R1's POA and explained it would be in the best interest if R1 was sent to the hospital for further evaluation. R1 was sent to the hospital and communication between the hospital and the facility showed R1 had a right hip fracture. At 1:42 PM in the progress notes, nursing charted R1 went to the hospital at 8:30 AM. The AM shift CNA stated that when the CNA tried to get R1 dressed, R1 complained of severe pain and the AM shift nurse sent R1 to the hospital where R1 was diagnosed as having a right femur fracture and waiting for possible surgery. No documentation was found of an RN doing an assessment of R1 after the fall on 4/22/2024. R1 did not return to the facility and was not a resident at the time of the survey. In an interview on 6/3/2024 at 3:35 PM, Surveyor asked LPN-L to describe the events of 4/22/2024 when R1 fell in R1's room. LPN-L stated R1 was found on the floor and was not sure if R1 fell from the bed or from the recliner in the room. LPN-L stated R1 had a skin tear and bruising to the upper arm. LPN-L stated R1's legs were straight and R1 did not complain of any pain to the legs. LPN-L stated R1 was lifted back to bed using a Hoyer lift and did not complain of any pain to the leg when R1 was moved. LPN-L stated the LPN supervisor came to R1's room after R1 fell . LPN-L stated if there is no RN in the building, the facility assigns an LPN to be the supervisor. Surveyor asked LPN-L if an RN came to assess R1 after the fall. LPN-L could not recall if any other nurse came to the room. LPN-L reiterated R1 did not complain of any pain to the leg or have any range of motion problems at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 6/4/2024 at 10:34 AM, Surveyor asked LPN MDS-M what the facility process was for completing the MDS assessments and creating care plans. LPN MDS-M stated LPN MDS-M works with a Registered Nurse (RN) to complete all the MDS assessments for the facility. LPN MDS-M stated each discipline completes the appropriate section of the MDS and then if a Care Area Assessment (CAA) is triggered, that discipline would complete the CAA to address the triggered area. Surveyor asked LPN MDS-M who initiates care plans for new residents. LPN MDS-M stated the nurse on the floor opens a baseline care plan and then the MDS nurses make sure all areas are completed on the care plan. LPN MDS-M stated the baseline care plans are part of the admission assessment. Surveyor shared with LPN MDS-M the concern R1's Fall CAA was triggered, was assessed to be at risk for falls, the CAA documented falls were to be addressed in the care plan to minimize risks, and no falls care plan was initiated. LPN MDS-M stated a fall care plan should have been initiated and would look to see if one could be located. At 11:35 AM, LPN MDS-M stated R1 did not have a fall care plan on file. LPN MDS-M stated the RN supervisor helps the floor nurse with the baseline care plan. LPN MDS-M stated the MDS nurse, when completing the Fall CAA, should have caught R1 did not have a fall care plan. In an interview on 6/4/2024 at 2:21 PM, DON-B stated an RN is always called in to assess a resident after a fall. Surveyor reviewed the staff schedule for 4/22/2024 and an RN was listed as being on the second shift at the time of R1's fall. DON-B stated the RN on the schedule was an agency RN and the agency staff do not always chart even though they are instructed to do so. DON-B stated the RN should have charted an assessment and agreed no documentation was found indicating R1 was assessed by an RN after the fall. On 6/4/2024 at 2:36 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and DON-B R1 was assessed on admission to be at risk for falls per the Fall Risk Assessment and no Falls Care Plan was initiated on the baseline care plan. R1 triggered the Fall CAA on the Admission MDS, and no Fall Care Plan was initiated at any time while R1 was a resident at the facility by either the nurse unit manager, supervisor, or MDS nurse. Surveyor shared the concern when R1 fell on [DATE], R1 was not assessed by an RN at the time of the fall and R1 sustained a right hip fracture requiring hospitalization . At 3:16 PM, NHA-A stated fall care plan interventions include low beds, and all beds are low beds except for ones that have not been swapped out as the building is being renovated so R1 would have had a low bed even without a care plan in place for falls. NHA-A stated each new admission is reviewed to make sure care plans are addressed. NHA-A stated NHA-A looked at the admission checklist for R1 and the Fall Care Plan was checked as being completed. NHA-A agreed R1 did not have a Fall Care Plan in place at any time while a resident of the facility. On 6/5/2024 at 9:37 AM, Surveyor interviewed LPN-N. LPN-N was the nurse that admitted R1 to the facility on [DATE]. Surveyor asked LPN-N what the process was for a newly admitted resident. LPN-N stated the electronic charting system generates all the admission forms that need to be completed including the