STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525588	A. Building B. Wing	07/29/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure staff members timely reported an allegation of suspected abuse to the Administrator for 4 (Residents #1, #2, #3, and #4) of 4 sampled residents related to 2 incidents (01/12/2025 and 07/01/2025) of 3 sampled for abuse. The facility also failed to ensure the facility timely reported an allegation of suspected abuse to the state agency for 2 (Resident #1 and Resident #2) of 4 sampled residents related to 2 incidents (05/20/2025 and 07/01/2025) of 3 sampled for abuse.Findings included:The facility's policy titled, Abuse, Neglect, Misappropriation, and Exploitation, implemented June 2025, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy revealed the section titled, Policy Explanation and Compliance Guidelines, included, 2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The policy revealed the section titled, VII. Reporting/Response, included, A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, Nurse Manager, Director of Nursing Services, state agency, adult protective services and to all other required agencies (e.g. [exempli gratia, for example], law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.1.) Resident #1 was admitted to the facility on [DATE] with a medical history that included diagnoses of dementia without behavioral disturbance, generalized anxiety disorder, and major depressive disorder.Resident #1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/16/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident used a wheelchair and propel it 50 feet with two turns independently. The MDS also indicated the resident had no behaviors during the assessment's lookback period and required set-up and clean-up assistance with eating.Resident #1's Care Plan Report, included a problem statement initiated on 12/11/2024, that indicated the resident had episodes of forgetfulness and confusion related to dementia. Interventions directed staff to ask yes/no questions in order to determine the resident's needs. Resident #2 was admitted to the facility on [DATE] with a medical history that included diagnoses of dementia with mood disturbance and anxiety disorder.Resident #2's quarterly MDS, with an ARD of 06/30/2025, revealed Resident #2 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident utilized a wheelchair and required substantial to maximum assistance to propel the wheelchair 50 feet with two turns. The MDS also indicated the resident had verbal behaviors during the assessment's lookback period and could eat independently. Resident #2's Care Plan Report, included a problem statement initiated on 09/18/2024 and revised on 07/11/2025, that indicated the resident had actual physical aggressiveness toward harming others related to anger, dementia, and poor impulse control, and on 07/03/2025 the resident was offered a new dining room experience in relation to a facility reported incident. Interventions directed staff that for communication provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff member when agitated. The interventions instructed staff that the resident's triggers for physical aggression were related to loud noises/sensory overload towards other and the resident's behaviors were de-escalated by removing the resident from heightened situations to avoid conflict. A facility Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report, dated 05/20/2025 at 1:29 PM, revealed that on 05/20/2025 at 1:08 PM Resident #2 attempted to push themselves in their wheelchair through the dining room where other residents were. The report revealed Resident #2 could not get through and became frustrated and made contact with Resident #1. The report did not indicate the police or state authorities were notified.A document titled, Physical Aggression Received, dated 05/20/2025 at 12:45 PM, for Resident #2, revealed Certified Nursing Assistant (CNA) A reported that after lunch Resident #2 was trying to move away from the table and bumped into another resident. The document revealed the other resident yelled at Resident #2 and then Resident #2 hit the other