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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Luther Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review, the facility did not ensure that a written consent explaining the risks and benefits of psychotropic medications was obtained for 1 of 1 Residents reviewed (R58). * R58 was prescribed Seroquel, 12.5 mg (milligrams) 2 times daily, an antipsychotic medication for agitation related to Delusional Disorder diagnosis on 9/27/24. On 10/8/24, Seroquel was increased to 12.5 mg 3 times daily. The facility did not have a written, signed consent explaining the risks and benefits of Seroquel by R58's activated power of attorney (POA). Findings Include: 1.) R58 was admitted to the facility on [DATE] with diagnoses of Depression, Fracture of Left Femur, Unspecified Severe Protein-Calorie Malnutrition, Polyneuropathy, and Anemia. R58 currently has an activated Health Care Power of Attorney(HCPOA). Surveyor noted the facility was not able to provide Surveyor with documentation of the competency evaluation for R58 that determined R58 was no longer able to make health care decisions for herself. It appears activation of the HCPOA may have occurred 9/27/24, however, there are 3 different activation forms with different activation dates. The facility was not able to clarify the activation date to Surveyor at time of survey. R58's Admission Minimum Data Set (MDS) dated [DATE] documents R58's Brief Interview for Mental Status(BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's Admission MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 is requiring partial/moderate assistance with mobility and transfers. R58 has not been assessed for a new MDS assessment since admission. On 8/9/24, R58 was evaluated by Psychologist (Psych)-D who diagnosed R58 with Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent, Moderate. On 9/27/24, Psych-D documents a diagnosis of Psychotic Disorder with Delusions for R58 after a regular psychology visit. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24, Psychiatrist (Psych)-E agreed with the Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent Diagnoses and added Generalized Anxiety Disorder and Unspecified Dementia, Unspecified Severity with Mood Disturbance as a diagnosis. R58's physician orders document that R58 was prescribed Seroquel 12.5 mg tablet two times a day with a start date of 9/27/24. On 10/8/24 R58's Seroquel was increased to 12.5 mg three times a day and remains currently at that dose. Surveyor reviewed R58's electronic health record (EHR) and could not locate a written consent for the reason for the antipsychotic medication, alternative modes of treatment, the risks of taking the medication and the benefit of taking the medication. On 10/30/24, Surveyor requested documentation for signed consent of R58's Seroquel from Nursing Home Administrator (NHA)-A. On 10/30/24 at 3:07 PM, Surveyor shared the concern with NHA-A, that there is no documentation that R58's consent for Seroquel which includes the reason for the antipsychotic medication, alternative modes of treatment, the risks of taking the medication and the benefit of taking the medication. NHA-A stated the facility will look for R58's signed consent. On 10/31/24 at 11:36 AM, Medical Records (MR)-I was interviewed by Surveyor. MR-I confirmed that MR-I is responsible for making sure consents are signed either by the Resident or responsible party. MR-I stated the nurse reviews the medication and gets the signature either at admission or when a new medication is prescribed that requires consent. MR-I informed Surveyor that MR-I spoke to R58's activated HCPOA this morning and R58's activated HCPOA had further questions but gave verbal consent for the Seroquel. MR-I stated 're-training' needs to be completed. On 10/31/24 at 12:04 PM, MR-I informed Surveyor that MR-I was further able to answer R58's activated HCPOA questions and gave verbal consent for the Seroquel and will come in to the facility and sign the consent. Surveyor shared the concern that the consent for the Seroquel should have been obtained back on 9/27/24, when the Seroquel was first prescribed to R58. MR-I agreed the consent should have been obtained and signed. On 10/31/24 at 1:58 PM, Surveyor reviewed the concern with NHA-A that R58's Seroquel consent had not been obtained when first prescribed on 9/27/24. NHA-A acknowledged the concern and has no additional information. NHA-A informed Surveyor there is no facility policy and procedure for obtaining consents for required medications. No additional information was provided as to why the facility did not ensure that R58 had written consent explaining the risks and benefits of psychotropic medications that were prescribed.

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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	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 UNCORRECTED ON VERIFICATION VISIT Based on record review and staff interviews, the facility did not ensure that 3 allegations of abuse involving 2 residents (R2 and R58) and 1 Resident to Resident (R3 and R4) altercation were reported to the State Survey Agency within the required reporting timeframe . * R2's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting a bruise of unknown origin was submitted to the State Survey Agency on 9/3/24. The Misconduct Incident Report was not submitted to the State Survey Agency until 10/16/24. * R58's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting an allegation of rape was submitted to the State Survey Agency on 9/26/24. The Misconduct Incident Report was not submitted to the State Survey Agency until 10/16/24. On 10/15/24, R58 called the police alleging an assault had taken place over the weekend. The facility did not submit an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report and a Misconduct Incident Report to the State Survey Agency. * An Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting Resident to Resident abuse involving R3 and R4 was submitted to the State Survey Agency on 9/19/24. The Misconduct Incident Report was not submitted to the State Survey Agency until 10/29/24. Findings Include: The facility Policy titled Alleged Incidents of Abuse, Neglect, Exploitation and Mistreatment-Reporting and Investigation revised 2/2020, documents: .Purpose -Facility will prohibit and prevent abuse, neglect, exploitation, mistreatment, injuries of unknown sources and resident to resident altercations. -Facility is in compliance with the reporting and investigation guidelines specific to each program area governed by the 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Division of Quality Assurance (DQA)/Office of Caregiver Quality (OCQ) as soon as possible, but not to exceed 24 hours from the discovery. Guidelines 1. Protect the Resident a. The safety of the resident(s) is the first priority. The resident(s) must be protected from possible subsequent injury or incidents of misconduct. b. After ensuring the safety of the resident(s), all employees are to immediately report any alleged incidents of abuse, neglect, and mistreatment to the Supervisor to ensure that appropriate notification and a timely investigation are initiated. c. The Supervisor immediately assesses the resident's personal safety and potential of harm to other residents. d. The Director of Nursing/Director of Resident and Patient Services and/or designee is to be contacted immediately for all allegations of caregiver misconduct or Resident-to-Resident abuse. The Administrator/CCO will be notified immediately . 1.) R2 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Essential Hypertension, Paroxysmal Atrial Fibrillation, and Depression. R2 has an activated Health Care Power of Attorney(HCPOA). R2's Quarterly Minimum Data Set (MDS) completed 10/4/24 does not assess R2's cognitive status. R2's MDS documents R2 has no range of motion impairment, R2 requires substantial/maximum assistance for showers, upper body dressing, and mobility. R2 is dependent for transfers, lower body dressing, and sit to stand. R2 is independent with eating. On 7/5/24, R2 had a significant change MDS completed which documents R2's Brief Interview for Mental Status(BIMS) score to be 15, indicating R2 was cognitively intact for daily decision making at that time. R2's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting a bruise of unknown origin was submitted to the State Survey Agency on 9/3/24. On 9/4/24, R2's nurse practitioner diagnosed R2 with cellulitis to the right eye and started her on an antibiotic. The facility determined this was the cause of the discoloration to the right eye. However, the facility did not submit the Misconduct Incident Report to the State Survey Agency until 10/16/24 with a summary explaining the quick conclusion to the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 2:45 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R2's Misconduct Incident Report to the State Survey Agency was not submitted until 10/16/24. NHA-A stated this report was during the transition time of the former Director of Nursing (DON) no longer being an employee at the facility. Surveyor shared that the investigation was over a month late. NHA-A agreed R2's Misconduct Incident Report to the State Survey Agency was late. The facility provided no additional information as to why the report was not submitted until 10/16/24. 2.) R58's Admission Minimum Data Set (MDS) completed on 7/22/24 documents R58's Brief Interview for Mental Status (BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 is requiring partial/moderate assistance with mobility and transfers. R58's MDS also documents that R58 is to be discharged to the community, a referral has been made, and R58 has a discharge plan. R58 has not been assessed for a new MDS since admission. R58's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting an allegation of rape was submitted to the State Survey Agency on 9/26/24. The Misconduct Incident Report was not submitted to the State Survey Agency until 10/16/24. On 10/15/24, R58 called the police alleging an assault had taken place over the weekend. The facility did not submit an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report to the State Survey Agency and did not submit a Misconduct Incident Report. On 10/15/2024, in R58's electronic medical record (EMR) it is documented that R58 contacted the police and reported that R58 was assaulted over the weekend and that management has been made aware. On 10/29/24 at 2:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regard to R58's allegations. NHA-A stated these allegations occurred during transition time. NHA-A stated Department of Human Services (DHS) called and informed NHA-A that a complete investigation had not been received. NHA-A stated NHA-A had to complete an investigation all over again. NHA-A wanted to send a complete investigation in. NHA-A was unaware of R58 calling the police and alleging an assault on 10/15/24. NHA-A believes NHA-A may have triggered R58 when questioning and then R58 called the police. Surveyor shared the concern of the 9/26/24 allegation of rape Misconduct Incident Report not being submitted to the State Survey Agency within the required timeframe. Surveyor also shared the concern that R58's allegation of assault on 10/15/24 did not get reported to the State Survey Agency. On 10/30/24 at 3:07 PM, Surveyor shared the concern again with the facility reporting R58's allegations of rape and assault within the required reporting timeframes. NHA-A responded, We always screw up self reports. No additional information has been provided by the facility at this time in regard to R58's self reports being submitted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) R3 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Severe, with Other Behavioral Disturbance, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Unspecified Atrial Fibrillation, and Unspecified Protein-Calorie Malnutrition. R3 has an activated Health Care Power of Attorney(HCPOA). R3's Quarterly Minimum Data Set (MDS) completed 8/14/24 documents R3's BIMS score to be 0, indicating R3 is severely cognitively impaired for daily decision making. R3 has no behaviors. R3 has range of motion impairment on one side of upper and no impairment on lower. R3 needs supervision for eating. R3 is dependent for showers, upper and lower dressing, mobility, and transfers. R4 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Unspecified Severity, with Mood Disturbance, Anxiety Disorder, Type 2 Diabetes Mellitus, and Chronic Kidney Disease. R4 has an activated HCPOA. R4's Quarterly MDS completed 10/4/24 documents R4's BIMS score is 3, indicating R4 is severely impaired for daily decision making. R4's MDS documents that R4 has had physical behaviors for 1-3 days and verbal behaviors for 4-6 days. R4 has no range of motion impairment. R4 is independent with eating. R4's MDS documents that R4 requires substantial/maximum assistance for showers and mobility. R4 requires partial/moderate for upper body dressing. R4 is dependent for lower body dressing, transfers, and sit to stand. R3 and R4's Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report documenting a Resident to Resident altercation where R4 wheeled up and punched R3 in the face on the right side and started cursing at R4 was submitted to the State Survey Agency on 9/26/24. The Misconduct Incident Report was not submitted to the State Survey Agency until 10/29/24. On 10/29/24 at 2:45 PM, Nursing Home Administrator (NHA)-A informed Surveyor that NHA-A did not know the Misconduct Incident Report was not submitted to the State Survey Agency for R3 and R4's Resident to Resident Altercation. NHA-A understands the concern that Surveyor communicated that R3 and R4's Resident to Resident altercation Misconduct Incident Report was not submitted to the State Survey Agency until 10/29/24. No additional information was provided by the facility.