Admission Data Collection and Baseline Care Plan Tool. Surveyor asked LPN-N if that tool is what creates the baseline care plan with interventions. LPN-N was not sure. Surveyor showed LPN-N R1's Admission Data Collection and Baseline Care Plan Tool that LPN-N had completed with the possible fall interventions not selected. LPN-N stated LPN-N does not do anything with care plans per facility policy because LPN-N is an LPN. Surveyor shared with LPN-N R1 did not have a Fall Care Plan in place even after being assessed at risk for falls. LPN-N was not aware R1 did not have a Fall Care Plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 6/5/2024 at 10:05 AM, Surveyor asked CNA-O what CNA-O could recall of R1's fall on 4/22/2024. CNA-O stated CNA-O had put R1 to bed and then R1 was on the floor after hearing yelling coming from R1's room. CNA-O did not know how R1 fell . CNA-O stated R1 had a bruise and was bleeding from the arm. CNA-O stated nothing else was wrong or injured. CNA-O stated an LPN and one other nurse came to look at R1. Then R1 was put back in bed using a Hoyer lift. CNA-O stated R1 did not complain of any pain and remembered the nurse moving R1's legs without any difficulty. CNA-O stated when R1 was put back in the bed, they put pillows on the side to protect R1 from falling again. No additional information was provided as to why R1 was assessed to be a high risk for falls and no care plan was developed to address the fall risk. On 4/22/2024, R1 fell from bed and sustained a fracture to the right hip. 38829 Surveyor reviewed the facility's policy and procedure last reviewed 4/23 and notes the following in regards to falls: .Policy: Each Resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a Resident's fall risk. a. The risk assessment categorizes Residents according to low, moderate, or high risk. b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. 2. Upon admission the nurse will complete a fall risk assessment along with the admission assessment to determine the Resident's level of fall risk. 3. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of Resident falling, including but not limited: i. A clear pathway to the bathroom and bedroom doors ii. Bed is locked and lowered to a level that allows the Resident's feet to be flat on the floor when the Resident is sitting on the edge of the bed. iii. Call light and frequently used items are within reach. iv. Adequate lighting. v. Wheelchairs and assistive devices are within reach b. Implement routine rounding schedule. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c. Monitor for changes in Resident's cognition, gait, ability to rise/sit and balance. d. Encourage Residents to wear shoes or slippers with non-slip soles when ambulating. e. Ensure eye glasses, if applicable, are clean and the Resident wears them when ambulating. f. Monitor vital signs in accordance with facility policy. g. Complete a fall risk assessment every 90 days and as indicated when the Resident's condition changes. 4. High Risk Protocols: a. The Resident will be placed on the facility's Fall Prevention Program. i. Indicate fall risk on care plan b. Implement interventions from Low/Moderate Risk Protocols c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. d. Provide additional interventions as directed by the Resident's assessment, including but not limited to: i. Assistive devices ii. Increased frequency of rounds iii. Sitter, if indicated iv. Medication regimen review v. Low bed vi. Alternate call system access vii. Scheduled ambulation or toileting assistance viii. Family/caregiver or Resident education ix. Therapy services referral 5. When a Resident who does not have a history of falling experiences a fall, the Resident will be placed on the Facility's Fall Prevention Program. 6. Each Resident's risk factors and environmental hazards will be evaluated when developing the Resident's comprehensive plan of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525588	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Manor	4545 N 92nd St Milwaukee, WI 53225

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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 0689 Level of Harm - Actual harm Residents Affected - Few	a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 7. When any Resident experiences a fall, the facility will: a. Assess the Resident b. Complete a post-fall assessment c. Complete an incident report d. Notify physician and family e. Review the Resident's care plan and update as indicated f. Document all assessments and actions g. Obtain witness statements in the case of injury 2) R3 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, Dementia with Psychotic Disturbance, Generalized Anxiety Disorder, Essential Hypertension, Type 2 Diabetes, Pulmonary Fibrosis, and Type 2 Diabetes Mellitus. R3 has a legal guardian. R3's Quarterly Minimum Data Set(MDS) dated [DATE] documents that R3's Brief Interview for Mental Status(BIMS) could not be assessed