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	01/14/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure residents at risk for pressure injuries received necessary treatment and services consistent with professional standards of practice to prevent the development of pressure injuries and to promote healing for 2 (R1 and R2) of 3 residents reviewed with pressure injuries. *R2 is at risk for developing pressure injuries. Facility staff did not document multiple weekly skin checks in the weeks prior to 8/31/25 when R2 developed a facility-acquired stage 3 pressure injury of R2's Sacrum. On 10/22/25, R2 developed two additional facility-acquired stage 2 pressure injuries to R2's right and left hip. On 11/23/25, R2's two hip pressure injuries were resolved but a week later, R2's left hip pressure injury re-opened. A treatment order for R2's left hip was not placed until 11/27/25 resulting in R2 going 6 days without treatment to R2's left hip pressure injury. After the initial development of these pressure injuries, facility staff did not always follow the Wound Care Providers' treatment plan recommendations and did not always document a wound care treatment was completed as the Wound Care Provider ordered. On 1/14/26, Surveyor observed R2's pressure injuries and noted R2's sacrum pressure injury had worsened and R2's hip pressure injury went from a stage 2 to an unstageable pressure injury. *R1 developed avoidable, facility acquired, bilateral (both sides) heel pressure injuries on 12/12/2025. Contributing factors include heels not floated prior to development of bilateral heel pressure injuries, multiple absent weekly skin checks before and after discovery of heel pressure injuries and infrequent repositioning based on interview and observation. Air mattress was not provided until five days post discovery of pressure injuries on 12/17/2025. Findings include: The facility's policy titled, Wound Prevention Program and dated July 2021, last reviewed 6/14/2024, documents the following, in part: The purpose of this program is to assist the facility in the care, services, and documentation related to the occurrence, treatment, and prevention of pressure and non-pressure related skin injuries. Process: The licensed nurses will conduct weekly skin checks. This will be documented in the resident's electronic medical record (EMR). During routine care, the Certified Nursing Assistant (CNA) will observe the resident's skin. When abnormalities are noted, this will be communicated to the licensed nurse. The licensed nurse will proceed as mentioned in the step above and complete initiate a skin event in Risk Management. Pressure Relief: All residents will have a pressure redistribution mattress. As tolerated, needed position and reposition the resident with pillows and other supportive devices. Wheelchair cushion as (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	indicated. The facility's policy titled Treatment/Services to Prevent/Heal Pressure Ulcer, and dated 12/22/2021, last reviewed 6/14/24, documents the following, in part: The facility's policy is to ensure it identifies and provides needed care and services that are resident-centered, per the resident's preferences, goals for care, and professional standards of practice that will meet each resident's physical, mental and psychosocial needs. Guidelines: The facility will ensure that based on the comprehensive assessment of a resident: A resident receives care, consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Procedure: Interventions will be implemented in the resident's plan of care to prevent pressure injury development. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure injury. The pressure ulcer(s) will be evaluated weekly by a Registered Nurse or Wound Physician, and the following will be documented in the resident's electronic medical record: the size, location, odor (if any), drainage (if any), and current treatment ordered. 