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	12/16/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and include the expiration date when applicable for 1 of 2 medication rooms and 1 of 3 medication carts observed, affecting more than 3 residents but less than widespread. Findings include:The facility policy titled Labeling of Medications and Biologicals implemented 9/21 documents (in part) . 4. Labels for individual drug containers must include:h. The expiration date when applicable.8. Labels for multi-dose vials must include:a. The date the vial was initially opened or accessed (needled punctured).b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. The facility policy titled Multi-Dose Vials implemented 8/21 documents (in part) . It is the policy of this facility to ensure proper and safe use of multi-dose vials of medications.2. Multi-dose vials will be re-labeled with a beyond use date, 28 days after the vial is opened or punctured (unless otherwise specified by the manufacturer). The beyond use date rule will begin on the first (1st) day the multi-dose vial is opened or punctured.3. The medication label will also include the initials of the nurse who opened the vial.6. Discard the vial accordingly if the vial is out of date (past the beyond use date/manufacturer's expiration date).7. Unit Manager will perform random checks of opened multi-dose vials for appropriate dating. The Health Direct pharmacy services list of Insulin Expiration Dates updated October 2022 documents:Expiration upon opening or removing from refrigerator: Lantus 28 days. Lispro 28 days.The Health Direct pharmacy services list of Ophthalmic Medication Beyond-use date guide dated April 2024 documents:Oflaxacin drops 0.3% expiration date 28 days from opening. Latanoprost solution 0.005% expiration date 42 days from opening. 1. On 12/11/25 at 8:00 AM, Surveyor observed the medication room on the 2500 unit. Inside the refrigerator was a metal bin and clear bag containing insulin. Surveyor located the following insulin vials that were open and used, but not dated when opened:Two Lantus insulin vials belonging to R29, a Lantus insulin vial belonging to R4, a Lantus insulin vial belonging to R28 (the label read expires 28 days once opened), a Lispro insulin vial belonging to R28, and a Lispro insulin vial belonging to R56. All the above insulin vials were open and used but not dated when opened. On 12/11/25 at 8:15 AM, Surveyor advised Licensed Practical Nurse (LPN)-K of the observed resident insulins that were not dated when opened. Surveyor advised they were placed separately in the plastic bag and placed in the refrigerator. LPN-K reported she will reorder the insulin as needed. 2. On 12/11/25 at 8:30 AM, Surveyor observed the medication cart on the rehabilitation unit. Inside the top drawer of the medication cart, Surveyor located the following:A bottle of Latanoprost 0.005% eye drops belonging to R49 which was open and used but not dated when opened. The label read Start date 9/15/25, expires 42 days after opened.A bottle of Ofloxacin 0.3% eye drops belonging to R38 which was open and used but not dated when opened. The label read Start date 10/12/25.On 12/11/25 at 11:06 AM, Nursing Home Administrator (NHA)-A provided Surveyor the facility policy and procedure for insulin and eye drops and the pharmacy list of insulin and eye drop expiration dates once opened. On 12/11/25 at 3:00 PM, during the daily exit (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meeting, NHA-A and Director of Nursing (DON)-B were notified of the observations and concern of the above residents' insulin and eye drops that were not dated when opened. No additional information was provided.

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not address and resolve grievances conveyed on behalf of 1 (R9) of 6 grievances reviewed.*R9 expressed care concerns. There was no documentation this was thoroughly investigated, along with an appropriate resolution.Findings include:The facility policy last revised February 2025 and titled Grievance documents:Objective of Grievance PolicyThe objective of the grievance policy is to ensure the facility makes prompt efforts to resolve grievances a resident may have in a timely manner. The intent of the grievance process is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving complaint/grievance, the facility actively seeks a resolution and keeps the resident appreciated its progress toward resolution. E. A grievance or concern can be expressed orally to the Grievance Official or facility staff or in writing using a grievance form which will be located adjacent to the [NAME] of Rights posting located throughout the facility. G. ResponseAny employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority. If a complaint cannot be immediately resolved the employee shall escalate that complaint to their supervisor and the facility Grievance Officer. The investigation will consist of at least the following: * A review of the completed complaint report An interview with the person or persons reporting the incident if applicable Interviews with any witnesses to the incident or concern A review of the resident medical record