as well as the Patient Health Questionnaire(PHQ-9). R3's delusions and hallucinations are not documented. R3's MDS documents that R3 has physical and verbal symptoms which occurred 1-3 days, wandering 1-3 days, and rejection of care 4-6 days during the assessment period. R3 has no range of motion issues. R3 utilizes a walker and wheelchair. The MDS also documents that R3 requires supervision for upper and lower dressing and chair/bed-to-chair transfer. R3 is independent with mobility and transfers. Surveyor reviewed R3's Kardex as of 6/3/24 only documents to ensure R3 has unobstructed path to the bathroom. The following care plans related to falls for R3 are in place: Problem 1. R3 is at risk for falls due to bladder and bowel incontinence, cognitive impairment, anxiety, medication regimen. -12/16/23 Unwitnessed Fall with injury Date Initiated: 09/25/2022 Revision on: 12/18/2023 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interventions in place o Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 09/25/2022 o Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 09/25/2022 o Ensure that the resident is wearing appropriate footwear Date Initiated: 09/25/2022 o Follow facility fall protocol. Date Initiated: 09/25/2022 Problem 2. R3 has impaired physical mobility due to right intertrochanteric fracture, status post trochanteric nailing. Also has Alzheimer's dementia, Cardiac conditions, Anxiety and Osteoarthritis. Date Initiated: 09/25/2022 Revision on: 04/02/2024 Interventions in place o The resident is WEIGHT-BEARING Date Initiated: o LOCOMOTION: The resident uses wheelchair for locomotion. Assist as needed. Date Initiated: 12/27/2023 o PT, OT referrals as ordered, PRN. Date Initiated: 09/25/2022 Surveyor notes that no new interventions were put in place after the 12/16/23 unwitnessed fall resulting in a right intertrochanteric fracture. R3's fall assessment dated [DATE] documents a score of 18, which indicates that R3 is high risk for falls. Surveyor reviewed an investigation dated 12/16/23 which documents R3 was found at 3:30 PM by a certified nursing assistant(CNA) laying on left side, screaming of pain pointed to right hip. Reluctant to move or wiggle right foot due to pain. Observed R3's right foot wearing left shoe and left foot wearing right shoe. Floor notes no debris, dry, small bag full of own personal things on floor next to R3. R3 was transported to the emergency room for evaluation. Surveyor notes that both physician and guardian were notified. Surveyor notes the investigation of R3's unwitnessed fall does not document a head to toe assessment, staff statements, and a root cause analysis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor reviewed R3's hospital discharge summary dated 12/20/23 which documents that R3 had a right intertrochanteric femur fracture status post insertion of trochanteric femoral nail. On 6/3/24 at 11:33 AM, Surveyor observed R3 in normal height bed sleeping. R3's call light was hanging down at the end of the bed not within reach of R3. On 6/3/24 at 1:47 PM, Surveyor again observed R3 in normal height bed sleeping, in same position as the morning. R3's call light was hanging down at the end of the bed not within reach of R3. On 6/5/24 at 10:05 AM, Surveyor observed R3 in normal height bed sleeping. R3's call light is on the floor in the corner of the room, far from head of bed where R3 was located. On 6/4/24 at 2:47 PM, Director of Nursing(DON-B) stated that there should be staff statements attached to the incident fall report. Statements should include last seen, last toileted, type of footwear, interventions in place etc. DON-B stated the statements should be very detailed. The interdisciplinary team(IDT) meets the next day to review the Resident falls. DON-B stated that routine rounding is defined as every 2-3 hours staff should be checking on Resident at a minimum by eyesight. Surveyor reviewed that R3's fall incident report did not have staff statements with the above details, and no documentation of an IDT meeting to discuss the root cause analysis of R3's fall. Surveyor also shared there have been new interventions since the fall which resulted in a fracture. Surveyor pointed out per policy, and based on R3's fall assessment indicating R3 is high risk for falls, R3 should be in a low bed. Nursing Home Administrator(NHA-A) explained the facility is in the process of changing all Resident beds to have the capability of being a low bed, however, NHA-A informed Surveyor that R3's unit has not been done yet. Surveyor shared the concern about R3's fall, no statements with details, no physical assessment, no care plan interventions updated, and no root cause analysis. NHA-A stated, Your aren't telling us anything we don't know already. No additional information was provided as to why the facility did not ensure that R3's fall on 12/16/23 was thoroughly investigated as to the root cause and why no care plan interventions were implemented to prevent future falls.