1.) R2 was admitted to the facility on hospice on 11/6/24. R2's diagnoses include degenerative disease nervous system (progressive loss or death of nerve cells), stroke (lack of blood flow to the brain causing brain cells to die from lack of oxygen), hemiplegia following a stroke (weakness or inability to control one side of the body following a stroke), vascular dementia (cognitive decline caused by conditions damaging brain blood flow), type 2 diabetes (body doesn't make insulin properly leading to high blood sugars), severe protein calorie malnutrition (not enough protein intake causing muscle wasting and slow healing), chronic kidney disease (kidneys are damaged and can't filter waste and extra fluid from the blood), anxiety (feeling unease, fear, or worry), depression (feeling sadness or loss of interest, that may impact quality of life), hypertension (high blood pressure), and adult failure to thrive (overall decline in physical and mental function without an immediate obvious cause). R2's Quarterly Minimum Data Set (MDS) completed on 8/14/25 documents that R2 has no hallucinations, delusions or behaviors. R2's MDS documents R2 has no impairment with upper and lower extremities, uses a manual wheelchair, and requires set up assistance for eating. R2 is dependent for cares and requires partial/moderate assistance with bed mobility and transfers. R2 is frequently incontinent of bowel and bladder. R2's MDS documents R2 as being at risk for pressure injuries with no current pressure injuries. R2 was documented as having a Brief Interview for Mental Status (BIMS) score of 3, indicating that R2 has severe cognitive impairment. R2's skin integrity care plan, dated 11/6/24, documents, in part: Encourage good nutrition and hydration in order to promote healthier skin. The resident needs a pressure-relieving/reducing mattress to protect the skin while in bed. The resident needs pressure reducing Equagel cushion to protect the skin while up in chair. Turn and reposition [every] 2-3 hours and [as needed] while in bed. R2's Activity of Daily Living (ADL) care plan, dated 11/6/24, documents in part: The resident requires skin inspection during bath/shower. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. A revision on 8/15/25 included: The resident is totally dependent on 1 staff for repositioning and turning in bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's Braden skin assessment (An assessment tool used to determine how at risk a resident is for developing a pressure injury) dated 8/8/25 documents a score of 16, indicating the resident is at risk for developing pressure injuries. R2's MD order with a start date of 2/17/25 documents: Weekly skin and shower check performed. If a new skin issue is identified, then a comprehensive assessment to be completed, in the morning every Monday. Surveyor reviewed facility documentation of R2's skin assessments starting in July of 2025. R2's order administration note dated 7/7/25 at 11:55 AM, documents, in part: Weekly skin and shower check. refused. Surveyor reviewed R2's medical record for a progress note of refusal and/or documentation of a completed skin assessment for 7/7/25 and did not locate documentation. R2's order administration note dated 7/14/25 at 6:53 PM, documents, in part: Weekly skin and shower check. Resident refused shower. No new skin issues noted. Surveyor noted that staff documented a refusal of shower but still documented a skin check. R2's progress note dated 7/21/25 at 1:15 PM, documents: Resident refused am shower today-several attempts made and unsuccessful. Body check completed, no new skin issues. Surveyor noted that staff documented a refusal of shower but still documented a skin check. R2's Treatment Administration Record (TAR) dated 7/28/25 documents a checkmark under weekly skin and shower check performed. R2's order administration note dated 8/4/25 at 11:39 AM, documents, in part: Weekly skin and shower check. refused. Surveyor reviewed R2's medical record for a progress note of refusal and/or documentation of a completed skin assessment for 8/4/25 and did not locate documentation. R2's order administration note dated 8/11/25 at 6:37 PM, documents, in part: Weekly skin and shower check. resident refused shower this day. Surveyor reviewed R2's medical record for a progress note of refusal and/or documentation of a completed skin assessment for 8/11/25 and did not locate documentation. R2's TAR dated 8/18/25 documents a checkmark under weekly skin and shower check performed. R2's TAR dated 8/25/25 documents the number 2, indicating a refusal. Surveyor reviewed R2's medical record for progress notes for details regarding the refusal and if R2 was reapproached to reattempt to complete a skin assessment for 8/25/25 and did not locate