if indicated A search of resident room (with resident permission) An interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident Interviews with the resident's roommate, family members, and visitors A root-cause analysis of all circumstances surrounding the incident. As necessary, the Grievance Official and facility leadership will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated.R9 was admitted to the facility on [DATE] with pertinent diagnoses that include diastolic (congestive) heart failure (occurs when the heart muscle doesn't pump blood as well as it should), chronic kidney disease stage 3 (kidneys are moderately damaged, filtering at 30-59% capacity), chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), spinal stenosis in lumbar region without neurogenic claudication (a narrowing of the spinal canal, stenosis can cause pressure on your spinal cord), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months).R9's Significant Change Medicare Minimum Data Set (MDS) with an assessment reference date of 9/22/2025 documents a Brief Interview for Mental Status score of 13 (cognitively intact) for R9. R9 is coded to make self understood and understands others.On 12/15/2025, at 9:18 AM, Surveyor interviewed R9 regarding a grievance R9 submitted on 9/15/25. R9 told Surveyor that there has been a couple more incidences since then with another staff member, Certified Nursing Assistant (CNA)-G. R9 reported the issues to Licensed Practical Nurse (LPN) Manager-D. The example R9 gave was R9 asked CNA-G to put R9's handbag back on the doorknob as it had fallen on the floor, CNA-G blew up at R9 and said that's not my job. R9 stated that it was very upsetting and even made R9 cry. R9 asked LPN Manager-D that CNA-G not be allowed in R9's room. Surveyor found no grievance regarding CNA-G filed on R9's behalf.On 12/15/25, at 1:30 PM, Surveyor interviewed LPN Manager-D regarding any known issues R9 has with staff members. LPN Manager-D stated that R9's care plan shows that R9 refuses cares and will send staff away. LPN Manager-D does not recall any staff not being allowed in R9's room. Surveyor asked LPN Manager-D about CNA-G and LPN Manager-D does not remember R9 reporting anything about CNA-G.On 12/15/25, at 2:44 PM, LPN Manager-D followed up with Surveyor (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that R9 did come and say I don't want CNA- G to take care of me anymore. This was about a month ago, LPN Manager-D stated that no grievance was completed. At the time LPN Manager-D asked CNA-G if there had been an issue and CNA-G didn't remember anything. LPN Manager-D asked CNA-G not to go in R9's room and ask R9 about it or start anything, just respect R9's wishes.Surveyor noted LPN Manager-D took complaint and acted to not have CNA-G go into R9's room, however no grievance process was initiated and investigation completed.On 12/16/25, at 8:36 AM, Surveyor interviewed Social Worker Lead-I and was told that no grievance for R9's issue with CNA-G was found. The only information Social Worker Lead-I had was what Surveyor had shared.On 12/16/25, at 9:07am, Surveyor interviewed Director of Nursing (DON)-B about no grievance being filed when R9 voiced a care concern and let DON-B know this is a concern.On 12/16/25, at 10:03am, Surveyor let Nursing Home Administrator (NHA)-A know the concern related to no grievance being filed when R9 voiced a care concern.No additional information was provided regarding no grievance being filed when a resident expressed care concerns. No documentation was provided that this was thoroughly investigated, or an appropriate resolution found.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure a resident who uses a psychotropic PRN (as needed) drug had an order limited to 14 days for 1 (R9) of 6 residents reviewed for medications.R9 had an order for PRN Lorazepam with a start date of 11/14/2025 and no end date.Findings include:The facility policy and procedure implemented 9/3/25 and titled, Use of Psychotropic Medication documents:Policy Explanation and Compliance Guidelines:16. Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted:a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration.R9 was admitted to the facility on [DATE] with pertinent diagnoses that include diastolic (congestive) heart failure (occurs when the heart muscle doesn't pump blood as well as it should), chronic kidney disease stage 3 (kidneys are moderately damaged, filtering at 30-59% capacity), chronic obstructive pulmonary disease (lungs become inflamed, damaged and narrowed), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (persistent, excessive fear or worry in situations that are not threatening), spinal stenosis in lumbar region without neurogenic claudication (a narrowing of the spinal canal, stenosis can cause pressure on your spinal cord), and chronic pain syndrome (a condition characterized by persistent pain that lasts for more than three months).R9's Significant Change Medicare Minimum Data Set (MDS) with an assessment reference date of 9/22/2025 indicates R9 had a Brief Interview for Mental Status score of 13 (cognitively intact). R9 is coded to make self understood and understands