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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

UNCORRECTED ON VERIFICATION VISIT

Based on record review and staff interview, the facility did not ensure all allegations involving potential abuse (R58) and Resident to Resident altercation (R3 and R4) were thoroughly investigated for 3 of 3 reviewed self reports.

* R58's Facility Reported Incident (FRI) dated 9/12/24 documents an allegation of R58 being raped along with R58 sustaining blunt force trauma to the chest. The FRI does not contain other resident statements, all staff statements, or a root cause analysis of the circumstances of the allegation. The FRI does not contain an investigation of the blunt force trauma.

Facility Reported Incident (FRI) dated 10/16/24 documents an allegation of R58 being raped by a male caregiver. The FRI does not contain other resident statements, all staff statements, or a root cause analysis of the circumstances of the allegation.

On 10/15/24, R58 called the police alleging an assault had taken place over the weekend. The facility did not submit an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report and a Misconduct Incident Report to the State Survey Agency. Consequently, the facility did not complete a thorough investigation of this allegation.

* R3 and R4's Facility Reported Incident (FRI) dated 10/29/24 documents an allegation of R4 wheeling up and punching R3 on the right side of the face and cursing at R3. The FRI does not contain other resident statements, all staff statements, the reasoning for why the local law enforcement was not notified, or a root cause analysis of the circumstances of the allegation. Staff statements were not obtained prior to the incident to evaluate both R3 and R4's pattern of behavior/agitation prior to Resident to Resident altercation.

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 a thorough investigation: Thorough investigation and corrective action ensures that the safety of the Resident has not been jeopardized.

Purpose

-Facility is in compliance with the reporting and investigation guidelines specific to each program area governed by the Division of Quality Assurance (DQA)/Office of Caregiver Quality (OCQ)

-Thorough investigation and corrective action ensures that the safety of the Resident has not been jeopardized.