documentation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/14/26 at 10:02 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-F. CNA-F stated that skin assessments are completed by the nurse on every shower day. CNA-F stated that R2 does refuse showers at times and a bed bath will be done instead. CNA-F stated that if a skin concern is found, CNA-F would tell the nurse right away. On 1/14/26 at 10:10 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-E about the facility's skin assessment policy. LPN-E indicated that skin assessments are completed weekly on shower days. Surveyor asked where they are documented. LPN-E stated that they are documented in the resident's medical record. Surveyor asked if there should be some sort of documentation of skin assessment even if a shower is refused. LPN-E stated that the skin checks should still be completed and documented in the medical record weekly. On 1/14/26 at 1:20 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what the facility policy is on resident skin assessments. DON-B stated that skin checks are completed weekly on the same day as the resident's shower. If a new issue is identified, a skin issue assessment is completed. DON-B stated the CNA will complete the shower and nurse will come in and do the skin assessment. Surveyor asked what happens if a resident refuses a shower. DON-B stated that if a resident refuses, the nurse should re-approach the resident and document the attempts. Surveyor asked where this would be documented. DON-B stated the CNA documents in the POC. Nurses would document a skin check in the TAR. If the shower was refused, the nurse should document that in a progress note and address the skin check in the progress note. Surveyor noted in the 8 weeks prior to 8/31/25, the facility did not document complete weekly skin checks, per their policy, 4 times. Surveyor noted a progress note documenting the shower refusal and completed skin assessment was not always completed in the 8 weeks prior to 8/31/25. R2's progress note dated 8/31/25 at 10:47 PM, documents, in part: . Resident has open area on [R2's] sacrum. Supervisor was made aware and assessed. Writer called. provider. new order received to cleanse sacrum open area with [Normal Saline], pat dry and apply Medi-honey, followed by bordered foam dressing. Change daily and [as needed] . Wound care to see. R2's skin issues assessment dated [DATE] at 11:20 PM, documents in part: . New skin issue. Location: sacrum. Issue type: pressure ulcer/injury. Stage 3 pressure ulcer- full thickness skin loss. Wound acquired in-house. Length 1.5 [centimeters (cm)] Width 1 cm. Depth 0.1 cm. Granulation 80%. Slough 20% . Resident reports pain when completing treatment. R2's pressure injury care plan dated 9/1/25 documents, in part: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. Weekly treatment documentation to include measurement of each are of skin breakdown's (sic) width, length, depth, type of tissue and exudate. R2's MD order with a start date of 9/1/25 documents: Sacrum treatment: cleanse sacrum open area with normal saline. Pat dry. Apply Medi-honey. Followed by foam dressing. Change daily and [as needed] until wound care MD to see. Facility staff documented that treatments were addressed and completed from 8/31/25 to 9/3/25. R2's Provider wound note dated 9/3/25 documents, in part: Unstageable (due to necrosis) sacrum full (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	thickness Pressure wound. 1.9 x 1.3 x 0.1 cm. 30% necrotic tissue. 20% slough. 50% granulation. Treatment plan: Hydrocolloid sheet (thin) apply three times per week and as needed. R2's MD order dated 9/5/25 documents, in part: [Treatment] to unstageable. wound to sacrum. Cleanse with normal saline. Pat dry and apply hydrocolloid dressing every day shift. Every Monday, Wednesday and Friday for wound care. R2's Interdisciplinary (IDT) note dated 9/5/25 at 2:51 PM, documents, in part: The IDT reviewed a new skin issue on the sacrum. The wound was initially classified as a stage III wound on 8/31/25. The physician was notified, treatment was put in place, and the mattress was changed to a Geo-Mattress Ultramax. The Wound Physician assessed the wound on 9/3/2025. The wound progressed to an unstageable pressure injury. The IDT recommended a Span-care convertible mattress, a dietitian consultation, and a change to a w/c with Ecogel Plus. The resident was on