others.R9's care plan documents The resident uses anti-anxiety medications scheduled Hydroxyzine, Sertraline, Buspirone (PRN Lorazepam medications) r/t (related to) anxiety disorder, Date Initiated: 03/10/2025, Revision on: 09/01/2025.Pertinent interventions include: Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q (per)-SHIFT. Date Initiated: 03/10/2025 Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Clonazepam, Lorazepam, Buspirone, Sertraline: antianxiety medication drugs being given). Date Initiated: 03/10/2025 Monitor the resident (every shift for safety. The resident is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Date Initiated: 03/10/2025.R9's physician order dated 11/14/25 documents Lorazepam Oral Tablet 0.5 mg. Give 0.5 mg by mouth every 12 hours as needed for anxiety.Surveyor noted that the PRN order date was beyond 14 days with no end date indicated. Surveyor noted according to the State Operations Manual, the need to limit the timeframe for PRN psychotropic medications, which are not antipsychotic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner. Surveyor noted this was not documented.On 12/16/25, at 9:06am, Surveyor interviewed Director of Nursing (DON)-B regarding the PRN Lorazepam order for R9 not having a stop date. DON-B responded will look for documentation and get back to Surveyor.On 12/16/25, at 10:00am, Surveyor let Nursing Home Administrator (NHA)-A know of concern that a PRN psychotropic medication was ordered without a 14 day stop date or documentation of why a longer timeframe would be appropriate.On 12/16/25, at 11:05am, DON-B followed up and stated that the provider said the order for Lorazepam has been filled multiple times so is relevant. The most recent Psychiatry Follow Up was provided to Surveyor which states no changes to psychiatric medications were made at this visit. Surveyor explained this does not provide (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a stop date or document a reason why a longer timeframe would be appropriate.No additional information was provided regarding the PRN Lorazepam physician order R9 had without a stop date.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for 2 (R6 and R5) of 5 residents reviewed for falls. *R6 has a history of falls and is at high risk for falls. R6 experienced falls while at the facility. R6's fall care plan was not updated timely after a fall. R6 has an active intervention for a seat belt while in the wheelchair. On 10/24/25, R6 slid out of R6's wheelchair at the dining room table. After the fall, facility staff entered a new intervention on R6's care plan that documented, Locate [wheelchair] with seat belt, ensure positioning of [wheelchair] on [dining room] table appropriate and close to the table. R6's seat belt was not on the wheelchair at the time of the fall. During interviews, Surveyor was informed that R6's wheelchair with the seatbelt was out for repair and R6 did not have a seatbelt on at the time of the 10/24/25 fall. Surveyor observed R6's fall care plan interventions not in place during survey. *R5 had a fall on 8/2/25 and the facility did not revise the care plan interventions timely. Findings include: The facility policy with a last reviewed/revised date of 8/2024 and titled, Fall Prevention Program, documents: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. When any resident experiences a fall, the facility will: Assess the resident. complete a fall packet. review the resident's care plan and update as indicated. 1.) R6 was admitted to the facility on [DATE] with diagnosis that includes Parkinsons disease, Dementia, Orthostatic hypotension, Cancer and History of falling. R6's admission Minimum Data Set assessment dated [DATE], documents R6 is cognitively intact and that R6 requires substantial/maximum assistance for transfers. The MDS also documents that R6 had falls in the 2 to 6 months before admission to the facility. R6's high risk for falls care plan initiated on 1/19/25 documents the following pertinent interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Bed in locked and lowered position. Ensure adequate lightning is appropriate and/or per resident request. Ensure that the resident is wearing appropriate footwear. Follow facility fall protocol. R6's Fall Risk Evaluation dated 3/15/25 documents R6 is at high risk for falls. R6's progress note dated 4/10/25 at 3:10 PM, documents: Writer was called to resident's room after [R6] was noted on the floor next to his recliner. Writer assessed resident and noted no skin, musculoskeletal or head trauma complications. Surveyor reviewed the facility's fall investigation. Surveyor noted R6 fell in R6's room because of trying to complete a self-transfer from R6's recliner. R6 did not sustain an injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R6's progress note dated, 5/1/2025 at 2:14PM documents: [Interdisciplinary team (IDT)] reviewed fall from 4/10/2025. Interventions in place, care plan updated. On 5/1/25, R6's fall care plan was updated with the following intervention: Encourage participation in group activities and provide a sensory lap apron to reduce instances of self-transfer in his room. Surveyor noted R6's fall