-Corrective action will be taken when appropriate.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. e. If Resident to Resident abuse has occurred, Social Services will work with Residents and their responsible parties to determine if relocation/other interventions are needed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.) R58's Admission Minimum Data Set (MDS) completed on 7/22/24 documents R58's Brief Interview for Mental Status (BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 requires partial/moderate assistance with mobility and transfers. R58's MDS also documents that R58 is to be discharged to the community, a referral has been made, and R58 has a discharge plan. R58 has not been assessed for a new MDS since admission. Surveyor reviewed the Misconduct Incident Report submitted to the State Survey Agency dated 9/12/24. On 9/3/24, R58 voiced an allegation of being raped and punched in the chest. The facility did not obtain all staff statements. The facility did not obtain any resident statements to determine if there was a pattern. R58's emergency room documentation dated 9/4/24 documents a diagnosis of blunt force trauma. The facility's Misconduct Incident Report summary does not document a thorough investigation of the R58's diagnosis of blunt force trauma was completed. Surveyor reviewed the Misconduct Incident Report submitted to the State Survey Agency dated 10/16/24. On 9/26/24, R58 made an allegation that R58 had been raped by a male caregiver. The FRI does not contain other resident statements, all staff statements, or a root cause analysis of the circumstances of the allegation. On 10/15/2024, it is documented in R58's electronic medical record (EMR) that R58 contacted the police department and stated R58 was assaulted over the weekend. Management has been made aware. On 10/15/24, R58 called the police alleging an assault had taken place over the weekend. The facility did not submit an Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report and a Misconduct Incident Report to the State Survey Agency. The facility did not complete a thorough investigation of this allegation. On 10/29/24 at 2:45 PM, Surveyor shared the concern that thorough investigations had not been completed with R58's allegations. Nursing Home Administrator (NHA)-A was not aware of R58's allegation of assault on 10/15/24. NHA-A stated maybe NHA-A triggered R58 to say that when NHA-A had questioned R58 about the 9/26/24 allegation of being raped by a male caregiver. On 10/30/24 at 3:07 PM, Surveyor shared the concern again with NHA-A that a thorough investigation has not been completed in regards to R58's allegations. NHA-A agreed and stated that NHA-A did not like how the investigation was completed. No further information was provided by the facility at this time. 2.) R3 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Severe, with Other Behavioral Disturbance, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Unspecified Atrial Fibrillation, and Unspecified Protein-Calorie Malnutrition. R3 has an activated Health Care Power of Attorney (HCPOA). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Quarterly Minimum Data Set (MDS) completed 8/14/24 documents R3's Brief Interview for Mental Status (BIMS) score to be 0, indicating R3 is severely cognitively impaired for daily decision making. R3 has no behaviors. R3 has range of motion impairment on one side of upper and no impairment on lower. R3 needs supervision for eating. R3 is dependent for showers, upper and lower dressing, mobility, and transfers. R4 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia, Unspecified Severity, with Mood Disturbance, Anxiety Disorder, Type 2 Diabetes Mellitus, and Chronic Kidney Disease. R4 has an activated HCPOA. R4's Quarterly MDS completed 10/4/24 documents R4's BIMS score to be a 3, indicating R4 is severely impaired for daily decision making. R4's MDS documents that R4 has had physical behaviors for 1-3 days and verbal behaviors for 4-6 days. R4 has no range of motion impairment. R4 is independent with eating. R4's MDS documents that R4 requires substantial/maximum assistance for showers and mobility. R4 requires partial/moderate for upper body dressing. R4 is dependent for lower body dressing, transfers, and sit to stand. On 9/18/24, R4 wheeled up to R3 and punched R3 on the right side of the face and started cursing at R3 in the dining room while both were waiting for dinner. A staff statement documented that R4 did not like how loud R3 had been during the day. The facility did not obtain staff statements from the day shift to establish a pattern of behavior or possible increased agitation from either R4 or R3. The facility did not obtain any resident statements and the facility did not notify the police of the Resident to Resident altercation. The facility did not complete a Misconduct Incident Report until 10/29/24, when Surveyor brought it to the facility's attention. The Misconduct Incident Report does not include a thorough investigation of the Resident to Resident altercation. On 10/29/24 at 2:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regard to R3 and R4's Resident to Resident altercation. NHA-A informed Surveyor that NHA-A was not aware that a Misconduct Incident Report had not been submitted. NHA-A stated the former Director of Nursing made that decision. NHA-A stated that R3 can be vocal and stated that R3's Broda chair is up higher than R4 in the wheelchair and does not think R4 could have caused any injury to R3. NHA-A did inform Surveyor that R4 hit R3 with an open hand. On 10/30/24 at 3:07 PM, Surveyor shared the concern with NHA-A that R3 and R4's Resident to Resident altercation was not thoroughly investigated. Surveyor asked NHA-A why the police had not been notified. NHA-A stated, That's a good question. NHA-A understands the concern of the facility not completing a thorough investigation and provided no further information at this time. No additional information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Luther Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on record review and interview, the facility did not incorporate the recommendations from the Preadmission Screen and Resident Review (PASARR) Level 2 determination and evaluation report into a Resident's assessment, care planning, and transitions of care for 1 (R58) of 1 Resident reviewed with PASARR level 2 recommendations. *R58's PASARR dated 10//21/24 determination states R58 requires specialized psychiatric rehabilitation services to address R58's mental illness. Findings Include: The facility's policy Resident Assessment-Coordination with PASARR Program dated 10/22/21 documents: Policy: This facility coordinates assessments with the preadmission screening and resident review(ASA) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level 1-Initial pre-screening that is completed prior to admission i. Negative Level 1 Screen-permits admission to proceed with and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level 1 Screen-necessitates PASARR Level 11 evaluation prior to admission b. PASARR Level 11-a comprehensive evaluation by the appropriate state-designated authority that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 5. If a Resident who not screened due to an exception above and the Resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level 1 screening process and refer to any Resident who has or may have MD, ID, or a related condition to the appropriate state-designated authority for Level 11 PASARR evaluation and determination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The Level 11 Resident review must be completed within 40 days of admission. 6. The Social Services shall be responsible for keeping track of each Resident's PASARR screening status, and referring to the appropriate authority. 