a turning schedule, had a pressure reduction mattress, and an Ecogel cushion before the initial pressure injury. The resident is in hospice due to dementia. The resident is declining oral intake, and functional needs have increased. Surveyor reviewed R2's MD orders and TAR. Surveyor noted facility staff documented R2's treatments were addressed and completed as ordered from 9/5/25 through 10/22/25. Surveyor noted through this time period the sacral wound was progressively decreasing in size. R2's Significant Change MDS completed on 9/11/25 documents the following Care Area Assessments (CAA)s: Pressure Ulcer/Injury CAA – R2 has an unstageable pressure injury due to necrosis to her sacrum and is followed by the wound team. Care plan to address and to minimize the risk for pressure ulcer impairments. R2's progress note dated 10/22/25 at 6:50 PM documents, in part: Resident has new open blisters/stage 2 pressure ulcers to the right and left lateral hip. Wound Doctor and wound Team will assess and treat resident wound. R2's Provider wound note dated 10/22/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 1 x 0.5 x 0.1. 100% granulation. Treatment plan: Leptospermum honey apply once daily and as needed. Gauze island with boarder dressing apply once daily and as needed. Stage 2 pressure wound of the right, lateral hip partial thickness. Wound size 1 x 1 x 0.1. Open areas with exposed dermis. Treatment plan: Leptospermum honey apply once daily and as needed. Gauze island with boarder dressing apply once daily and as needed. Stage 2 pressure wound of the left, lateral hip partial thickness 3.5 x 2.1 x 0.1. Open areas with exposed dermis. Treatment plan: Leptospermum honey apply once daily and as needed. Gauze island with border dressing apply once daily and as needed. Surveyor noted 2 new hip pressure injuries were found on 10/22/25. R2s MD order with a start date of 10/24/25 documents, in part: . Treatment to stage 2 pressure wound of the left lateral hip: Cleanse with normal saline. Pat dry. Skin prep peri wound. Apply Leptospermum honey to wound bed and cover with foam wound dressing every day shift for wound care. R2's MD order with a start date of 10/24/25 documents, in part: . Treatment to stage 2 pressure wound of the right lateral hip: . Cleanse with normal saline, Pat dry. Skin prep peri wound. Apply Leptospermum honey to wound bed and cover with foam wound dressing every day shift for wound care. Surveyor noted that the start date of the MD orders for R2's two new pressure injuries were started (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2 days after the wounds were found. Surveyor reviewed R2's progress notes and TAR and noted R2's wound treatments for the 2 new hip pressure injuries were not documented as completed on 10/23/25. R2's IDT note dated 10/27/25 documents, in part: IDT reviewed new skin issues. Treatment in place. Increased ProSource to 60 [milliliters (ml)] [two times a day]. Care plan reviewed. Surveyor reviewed R2's MD orders and TAR and noted that assessments and treatments were completed for all 3 wounds as ordered from 10/24/25 through 11/5/25. R2's skin assessment note dated 11/5/25 documents, in part: Wound team re-evaluated resident; resident being followed for stage 3 [pressure injury] to sacrum. Resident being followed for stage 2 [pressure injuries] to [both] hip[s]. Sacrum 1.4 x 0.8 x 0.1 Full thickness skin loss. Right hip 1.4 x 1.3 x 0.1 Partial-thickness skin loss with exposed dermis. Left hip 2.5 x 2.5 0.1 Partial-thickness skin loss with exposed dermis. All wounds appear stalled as evident by increased wound size. Wound team recommends changing Medihoney to Santyl for sacrum wound for debridement as wound physician is unavailable for debridement. Resident tolerated assessment and treatment well. Air mattress and heel boots in place. R2's MD order with a start date of 11/6/25 documents, in part: Santyl External Ointment 250 unit/[gram]. Apply to Sacrum topically every day shift for [pressure injury]. Skin prep peri wound. Apply foam border dressing after application. Surveyor noted the Medication/Treatment order for R2's Sacral wound did not include directions for cleansing the wound. R2's Orders Administration Note dated 11/6/25 at 12:56 PM, documents, in part: Santyl. ointment unavailable. wound cleaned and covered. Surveyor noted R2's wound was not treated as ordered on 11/6/25. R2's Provider wound note dated 11/7/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 0.9 x 1 x 0.1. 