

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 03/26/2025
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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27104</p> <p>Based on record review, review of hospital discharge summary, interview, and facility document review, the facility failed to ensure orders were transcribed correctly for one of three residents (Resident (R) 4) reviewed for medication orders out of 13 sample residents to ensure medications were administered as ordered. This had the potential for the residents to have unmet health care needs.</p> <p>Findings include:</p> <p>Review of R4's Admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a diagnosis of cytomegaloviral disease (CMV/common virus). The resident discharged from the facility on 12/23/24.</p> <p>Review of R4's hospital After Visit Summary, dated 11/26/24 to 12/11/24 and located in the EMR under the Misc tab, revealed the resident was to continue to receive ganciclovir (antiviral medication to treat viruses) 2.5 milligrams (mg/kg [kilogram]) = 250 mg in dextrose 100 ml (milliliter) bag by intravenous (IV) route two times a day. There was no stop date indicated.</p> <p>Review of R4's Care Plan, initiated 12/11/24 and located in the EMR under the Care Plan tab, revealed the resident was on an antiviral therapy ganciclovir related to CMV infection. Interventions included administering the antiviral medication as ordered by the physician.</p> <p>Review of R4's Progress Note, dated 12/12/24 located in the EMR under the Progress Note tab, revealed an order was received from the Infectious Disease Clinic to change the ganciclovir to once a day. There was no stop date indicated.</p> <p>Review of R4's Medication Administration Record (MAR), located in the EMR under the Orders tab, revealed an order for ganciclovir, intravenous solution. Use 250 mg IV one time a day for CMV infection until 12/18/24. Start date 12/13/24. The MAR documented the resident received the ganciclovir everyday with the last dose given on 12/18/24.</p> <p>Review R4's Progress Note, dated 12/23/24 and located in the EMR under the Progress Note tab, revealed a call was received from the Registered Nurse (RN) from the Infection Disease Clinic who wanted to know who gave authorization for the resident's ganciclovir to stop on 12/18/24. The RN indicated she gave specific instructions that the anticipated completion date would be 12/23/24 dependent on the repeat antiviral levels and his follow up appointment. A Risk Management was completed for the medication error.</p> <p>(continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation provided by the facility revealed at the time of admission, the resident was to receive IV antiviral daily infusion through 12/23/24. When he went to his appointment on 12/23/24 it was noted that there was a discrepancy in medication administration regarding the IV antiviral stopping on 12/18/24. In conclusion, although there was a medication administration error, the error did not cause a negative outcome to the resident. Licensed nurses were involved in education of the five rights of medication administration as well as order clarification.</p> <p>During an interview on 03/26/25 at 1:00 PM with the Administrator, she confirmed RN1 transcribed R4's orders received from the Infectious Disease Clinic incorrectly and put a stop date for the ganciclovir on 12/18/24 and the resident should have received the medication until his next appointment on 12/23/24.</p> <p>During an interview on 03/26/25 at 1:20 PM, the Director of Nursing (DON) confirmed a medication error occurred for R4 when RN1 put a stop date on his ganciclovir of 12/18/24. She confirmed the resident was to receive the medication until 12/23/24 and he missed five doses of the antiviral medication. She confirmed licensed nurses were educated on medication errors and order transcription. She confirmed all residents' orders were not reviewed after the medication error was found by the Infection Disease Clinic to ensure there were no other medication errors. She confirmed a Performance Improvement Plan (PIP) had not been developed.</p> <p>During an interview on 03/26/25 at 1:40 PM with RN1, she confirmed she put a stop date on the ganciclovir of 12/18/24 and the resident should have received the medication through 12/23/24, until his follow up appointment with Infectious Disease.</p> <p>Review of the undated document titled, How do you ensure accuracy of physician order transcription? provided by the facility revealed, Physician order transcription is a crucial step in the delivery of quality patient care .1. Understand the order: You need to pay attention to the details, such as .duration .3. Check for errors .check for errors and inconsistencies. You need to proofread you transcription and compare it with the original order.</p>		