7. Recommendations, such as any specialized services, from a PASARR level 11 determination and/or PASARR evaluation report will be incorporate into the Resident's assessment, care planning, and transitions of care. 1.) R58 was admitted to the facility on [DATE] with diagnoses of Depression, Fracture of Left Femur, Unspecified Severe Protein-Calorie Malnutrition, Polyneuropathy, and Anemia. R58 currently has an activated Health Care Power of Attorney(HCPOA). Surveyor notes the facility was not able to provide Surveyor with documentation of the competency evaluation of R58 that determined R58 was no longer able to make health care decisions for herself. It appears activation of the HCPOA may have occurred 9/27/24, however, there is 3 different activation forms with different activation dates. The facility was not able to clarify the activation date to Surveyor at time of survey. R58's Admission Minimum Data Set(MDS) completed on 7/22/24 documents R58's Brief Interview for Mental Status(BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 is requiring partial/moderate assistance with mobility and transfers. R58 has not been assessed for a new MDS since admission. On 8/9/24, R58 was evaluated by Psychologist (Psych)-D who diagnosed R58 with Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent, Moderate. On 9/27/24, Psych-D documents a diagnosis of Psychotic Disorder with Delusions for R58 after a regular psychology visit. On 10/1/24, Psychiatrist (Psych)-E agreed with the Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent Diagnoses and added Generalized Anxiety Disorder and Unspecified Dementia, Unspecified Severity with Mood Disturbance as a diagnosis. R58's current physician orders documents R58 is prescribed: -Buspar 9/24/24 -Duloxetine 7/16/24 -Remeron 10/22/24 -Seroquel 10/8/24 R58's original Level 1 PASARR screen dated 7/15/24 documents R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. R58's Level 1 PASARR screen documents R58 is only expected to be at the facility 30 days or less. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new Level 1 PASARR screen was re-submitted on 10/16/24 documenting R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. On 10/21/24, it was determined that R58 requires services called 'specialized psychiatric rehabilitation services' for R58's mental illness. R58's Level 11 PASARR Evaluation Summary dated 10/21/24 documents: .R58 was referred due to R58's diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Adjustment Disorder with Depressed Mood, Delusional Disorder, and Adjustment Disorder with Mixed Disturbance of Emotions. R58 currently receives Buspar, Duloxetine, Remeron, Seroquel and Gabapentin for Neuropathy. R58 is in need of specialized psychiatric rehabilitation services(SPRS). The focus of SPRS is to maintain or improve current level of functioning. SPRS should include a thorough assessment of this individual's unique capabilities, psychiatric symptoms, and behaviors, if any, by a Qualified Mental Health Professional(QMHP). -frequently refuses care -displays paranoid and accusatory behavior towards others -frequent yelling out, threatening behavior noted -consulting psychiatrist completing medication review notes that: SNRI clinicians to monitor for worsening depression and suicidal ideation; Gabepetin history has been reportedly associated with rare cases of depression and suicidal ideation. R58 may benefit from group therapy, 1:1 talk therapy, medication management, coping skill/problem solving techniques, behavioral management, and therapy for building self esteem. R58's comprehensive care plan is noted not to be person-centered and does not incorporate the need for specialized psychiatric rehabilitation services with person-centered interventions. All interventions except for one were implemented prior to the determination on 10/21/24 that R58 required specialized psychiatric rehabilitation services. R58's care plan documents with interventions: -Alteration in mood evidenced by intermittent episodes of anxious demeanor/verbalizations 8/1/24 No interventions have been updated since 10/22/24 -Resident has behavior problem due making untrue accusations of harm/abuse 9/5/24 No interventions have been updated since 9/5/24 -R58 experiences loneliness and/or isolation 9/6/24 No interventions have been updated since 9/6/24 -R58 is resistive to care bedside cares due to adjustment to nursing home 9/6/24 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No interventions have been updated since 9/18/24 -R58 is at risk for signs/symptoms of resident relocation stress syndrome 9/25/24 No interventions have been updated since 9/25/24 -R58 has potential to be verbally aggressive due to ineffective coping skills, mental/emotional illness 10/15/24 No interventions have been updated since 10/15/24 -Potential for anxiety due to traumatic life event due to sexual assault 10/15/24 No interventions have been updated since 10/18/24 Surveyor notes there have been no updated person centered interventions for R58 since 9/5/24. Surveyor notes that R58's comprehensive care plan is concentrated on R58's behaviors and what is perceived as R58's negative responses to facility interventions. The facility has not examined why R58 may be responding to triggering situations or boundaries in what the facility perceives as 'behaviors', thus the facility has not facilitated R58 to increase self independence physically and emotionally or promote physical and emotional health overall. On 10/30/24, at 10:26 AM, Surveyor interviewed Social Worker (SW)-C in regards to R58's Level 11 PASARR determination for the need for specialized psychiatric rehabilitation services. SW-C informed Surveyor that Psychologist (Psych)-D would continue to see R58 for the next 30 days. SW-C is not aware of any other services that are being provided to R58. SW-C confirmed that SW-C is not a QMHP. SW-C also confirmed that the IDT has not worked together to develop a person-centered care plan to include the need for specialized psychiatric rehabilitation services. On 10/30/24, at 11:20 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G who cares for R58 on a regular basis. LPN-G informed Surveyor that LPN-G is not aware that R58 requires specialized psychiatric rehabilitation services and has not been oriented to person-centered interventions to help decrease and approach R58's behaviors. On 10/30/24, at 12:45 PM, Surveyor interviewed Psych-D. Psych-D stated that R58's behavior has deteriorated since being admitted to the facility. R58 is very angry, anxious, and depressed. R58 has had limited episodes of delusions and paranoia. Psych-D was notified about a week ago that R58 required specialized psychiatric rehabilitation services, however, the plan was for Psych-D to see R58 on a weekly basis for 4 weeks at a time. Psych-D stated Psych-D was already treating R58 and stated nothing will change for treatment for R58. Psych-D also informed Surveyor that Psych-D has not been asked to be a part of any IDT discussion of R58's need for specialized psychiatric rehabilitation services. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24, at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R58's Level 11 PASARR determination found R58 requires specialized psychiatric rehabilitation services. Surveyor shared there is no documentation that specialized psychiatric rehabilitation services has been developed and implemented through R58's assessment, care planning, and transitions of care. NHA-A stated NHA-A is not familiar with specialized psychiatric rehabilitation services and questioned if the facility could provide specialized psychiatric rehabilitation services. NHA-A understands the concern and has no further information at this time. On 10/31/24, at 1:20 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J. CNA-J does not know what specialized psychiatric rehabilitation services and how it relates to R58. CNA-J stated it would be good to have an IDT meeting to discuss R58's behaviors and how to approach R58. CNA-J stated R58 is not motivated to do anything at this time. On 10/31/24, at 2:57 PM, Surveyor interviewed Psychiatrist (Psych)-E. Psych-E confirmed Psych-E has evaluated R58 for medication review. Psych-E was not notified that R58 requires and would benefit from specialized psychiatric rehabilitation services. On 10/31/24, LPN-F informed Surveyor of the following: I wish R58 would get a mental health evaluation and treatment. I wish R58 would get help. The facility assessment reviewed 6/13/24 documents that the facility is capable of caring for Residents with Major Depressive Disorder, Single Episode. Of all the Residents, 56% have a psychiatric diagnosis. Psychology services are provided. Quarterly IDT behavior management meetings are held to discuss both non-pharmacological and pharmacological interventions to assist with achieving the Resident's highest practical mental well being. The facility has a comprehensive process to assess Resident needs. The facility utilizes a comprehensive admission, readmission, and required assessment process in which the IDT identifies individualized Resident care needs. On 10/30/24, at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R58's Level 1 PASARR screen which documented R58 was admitted to the facility on a 30 day exemption should have re-submitted no later that 8/25/24. Surveyor shared that a new Level 1 PASARR screen for R58 was not submitted until 10/16/24, which determined that R58 requires specialized psychiatric rehabilitation services. NHA-A understood the concern. No additional information was provided.