20% slough. 80% granulation. Treatment plan: Leptospermum honey apply once daily and as needed. Gauze island with border apply once daily and as needed. Stage 2 pressure wound of the right, lateral hip partial thickness. 0.9 x 1.2 x 0.1. Open areas with exposed dermis. Stage 2 pressure wound of the left, lateral hip partial thickness 3 x 3.4 x 0.1. Open areas with exposed dermis. Surveyor noted the treatment to the hip pressure injuries remained the same. Surveyor noted R2's wound provider prescribed a treatment plan of Leptospermum honey for R2's sacral wound. Surveyor reviewed R2's MD orders and TAR and noted that facility staff did not change the sacral treatment order from Santyl to Leptospermum honey as the wound provider recommended on 11/7/25. R2's progress note dated 11/7/25 at 2:51 PM, documents, in part. [Treatment] to both hips completed as ordered. No pain or drainage noted. Both wounds in healing stage. Wound to sacrum cleaned and covered, ointment has not arrived. Surveyor noted R2's sacral wound is being cleansed but no treatment is being used as the Wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provider ordered on 11/7/25. Surveyor reviewed R2's MAR and noted the Santyl ointment to R2's sacral wound was documented as completed on 11/8, 11/9 and 11/10/25. Surveyor noted facility staff were documenting that the sacral wound was being treated with Santyl instead of Leptospermum honey that the Wound Provider ordered on 11/7/25. R2's progress note dated 11/11/25 at 11:26 AM, documents, in part: [Treatment] to both [hips] completed as ordered. [Treatment] to sacrum could not be completed due to Santyl being unavailable. Sacrum however was cleaned and rebandaged. Surveyor noted that R2's sacral wound was cleansed on 11/11/25 but not treated as the Wound Provider ordered on 11/7/25. R2's Wound Provider note dated 11/12/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 0.9 x 1 x 0.1. 20% slough. 80% granulation. Treatment plan: Leptospermum honey apply once daily and as needed. gauze island with border apply once daily and as needed. R2's right, lateral hip and left, lateral hip pressure injuries were documented as resolved. R2's MD order with a start date of 11/14/25 documents, in part: [Treatment] to stage 3 pressure wound sacrum: Cleanse with normal saline. Pat dry. Skin prep peri wound. Apply Leptospermum honey to wound bed [followed by] foam border wound dressing every day shift for wound care. Surveyor noted that the start date of the MD orders for R2's sacral pressure injury was started 2 days after the wound provider prescribed Leptospermum honey. Surveyor reviewed R2's TAR and noted R2's wound treatment for the sacral pressure injury was not documented as completed on 11/13/25. R2's Wound Provider note dated 11/19/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 0.9 x 1 x 0.1. 20% slough. 80% granulation. Revisit to care goals: Over the past month: closely monitor, serial debridement, ultrasound mist and dressing adjusted as needed. Encourage offloading of wound. This month's approach: Continue to monitor closely. Continue [ultrasound mist]. Encourage repositioning and prompt incontinence cares. Stage 2 pressure wound of the left hip partial thickness. 2.5 x 3.5 x 0.1. Periwound radius: Surrounding [deep tissue injury] Purple/Maroon. Open areas with exposed dermis. Treatment plan: Leptospermum honey apply once daily and as needed. Gauze island with border apply once daily and as needed. Surveyor noted the previously resolved pressure injury of the left hip had reopened on 11/19/25, one week after being resolved. Surveyor reviewed R2's progress notes, MD orders and TAR. Surveyor noted the facility did not enter the 11/19/25 treatment orders to include: Treatment plan: Leptospermum honey apply once daily and as needed. Gauze island with border apply once daily and as needed for the reopened left hip pressure injury. As a result, Surveyor noted R2's left hip wound was not receiving daily treatments as Wound Provider recommended from 11/20 through 11/26/25. R2's Wound Provider note dated 11/26/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 1.7 x 1.3 x 0.1. 100% granulation. Treatment plan: Iodosorb gel apply once daily and as needed. Gauze island with border apply once daily and as needed. Stage 2 pressure wound of the left hip partial thickness. 