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Luther Manor	4545 N 92nd St Milwaukee, WI 53225

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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** 38829 Based on interview and record review, the facility did not complete a Preadmission Screening and Resident Review (PASARR) for individuals with a mental disorder for 1 (R58) of 1 residents reviewed for PASARR screening. * R58 was admitted on [DATE] and the Level I PASARR was completed indicating R58 would be in the skilled nursing facility for less than 30 days. R58 is currently a Resident in the facility. A Level I PASARR was not resubmitted/updated indicating R58 was going to be at the facility longer than the 30 exemption period triggering a Level II PASARR to be completed until 10/16/24. On 10/21/24, it was determined that R58 requires services called 'specialized psychiatric rehabilitation services' for R58's mental illness. Findings include: The facility's policy Resident Assessment-Coordination with PASARR Program dated 10/22/21 documents: Policy: This facility coordinates assessments with the preadmission screening and resident review(ASA) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level 1-Initial pre-screening that is completed prior to admission i. Negative Level 1 Screen-permits admission to proceed with and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level 1 Screen-necessitates PASARR Level 11 evaluation prior to admission b. PASARR Level 11-a comprehensive evaluation by the appropriate state-designated authority that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 5. If a Resident who not screened due to an exception above and the Resident remains in the facility longer than 30 days: (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The facility must screen the individual using the State's Level 1 screening process and refer to any Resident who has or may have MD, ID, or a related condition to the appropriate state-designated authority for Level 11 PASARR evaluation and determination. b. The Level 11 Resident review must be completed within 40 days of admission. 6. The Social Services shall be responsible for keeping track of each Resident's PASARR screening status, and referring to the appropriate authority. 7. Recommendations, such as any specialized services, from a PASARR level 11 determination and/or PASARR evaluation report will be incorporate into the Resident's assessment, care planning, and transitions of care. 1.) R58 was admitted to the facility on [DATE] with diagnoses of Depression, Fracture of Left Femur, Unspecified Severe Protein-Calorie Malnutrition, Polyneuropathy, and Anemia. R58 currently has an activated Health Care Power of Attorney(HCPOA). Surveyor notes the facility was not able to provide Surveyor with documentation of the competency evaluation of R58 that determined R58 was no longer able to make health care decisions for herself. It appears activation of the HCPOA may have occurred 9/27/24, however, there is 3 different activation forms with different activation dates. The facility was not able to clarify the activation date to Surveyor at time of survey. R58's Admission Minimum Data Set(MDS) completed on 7/22/24 documents R58's Brief Interview for Mental Status(BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 is requiring partial/moderate assistance with mobility and transfers. R58 has not been assessed for a new MDS since admission. On 8/9/24, R58 was evaluated by Psychologist (Psych)-D who diagnosed R58 with Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent, Moderate. On 9/27/24, Psych-D documents a diagnosis of Psychotic Disorder with Delusions for R58 after a regular psychology visit. On 10/1/24, Psychiatrist (Psych)-E agreed with the Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent Diagnoses and added Generalized Anxiety Disorder and Unspecified Dementia, Unspecified Severity with Mood Disturbance as a diagnosis. R58's current physician orders documents R58 is prescribed: -Buspar 9/24/24 -Duloxetine 7/16/24 -Remeron 10/22/24 -Seroquel 10/8/24 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R58's original Level 1 PASARR screen dated 7/15/24 documents R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. R58's Level 1 PASARR screen documents R58 is only expected to be at the facility 30 days or less. A new Level 1 PASARR screen was re-submitted on 10/16/24 documenting R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. On 10/21/24, it was determined that R58 requires services called 'specialized psychiatric rehabilitation services' for R58's mental illness. On 10/30/24, at 9:29 AM, Surveyor interviewed Admissions Director (AD)-H who confirmed AD-H is responsible for the Level 1 and Level 11 PASARR screens. AD-H explained that the Level 1 PASARR screen is completed at time of admission. Once the results of the screen is forwarded from the state agency, social services is notified of the determination. AD-H was notified by MDS Coordinator (MDS)-O that R58 needed a new Level 1 PASARR screen completed. AD-H stated, R58's Level 1 PASARR screen may have been over the 30 day exemption period. On 10/30/24, at 10:26 AM, Social Worker (SW)-C confirmed that SW-C is alerted of Level 11 PASARR determinations. SW-C stated SW-C believes the breakdown in the process was that R58's HCPOA was being activated. On 10/30/24, at 10:37 AM, Surveyor interviewed MDS-O who stated MDS-O checked the status of R58's Level 1 PASARR screen determination because the Interdisciplinary Team(IDT) was discussing R58's behaviors. I looked to see R58's Level 1 PASARR screen and noticed R58's Level PASARR screen was past the 30 day exemption. I sent AD-H an email right away which was on 10/16/24. On 10/30/24, at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R58's Level 1 PASARR screen which documented R58 was admitted to the facility on a 30 day exemption should have re-submitted no later that 8/25/24. Surveyor shared that a new Level 1 PASARR screen for R58 was not submitted until 10/16/24, which determined that R58 requires specialized psychiatric rehabilitation services. NHA-A understood the concern. No additional information was provided as the facility did not complete a Preadmission Screening and Resident Review (PASARR) for R58.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 UNCORRECTED ON VERIFICATION VISIT Based on interview and record review, the facility did not update the person-centered care plan and ensure the comprehensive care plan was implemented to meet a resident's psychosocial needs for 1 (R58) of 1 resident. * R58's comprehensive care plan has not been updated with person-centered interventions including incorporating Level II PASARR recommendations of requiring 'specialized psychiatric rehabilitation services'. Findings Include: The facility policy titled Comprehensive Care Plans revised 9/23, documents: .Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. The facility policy Care Plan Revisions Upon Status implemented 9/21 documents: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those Residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a Resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a Resident experiences a status change: b. The MDS Coordinator and the the IDT(Interdisciplinary Team) will discuss the Resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the Resident will report Resident response to new or modified interventions. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the Resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all Residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect Resident needs. 1.) R58 was admitted to the facility on [DATE] with diagnoses of Depression, Fracture of Left Femur, Unspecified Severe Protein-Calorie Malnutrition, Polyneuropathy, and Anemia. R58 currently has an activated Health Care Power of Attorney (HCPOA). Surveyor notes the facility was not able to provide Surveyor with documentation of the competency evaluation of R58 that determined R58 was no longer able to make health care decisions for herself. It appears activation of the HCPOA may have occurred 9/27/24, however, there are 3 different activation forms with different activation dates. The facility was not able to clarify the activation date to Surveyor at time of survey. R58's Admission Minimum Data Set (MDS) completed on 7/22/24 documents R58's Brief Interview for Mental Status (BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 is requiring partial/moderate assistance with mobility and transfers. R58's MDS also documents that R58 is to be discharged to the community, a referral has been made, and R58 has a discharge plan. R58 has not been assessed for a new MDS since admission. R58's original Level I PASARR screen dated 7/15/24 documents R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. R58's Level I PASARR screen documents R58 is only expected to be at the facility 30 days or less. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new Level I PASARR screen was resubmitted on 10/16/24 documenting R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. On 10/21/24, it was determined that R58 requires services called 'specialized psychiatric rehabilitation services' for R58's mental illness. R58's Level 11 PASARR Evaluation Summary dated 10/21/24 documents: R58 was referred due to R58's diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Adjustment Disorder with Depressed Mood, Delusional Disorder, and Adjustment Disorder with Mixed Disturbance of Emotions. R58 currently receives Buspar, Duloxetine, Remeron, Seroquel and Gabapentin for Neuropathy. R58 is in need of specialized psychiatric rehabilitation services(SPRS). The focus of SPRS is to maintain or improve current level of functioning. SPRS should include a thorough assessment of this individual's unique capabilities, psychiatric symptoms, and behaviors, if any, by a Qualified Mental Health Professional(QMHP). -frequently refuses care -displays paranoid and accusatory behavior towards others -frequent yelling out, threatening behavior noted -consulting psychiatrist completing medication review notes that: SNRI clinicians to monitor for worsening depression and suicidal ideation; Gabapentin history has been reportedly associated with rare cases of depression and suicidal ideation. R58 may benefit from group therapy, 1:1 talk therapy, medication management, coping skill/problem solving techniques, behavioral management, and therapy for building self esteem. R58's comprehensive care plan is noted not to be person-centered and does not incorporate the need for specialized psychiatric rehabilitation services with person-centered interventions. All interventions except for one were implemented prior to the determination on 10/21/24 that R58 required specialized psychiatric rehabilitation services. (Cross Reference F644 and F645) R58's Admission MDS completed 7/22/24 documents that active discharge planning is in the process. R58's comprehensive care plan includes the following documentation: R58 would like to discharge home-Initiated 7/16/24 On 8/1/24, R58's care plan was revised and documented R58 would like to discharge to the most appropriate level of care. Interventions: Encourage R58 to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress. 7/16/24. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluate R58's motivation and ability to safely return to the community 7/16/24 : Evaluate/record R58's abilities and strengths, with family/caregivers/Interdisciplinary Team(IDT). Determine gaps in abilities which affect discharge. Address gaps by making community referral, pre-discharge PT/OT(physical/occupational therapy) or internal referral 7/16/24 Surveyor notes R58's discharge plans have not been updated since 7/16/24 and per documented care plan interventions it has not been updated at a minimum of every quarter. (Cross Reference F660) R58's care plan documents with interventions: -Alteration in mood evidenced by intermittent episodes of anxious demeanor/verbalizations 8/1/24 No interventions have been updated since 10/22/24 -Resident has behavior problem due making untrue accusations of harm/abuse 9/5/24 No interventions have been updated since 9/5/24 -R58 experiences loneliness and/or isolation 9/6/24 No interventions have been updated since 9/6/24 -R58 is resistive to care bedside cares due to adjustment to nursing home 9/6/24 No interventions have been updated since 9/18/24 -R58 is at risk for signs/symptoms of resident relocation stress syndrome 9/25/24 No interventions have been updated since 9/25/24 -R58 has potential to be verbally aggressive due to ineffective coping skills, mental/emotional illness 10/15/24 No interventions have been updated since 10/15/24 -Potential for anxiety due to traumatic life event due to sexual assault 10/15/24 No interventions have been updated since 10/18/24 Surveyor noted there have been no updated person centered interventions for R58 since 9/5/24. Surveyor noted that R58's comprehensive care plan is concentrated on R58's behaviors and what is perceived as R58's negative responses to facility interventions. The facility has not examined why R58 may be responding to triggering situations or boundaries in what the facility perceives as 'behaviors', thus the facility has not facilitated R58 to increase self independence physically and emotionally or promote physical and emotional health overall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 10:26 AM, Surveyor interviewed SW-C. SW-C stated SW-C is responsible for discharge, mood, behavior, cognition, and code status care plans. SW-C confirmed the expectation is to make revisions. On 10/30/24 at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA-A) that R58's comprehensive care plan has not been revised with person-centered interventions to assist R58 in reaching the highest practicable psychosocial well-being, receiving 'specialized psychiatric rehabilitation services', discharge planning, and achieving emotional health. NHA-A understands the concern. No additional information was provided as to why the facility did not update the person-centered care plan and ensure the comprehensive care plan was implemented for R58.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based on interview and record review, the facility did not develop and implement an effective discharge planning process focusing on resident discharge goals, and preparation for transition for 1 (R58) of 1 residents reviewed for discharge planning. * R58 was admitted to the facility on [DATE] with a Left Femur Fracture with the goal to discharge home and/or a lesser restrictive environment. R58 has not had consistent and active discharge planning since admission. Findings Include: The facility's policy Transfer and discharge date d 10/21 documents: .The comprehensive, person-centered care plan shall contain the Resident's goals for admission and desired outcomes and shall be in alignment with the discharge. 1.) R58 was admitted to the facility on [DATE] with diagnoses of Depression, Fracture of Left Femur, Unspecified Severe Protein-Calorie Malnutrition, Polyneuropathy, and Anemia. R58 currently has an activated Health Care Power of Attorney(HCPOA). Surveyor notes the facility was not able to provide Surveyor with documentation of the competency evaluation of R58 that determined R58 was no longer able to make health care decisions for herself. It appears activation of the HCPOA may have occurred 9/27/24, however, there is 3 different activation forms with different activation dates. The facility was not able to clarify the activation date to Surveyor at time of survey. R58's Admission Minimum Data Set(MDS) completed on 7/22/24 documents R58's Brief Interview for Mental Status(BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 is requiring partial/moderate assistance with mobility and transfers. R58's MDS also documents that R58 is to be discharged to the community, a referral has been made, and R58 has a discharge plan. R58 has not been assessed for a new MDS since admission. R58's care plan documents: R58 would like to discharge home-Initiated 7/16/24 On 8/1/24, R58's care plan was revised and documented R58 would like to discharge to the most appropriate level of care. Interventions: Encourage R58 to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress. 7/16/24. Evaluate R58's motivation and ability to safely return to the community 7/16/24 : (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluate/record R58's abilities and strengths, with family/caregivers/Interdisciplinary Team(IDT). Determine gaps in abilities which affect discharge. Address gaps by making community referral, pre-discharge PT/OT(physical/occupational therapy) or internal referral 7/16/24 The following is documented is regards to R58's discharge planning: 7/19/24 Care Conference Note documented by Social Worker (SW)-C: R58's goals are to move back in R58's apartment independently. 7/31/2024 IDT Medicare A Meeting documented by Registered Nurse (RN)-Q: Goal to discharge home with son. Plan B looking into assistive living facility. SW-C documented on 10/9/24 that HCPOA was contacted in regards to goals of care for discharge. On 10/11/2024, SW-C documented that R58 was informed that no assistive living facility appropriate then SW-C will work to find a long term care placement at another facility that fits R58's needs. At this time, R58 will remain in the facility until the next care conference and decision on long term care placement. On 10/15/2024, SW-C documented that SW-C will make referrals for long term care at another facility per R58's request. Surveyor notes there is no other documentation that referrals have been made in regards to whether or not R58 is assistive living appropriate or that referrals have been made to other long term care facilities per R58's request. On 10/29/24 at 11:40 AM, Surveyor interviewed R58. R58 informed Surveyor that R58 wishes to be discharged . R58 stated: I can't take it. I just lay in bed and watch the leaves come off the trees. Its pure misery. No one gives a crap. I can't stay here. Its making me crazy. Surveyor observed R58 crying throughout the interview. On 10/30/24 at 10:26 AM, Surveyor interviewed SW-C. SW-C informed Surveyor that no one will take R58 because of R58's behaviors. SW-C stated referrals have been sent to other facilities. On 10/30/24 at 12:45 PM, Surveyor interviewed Psychologist (Psych)-D. Psych-D stated that R58 has told Psych-D multiple times that R58 does not want to be at the facility. On 10/31/24, Surveyor reviewed R58's electronic medical record(EMR) again and notes there is no documentation that SW-C has sent out referrals to other facilities. On 10/30/24 at 1:10 PM, Surveyor interviewed R58 again. R58 informed Surveyor: I don't know what to do anymore. I hate it here. I want to leave desperately. Surveyor observed R58 crying throughout the interview. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that documentation of active discharge planning has not occurred for R58. Surveyor reviewed that R58's discharge care plan is not person-centered and has not been updated with interventions to ensure R58 has a safe discharge to the most appropriate placement. NHA-A stated that NHA-A believed SW-C was finding a place for R58, but no one will take R58 because of R58's behaviors. Surveyor shared the concern that R58 clearly does not want to be at the facility, and R58's psychosocial well being continues to be at risk. SW-C has not actively assisted R1 to identify and prepare for alternate placement. NHA-A acknowledged the concern. On 10/31/24, at 10:29 AM, Surveyor interviewed SW-C again in regards to R58's discharge planning. SW-C stated that an outside agency completed a referral blast, however, there is no documentation of this. SW-C does not recall when this was completed and stated, if there is no documentation, then its not there. No additional information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 20483 Based on interview and record review the facility did not ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming for 1 (R150) of 8 residents reviewed for ADL's (Activity of Daily Living). On 10/29/24, R150 was not provided with incontinence care every two hours and was observed with a saturated incontinence product. Findings include: The facility's policy titled, Incontinence and dated 10/21 under Policy Explanation and Compliance Guidelines documents 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. 1.) R150's was admitted to the facility with a diagnosis that includes diabetes mellitus, chronic kidney disease, history of malignant neoplasm of prostate, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominate side, quadriplegia and depression. The functional bladder incontinence care plan initiated 1/4/24 & revised 1/5/24 documents the following interventions: * Clean peri-area with each incontinence episode. Initiated 1/4/24. * Encourage fluids during the day to promote prompted voiding responses. Initiated 1/4/24. * INCONTINENT: Check Q (every) 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes. Initiated 1/4/24. The Urinary Incontinence and Indwelling Catheter CAA (care area assessment) dated 1/16/24 under analysis of findings for nature of the problem/condition documents During the look back period, [150's first name] was incontinent of urine. He requires assistance with bed mobility, sit up at edge of bed, and transfers. Currently using EZ stand to transfer. He also requires assistance with toileting cares, dressing and bathing/showering. He was admitted following long hospitalization for sepsis associated MSSA (methicillin resistant staphylococcus aureus) bacteremia d/t (due to) poor source control from previous cellulitis leading to infective endocarditis, and complicated by GI (gastrointestinal) bleeding and acute ischemic septic emboli associated infarcts involving L (left) caudate and R (right) cerebellum. Has residual L sided hemiplegia/hemiparesis. Other diagnosis includes Polyneuropathy, cramps and spasms, acute posthemorrhagic anemia, HTN (hypertension), CKD (chronic kidney disease), PDM (personal diabetes manager) with diabetic nephropathy, hyperlipidemia, depression and GERD (gastroesophageal reflux disease). He receives daily scheduled antihypertensives, antiplatelet, statin, antidepressant, diuretic, PPI (proton pump inhibitors), oral hypoglycemic, insulin, and multivitamin and potassium supplements. (continued on next page)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The Quarterly MDS (minimum data set) with an assessment reference date of 10/11/24 has a BIMS (brief interview mental status) score of 15 which indicates that R150 is cognitively intact. R150 is assessed as not having any behavior including refusal of care. R150 is assessed as requiring partial/moderate assistance for toileting hygiene, and supervision or touching assistance for chair/bed to chair transfer & toilet transfer. R150 is frequently incontinent of urine and bowel.