2.5 x 3.2 x 0.1. Open areas with exposed dermis. Treatment plan. Iodosorb gel (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	apply once daily and as needed. Gauze island with border apply once daily and as needed. Surveyor noted that R2's sacral wound had almost doubled in size. Surveyor noted that the Wound provider changed the treatment from Leptospermum honey to Iodosorb gel daily for both the sacral and hip pressure injuries. R2's MD order with a start date of 11/27/25 documents, in part: Treatment for left hip: Cleanse site with normal saline and pat dry. Apply Iodosorb to the site. Cover with gauze island with border every day. R2's MD order with a start date of 11/27/25 documents, in part: [Treatment] to stage 3 pressure wound sacrum. Cleanse with normal saline. Pat dry, skin prep periwound. Apply Iodosorb to wound bed [followed by] foam border wound dressing every day. R2's Wound Provider note dated 12/17/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 1.6 x 1.4 x 0.1. 30% slough. 70% granulation. Treatment plan: Iodosorb gel apply once daily and as needed. Alginate calcium apply once daily and as needed. Gauze island with border apply once daily and as needed. Stage 2 pressure wound of the left hip partial thickness. 2 x 3.1 x 0.1. Open areas with exposed dermis. Treatment plan: Iodosorb gel apply once daily and as needed. Alginate calcium apply once daily and as needed. Gauze island with border once daily and as needed. Surveyor noted the treatment recommended by the Wound Provider on 12/17/25 was not entered as a new MD order by facility staff. Surveyor reviewed R2's MD orders and TAR and noted facility staff continued to treat both wounds with just Iodosorb gel and did not include Alginate calcium as Wound Provider ordered from 12/18/25 through 12/21/25. R2's MD order with a start date of 12/22/25 documents, in part: Treatment for left hip: Cleanse site with normal saline and pat dry. Apply Iodosorb and calcium alginate to the site. Cover with gauze island with border every day. R2's MD order with a start date of 12/22/25 documents, in part: [Treatment to stage 3 pressure wound sacrum. Cleanse with normal saline. Pat dry. Skin prep peri wound. Apply Iodosorb and calcium alginate to wound bed [followed by] foam border wound dressing. Every day. Surveyor noted staff began treating both pressure injuries with the correct treatment 4 days after the Wound Provider recommended the treatment change. R2's Wound Provider note dated 12/24/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 2.8 x 1.6 x 0.1. Eschar 80% Granulation tissue 20% . Treatment plan: Leptospermum honey apply once daily and as needed. Xeroform gauze apply once daily and as needed. Gauze island with border apply once daily and as needed. Stage 2 pressure wound of the left hip partial thickness. 1.6 x 3 x 0.1. Open areas with exposed dermis. Treatment plan: Leptospermum honey apply once daily and as needed. Xeroform gauze apply once daily. Gauze island with gauze island with border apply once daily and as needed. Surveyor noted R2's sacral pressure injury almost doubled in size and developed 80% eschar. Surveyor noted that this change came after the incorrect treatment was done 4 days and the correct treatment done for 2 days prior to this assessment on 12/24/25. Surveyor reviewed R2's MD orders and TAR. Surveyor noted facility staff continued to treat both of R2's pressure injuries with Iodosorb and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	calcium alginate instead of the new recommended treatment order of Leptospermum honey and Xeroform gauze from 12/25/25 through 12/30/25. R2's Wound Provider note dated 12/31/25 documents, in part: Stage 3 pressure wound sacrum full thickness. 2.4 x 1.4 x 0.1. Eschar 80%. Granulation 20% . Treatment plan: Leptospermum honey apply once daily and as needed. Xeroform gauze apply once daily and as needed. Gauze island with border apply once daily and as needed. Stage 2 pressure wound of the left hip partial thickness. 