The CNA (Certified Nursing Assistant) Visual/Bedside Kardex Report as of 10/29/24 under the Bladder/Bowel section documents * INCONTINENT: Check Q 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. Under the Toileting section documents * Check resident every two hours and assist with toileting as needed. * Clean peri-area with each incontinence episode. * Provide pericare after each incontinent episode. * TOILET USE: The resident requires min (minimal) assist.

On 10/29/24 at 9:45 a.m., Surveyor spoke with R150 who was sitting in a wheelchair in his room. R150 informed Surveyor his progress is slow as he had a massive stroke. R150 informed Surveyor he can pivot out of bed with staff and a gait belt. R150 informed Surveyor he uses the toilet in his room and uses the call light. R150 informed Surveyor staff used to answer his call light right away but now it takes a minute.

On 10/29/24 at 10:47 a.m., Surveyor observed R150 sitting in the wheelchair in his room with his cell phone in his hand.

On 10/29/24 at 1:07 p.m., Surveyor observed R150 sitting in the wheelchair in his room with his cell phone in his hand.

On 10/29/24 at 1:48 p.m., Surveyor observed R150's call light on. Surveyor asked R150 why he placed his call light on. R150 informed Surveyor to go to the bathroom as he wants to go to a therapy group.

On 10/29/24 at 1:49 p.m., Surveyor observed CNA (Certified Nursing Assistant)-K enter R150's room stating sorry I was with someone else. R150 informed CNA-K he wants to go to the bathroom. CNA-K placed a gait belt around R150, shut R150's room door, and removed the foot rests from R150's wheelchair. R150 wheeled himself into the bathroom. CNA-K placed gloves on, R150 placed his hands on the grab bar and assisted R150 to stand, lowered the incontinence product & shorts, and sit on the toilet. CNA-K removed R150's incontinence product which Surveyor observed was saturated with urine. CNA-K removed her gloves, asked R150 if he was going to be awhile, and washed her hands. R150 informed CNA-K about 5 minutes. CNA-K closed the bathroom door indicating she would give R150 privacy. Surveyor asked CNA-K what is R150's routine for toileting. CNA-K informed Surveyor R150 usually let us know. Surveyor informed CNA-K Surveyor observed R150's incontinence product was pretty saturated with urine. CNA-K informed Surveyor she usually checks R150 every two hours but that didn't happen today. CNA-K informed Surveyor R150 dribbles urine and usually puts his call light on. Surveyor asked CNA-K why she didn't check R150 every two hours. CNA-K replied this is my fault, I should of ask if he was wet or has to go.

On 10/29/24 at 1:57 p.m., R150 placed on his call light & CNA-K entered the bathroom.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 11:09 a.m., Surveyor asked R150 yesterday when Surveyor observed [name of CNA-K] assist him with going to the bathroom prior to going to group therapy had he been to the bathroom before this time. R150 informed Surveyor once when he got up. Surveyor verified with R150 he was taken to the bathroom when he first got up and then when Surveyor observed prior to going to the group therapy. R150 replied yes. On 10/31/24 at 11:43 p.m., Surveyor asked LPN/UM (Licensed Practical Nurse/Unit Manager)-L what is the expectation if a Resident's care plan has they should be checked every two hours. LPN/UM-L informed Surveyor they should be changed every two hours. Surveyor informed LPN/UM-L of the observation on 10/29/24 with R150's incontinence product being saturated with urine and was not checked every two hours. On 10/31/24, at 12:21 p.m., NHA (Nursing Home Administrator)-A & DON (Director of Nursing)-B were informed of R150's incontinence product being saturated with urine and not being check & changed every two hours according to the care plan and Kardex. No additional information was provided to Surveyor as to why R150, whom is unable to carry out activities of daily living, received the necessary services to maintain good grooming.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38829 Based upon observation, interview and record review, the facility did not ensure 1 (R58) of 4 residents reviewed received medically related social services to address individual Resident needs in order to maintain the highest practicable physical, mental, and psychosocial well-being. * R58 has a history of trauma as identified in a trauma assessment completed on [DATE]. The facility social worker (SW)-C did not establish an individualized plan of care to address R58's trauma. On [DATE], a Level II PASARR screen determined that R58 requires specialized psychiatric rehabilitation services to promote the highest practicable psychosocial well-being for R58. The facility did not update R58's comprehensive care plan with person-centered interventions. SW-D has not actively assisted R58 to identify and prepare for alternate placement. Findings include: 1.) Surveyor requested a medically related social service policy and procedure and the facility was not able to provide a policy to Surveyor. The facility's assessment review completed [DATE] documents: .The facility is capable of caring for Residents with Major Depressive Disorder, Single Episode. Of all the Residents, 56% have a psychiatric diagnosis. Psychology services are provided. Quarterly IDT behavior management meetings are held to discuss both non-pharmacological and pharmacological interventions to assist with achieving the Resident's highest practical mental well being. The facility has a comprehensive process to assess Resident needs and determine required care and services. The facility utilizes a comprehensive admission, readmission, and required assessment process in which the IDT identifies individualized Resident care needs. Over the past year, the facility has developed numerous customized assessments, such as a Behavioral Intervention Summary, a GPEP Behavioral Assessment, and a Smoking Assessment. Due to out patient population and facility workflow, we also developed facility-specific Baseline Care Plans and Discharge Instructions. R58 was admitted to the facility on [DATE] with diagnoses of Depression, Fracture of Left Femur, Unspecified Severe Protein-Calorie Malnutrition, Polyneuropathy, and Anemia. R58 currently has an activated Health Care Power of Attorney(HCPOA). Surveyor noted the facility was not able to provide Surveyor with documentation of the competency evaluation of R58 that determined R58 was no longer able to make health care decisions for herself. It appears activation of the HCPOA may have occurred [DATE], however, there are 3 different activation forms with different activation dates. The facility was not able to clarify the activation date to Surveyor at time of survey. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R58's Admission Minimum Data Set(MDS) completed on [DATE] documents R58's Brief Interview for Mental Status(BIMS) score to be a 14, indicating R58 is cognitively intact for daily decision making. At the time of the assessment, R58 had no behaviors and was demonstrating minimal depression. R58's MDS documents R58 has range of motion impairment on one side of upper and lower extremities. R58 is independent with eating. R58 requires substantial/maximum assistance for showers/bathing and lower dressing. R58 is supervision for upper dressing and R58 is requiring partial/moderate assistance with mobility and transfers. R58's MDS also documents that R58 is to be discharged to the community, a referral has been made, and R58 has a discharge plan. R58 has not been assessed for a new MDS assessment since admission. On [DATE], R58 was evaluated by Psychologist (Psych)-D who diagnosed R58 with Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent, Moderate. On [DATE], Psych-D documents a diagnosis of Psychotic Disorder with Delusions for R58 after a regular psychology visit. On [DATE], Psychiatrist (Psych)-E agreed with the Adjustment Disorder with Depressed Mood and Major Depressive Disorder, Recurrent Diagnoses and added Generalized Anxiety Disorder and Unspecified Dementia, Unspecified Severity with Mood Disturbance as a diagnosis. R58's current physician orders documents R58 is prescribed: -Buspar [DATE] -Duloxetine [DATE] -Remeron [DATE] -Seroquel [DATE] Surveyor reviewed R58's Medication Administration Record(MAR). The MAR is directed to record behaviors in relation to medications. However, Surveyor notes that R58's MAR were not accurately completed. R58's MAR based on documentation indicates that R58 has had no behaviors since admission to the facility. R58's electronic medical record(EMR) does not document frequent behaviors or interventions applied to R58's behavior. R58's original Level 1 PASARR screen dated [DATE] documents R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. R58's Level 1 PASARR screen documents R58 is only expected to be at the facility 30 days or less. A new Level 1 PASARR screen was re-submitted on [DATE] documenting R58 has a major mental disorder and is receiving psychotropic medications for symptoms or behaviors of a major mental illness. On [DATE], it was determined that R58 requires services called 'specialized psychiatric rehabilitation services' for R58's mental illness. R58's Level II PASARR Evaluation Summary dated [DATE] documents: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525588	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Luther Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 4545 N 92nd St Milwaukee, WI 53225	