2.4 x 2.4 x 0.1. Open areas with exposed dermis. Treatment plan: Leptospermum honey apply once daily and as needed. Xeroform gauze apply once daily and as needed. Gauze island with border apply once daily and as needed. Surveyor noted that when facility staff did not follow the Wound Providers treatment recommendations from 12/25 through 12/30/25, R2's left hip pressure injury grew in size. R2's MD order with a start date of 1/1/26 documents, in part: Treatment for left hip. Cleanse site with normal saline and pat dry. Apply medihoney and calcium alginate to the site. Cover with gauze island with border every day. Surveyor noted that facility staff entered a new treatment order for the left hip that included medihoney (Leptospermum honey) and calcium alginate when the Wound Provider had recommended (medihoney) Leptospermum honey and Xeroform. R2's MD order with a start date of 1/1/26 documents, in part: [Treatment] to stage 3 pressure wound sacrum. Cleanse with normal saline. Pat dry. Skin prep peri wound. Apply medihoney and Xeroform to wound bed [followed by] foam border wound dressing every day. Surveyor noted facility staff entered the recommended Wound Provider orders for the sacral pressure injury. Surveyor reviewed R2's TAR and noted facility staff continued to treat R2's left hip wound with the incorrect treatment of Leptospermum honey and calcium alginate from 1/1/26 through 1/7/26. Facility staff treated R2's sacral pressure injury as ordered from 1/1/26 through 1/7/26. R2's Wound Provider note dated 1/7/26 documents, in part: Stage 3 pressure wound sacrum full thickness. 3.1 x 2.4 x 0.1. Eschar 80%. Granulation 20% . Treatment plan [remained the same from the previous week]. Stage 2 pressure wound of the left hip partial thickness. 2.1 x 1.9 x 0.1. Open areas with exposed dermis. Treatment plan: Leptospermum honey apply once daily and as needed. Xeroform gauze apply once daily. Gauze island with border apply once daily and as needed. R2's MD order with a start date of 1/10/26 documents, in part: Treatment for left hip. Cleanse site with normal saline and pat dry. Apply medihoney (Leptospermum honey) and xeroform to the site. Cover with gauze island with border every day. Surveyor noted facility staff continued to treat R2's left hip with the incorrect treatment of Leptospermum honey and calcium alginate on 1/8/26 and 1/9/26. Facility staff began treating R2's left hip with the correct Wound Provider recommended treatment on 1/10/26. On 1/14/26 at 9:55 AM, Surveyor observed R2 on back in bed. R2 had a pillow under R2's right hip. R2's air mattress was on and functioning. R2 responded to Surveyor's voice. R2 stated R2 ate (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525588	A. Building B. Wing	01/14/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	breakfast, and it was good. R2 stated that R2 was not in any pain. Surveyor observed R2's heel boots on and feet elevated on pillow. On 1/14/26 at 10:02 AM, Surveyor interviewed CNA-F. CNA-F stated that R2 has had a gradual decline. R2 stays in bed more than before but was up in the chair yesterday. R2 has had a pressure reducing mattress for as long as CNA-F can remember but was changed to an air mattress after pressure injuries were found. R2 is turned every 2 to 3 hours. On 1/14/26 at 10:10 AM, Surveyor interviewed LPN-E. Surveyor asked what caused R2 to develop pressure injuries. LPN-E indicated that R2 was getting up in chair every day but started to sleep more and more. LPN-E stated that when R2 would fall asleep in R2's chair, R2 would be leaning forward and almost putting R2's head on R2's lap. For that reason, R2 spends more time in bed for R2's safety and fall risk. Now, it is up to R2 if R2 wants to sit in chair or get up. LPN-E stated that R2's wounds are treated daily. R2 always has heel boots on, and skin prep is completed on heel to prevent injury. R2 is on high caloric boost since R2 does not eat as well as before. LPN-E indicated that R2 has had a gradual decline. On 1/14/26 at 2:50 PM, Surveyor interviewed Wound Care Nurse Practitioner (WC NP)-H. Surveyor asked how R2 developed R2's current pressure injuries. WC NP-H indicated that R2 has severe protein-malnutrition and is followed by dietary. R2 is non-ambulatory and has multiple diagnosis that would contribute to the development of pressure injuries. R2 has worsening dementia and is on hospice. WC NP-H indicated that R2 is very small and bony. WC NP-H continued and stated that R2 has been on the correct mattress. WC NP-H stated that R2 has a turning schedule, R2's heel boots are always on and air mattress on when WC NP-H sees R2. WC NP-H stated the facility is good about keeping up with offl