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R58 was referred due to R58's diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, Adjustment Disorder with Depressed Mood, Delusional Disorder, and Adjustment Disorder with Mixed Disturbance of Emotions. R58 currently receives Buspar, Duloxetine, Remeron, Seroquel and Gabapentin for Neuropathy. R58 is in need of specialized psychiatric rehabilitation services(SPRS). The focus of SPRS is to maintain or improve current level of functioning. SPRS should include a thorough assessment of this individual's unique capabilities, psychiatric symptoms, and behaviors, if any, by a Qualified Mental Health Professional(QMHP). -frequently refuses care -displays paranoid and accusatory behavior towards others -frequent yelling out, threatening behavior noted -consulting psychiatrist completing medication review notes that: SNRI clinicians to monitor for worsening depression and suicidal ideation; Gabepetin history has been reportedly associated with rare cases of depression and suicidal ideation. R58 may benefit from group therapy, 1:1 talk therapy, medication management, coping skill/problem solving techniques, behavioral management, and therapy for building self esteem. R58's comprehensive care plan is noted not to be person-centered and does not incorporate the need for specialized psychiatric rehabilitation services with person-centered interventions. All interventions except for one were implemented prior to the determination on [DATE] that R58 required specialized psychiatric rehabilitation services. (Cross Reference F644 and F645) R58's care plan documents with interventions: -Alteration in mood evidenced by intermittent episodes of anxious demeanor/verbalizations [DATE] No interventions have been updated since [DATE] -Resident has behavior problem due making untrue accusations of harm/abuse [DATE] No interventions have been updated since [DATE] -R58 experiences loneliness and/or isolation [DATE] No interventions have been updated since [DATE] -R58 is resistive to care bedside cares due to adjustment to nursing home [DATE] No interventions have been updated since [DATE] -R58 is at risk for signs/symptoms of resident relocation stress syndrome [DATE] (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No interventions have been updated since [DATE] -R58 has potential to be verbally aggressive due to ineffective coping skills, mental/emotional illness [DATE] No interventions have been updated since [DATE] -Potential for anxiety due to traumatic life event due to sexual assault [DATE] No interventions have been updated since [DATE] Surveyor notes there have been no updated person centered interventions for R58 since [DATE]. Surveyor notes that R58's comprehensive care plan is concentrated on R58's behaviors and what is perceived as R58's negative responses to facility interventions. The facility has not examined why R58 may be responding to triggering situations or boundaries in what the facility perceives as 'behaviors', thus the facility has not facilitated R58 to increase self independence physically and emotionally or promote physical and emotional health overall. (Cross-reference F657). Discharge Planning: R58's Admission MDS completed [DATE] documents that active discharge planning is in the process. R58's comprehensive care plan includes the following documentation: R58 would like to discharge home-Initiated [DATE] On [DATE], R58's care plan was revised and documented R58 would like to discharge to the most appropriate level of care. Interventions: Encourage R58 to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress. [DATE]. Evaluate R58's motivation and ability to safely return to the community [DATE] : Evaluate/record R58's abilities and strengths, with family/caregivers/Interdisciplinary Team(IDT). Determine gaps in abilities which affect discharge. Address gaps by making community referral, pre-discharge PT/OT(physical/occupational therapy) or internal referral [DATE] Surveyor notes R58's discharge plans have not been updated since [DATE] and per documented care plan interventions it has not been updated at a minimum of every quarter. (Cross Reference F660) (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R58's social history completed on [DATE] was completed 35 days after admission to the facility. The social history does not evaluate any psychosocial information pertinent to R58 maintaining the highest practicable physical, mental, and psychosocial well-being. A Brief Trauma Questionnaire was completed on [DATE]. The Trauma assessment documents R58 has had trauma that has impacted R58. Surveyor notes that this was not addressed by Social Worker (SW)-C and incorporated into R58's person-centered care plan with interventions. In response to R58's allegations of sexual misconduct, the facility developed a behavior problem outlining R58 making untrue accusations of harm/abuse on [DATE]. On [DATE], a care plan was implemented documenting R58 has the potential for anxiety due to traumatic life event due to sexual assault after the facility learned of past sexual traumatic events in R58's life. A new trauma assessment was not completed and a person-centered care plan was not implemented. On [DATE], Social Worker (SW)-C documented in R58's EMR that R58 continues to have behaviors and that R58 appears depressed. On [DATE] at 11:40 AM, Surveyor interviewed R58. R58 was at times crying during the interview and Surveyor observed facial grimacing. R58 stated R58 wants to be discharged . Its been pure misery. I can't take it. I just lay in bed and watch the leaves come off the trees through the window. What a life to wake up and count the leaves falling all day. No one gives a crap. I can't stay here. Its making me crazy, crazier than I've ever been. On [DATE] at 10:26 AM, Surveyor interviewed SW-C. SW-C informed Surveyor that SW-C would not complete a new trauma assessment even after learning of new identified trauma. SW-C stated SW-C is responsible for discharge, mood, behavior, cognition, and code status care plans. SW-C stated that R58 is so complex and a sad case. SW-C stated that R58 is accusatory, depressed, and has refusals of cares. SW-C stated R58 has mental health issues and is stuck in a mental health crisis. SW-C believes R58 just wants to be heard. On [DATE] at 11:20 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-G regarding R58. LPN-G stated LPN-G frequently takes care of R58. LPN-G stated that R58 requires a lot of reassurance and benefits from physical comfort touch. LPN-G also shared that R58 enjoys compliments. LPN-G confirmed that R58 has not gotten out of bed in a long time. On [DATE] at 12:45 PM, Surveyor interviewed Psychologist (Psych)-D. Psych-D has been treating R58 on a weekly basis. Psych-D stated that R58 shared with Psych-D that there was an incident from the past but will not elaborate at this time. Psych-D recommended to the facility that staff complete cares with the 'buddy system'. On [DATE], at 1:10 PM, Surveyor interviewed R58 again. R58 shared that R58 attempted to speak to daughter on the phone this morning, but was not able to finish the conversation because R58 was crying so much. R58 shared that R58 woke up thinking about R58's oldest son who died of COVID. R58 stated, Who would think retirement would be like this. I hate it here. On [DATE] at 1:20 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-J. CNA-J confirmed that R58 is on the buddy system for cares. CNA-J stated that R58 is not motivated to do anything and is not getting out of bed. (continued on next page)

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:57 PM, Surveyor interviewed Psychiatrist (Psych)-E who has evaluated R58 two times. Psych-E described R58 as being very irritable. On [DATE], at 3:07 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A that R58 has not been provided medically related social services in order for R58 to maintain the highest practicable physical, mental, and psychosocial well-being. NHA-A informed Surveyor that a new trauma assessment should have been completed upon learning that R58 has past sexual trauma. NHA-A informed Surveyor that NHA-A believes the buddy system is triggering to R58 and NHA-A stated that it is clear that R58 does not want to be at the facility. NHA-A stated, I am concerned about R58. On [DATE], at 9:35 AM, Surveyor interviewed LPN-F. LPN-F informed Surveyor that LPN-F wished R58 would get a mental health evaluation and treatment. LPN-F stated that R58 is constantly on the call light and needs reassurance. On [DATE] at 9:54 AM, NHA-A explained how the licensed staff should be filling out the MAR in regards to behavior monitoring. NHA-A agreed that R58's MAR detailing R58's behaviors has not been filled out correctly thus it appears R58 has had no behaviors. Surveyor shared the concern with NHA-A that non-pharmalogical interventions have not been implemented in order for R58 to maintain the highest practicable physical, mental, and psychosocial well-being. NHA-A understands the concern and at this time, the facility did not provide any additional information.