from 4/10/25 was reviewed by the IDT team on 5/1/25 and R6's care plan was reviewed and updated on 5/1/25, which is 21 days after the fall occurred. On 12/15/2025 at 10:40 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-F. Surveyor asked when a resident's care plan should be updated after a fall. LPN-F stated that the nurse can put in an intervention right away. Surveyor asked if it is typical to put in an intervention days to weeks after a fall. LPN-F stated that it should be put in the care plan right away. On 12/15/2025 at 1:38 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked what the workflow is if a resident falls. DON-B stated that if a resident is found by a Certified Nursing Assistant (CNA), the CNA will alert a nurse. There is an RN assessment completed, notifications made, and the nurse will complete all the documentation. The IDT team will meet and review each fall. The team meets every weekday and will make sure that the investigation is complete and will review and revise the care plan. Surveyor asked how long it takes to get the new intervention onto the resident's care plan. DON-B stated that DON-B cannot speak to an amount of time. DON-B continued and stated that IDT will typically talk about a fall within a couple days of the fall occurring. At that meeting, the interventions would be reviewed and a new one placed. Surveyor asked about R6's 4/10 fall and if it is typical for it to take 21 days for the care plan to be updated with a new intervention. DON-B stated that it is not normal and that 4/10/25 to 5/1/25 is an abnormally long time to go without updating the care plan with an intervention after a fall. R6's progress note dated 4/27/25 at 9:28 PM documents, in part: Writer notified by [Certified Nursing Assistant] that the resident was laying on the floor next to his bed. Resident is alert. laying on [R6's] right-side on the floor. [Registered Nurse (RN)] supervisor assessed the resident. Injury Noted, Closed hematoma to Right cheekbone. Closed Hematoma over right eyebrow. Surveyor reviewed the facility fall investigation and noted R6 fell in R6's room because R6 was trying to complete a self-transfer out of bed. R6's progress note, dated 5/1/2025 2:32 PM documents, in part: IDT reviewed fall from 4/27/2025. Interventions and care plan updated. As a result of this fall, Physical Therapy was consulted to build R6's strength. On 5/1/25, R6's fall care plan was updated with the following intervention: Trial seat belt when in wheelchair to remind resident not to attempt to self-transfer. Surveyor noted, R6's care plan was reviewed and updated on 5/1/25, which is 4 days after the fall occurred. R6's progress note dated 7/9/2025 at 3:42 PM, documents: Resident transferred [R6's self-] into bed, as none of the aides stated that they helped [R6]. A few minutes later [writer] walked past and saw [R6] on the floor between the wheelchair and bed. Resident was placed in dining area for supervision. Surveyor reviewed the facility fall investigation. R6 was able to get to R6's room from the dining room. R6 was able to remove the seatbelt and transfer into bed. Later, R6 was trying to self-transfer (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of bed and into the wheelchair and that is when R6 fell. R6 did not sustain any injury. On 7/16/25, R6's fall care plan was updated with the following intervention: Stop sign to be placed across doorway for visual reminder. Surveyor noted, R6's care plan was reviewed and updated on 7/16/25, which is 7 days after the fall occurred. R6's progress note dated 8/8/2025 at 7:51 PM documents, in part: Writer notified by CNA that the resident was sitting on the floor next to [R6's} bed. RN supervisor assessed the resident . No injury noted. Surveyor reviewed the facility fall investigation. Fall interventions were documented as being in place. R6 stated that R6 was going to bed. R6 was able to get from the dining room to R6's room and was trying to self-transfer to bed when R6 fell. R6 did not sustain an injury. On 8/14/25, R6's fall care plan was updated with the following intervention: Resident to be offered to go to bed right after dinner. Surveyor noted R6's care plan was reviewed and updated on 8/14/25, which is 7 days after the fall occurred. On 9/3/25, R6's fall care plan was updated with the following intervention: Keep the room door closed when the resident is not in the room with a stop sign in place. R6's progress note dated, 10/24/2025 at10:52 PM, documents, in part: Resident was in the dining room eating, when [resident] slid out of [the] wheelchair and onto the floor. Surveyor reviewed the facility fall investigation. Surveyor noted facility staff did not document that R6's seat belt was on and in place at the time of the fall. R6 did not sustain an injury. On 10/29/25, R6's fall care plan was updated with the following intervention: Locate [wheelchair] with seat belt, ensure positioning of [wheelchair] on [dining room] table appropriate and close to the table. Surveyor noted R6's care plan was reviewed and updated on 10/29/25, which is 5 days after the fall. In addition, Surveyor noted that according to this intervention, R6's wheelchair with seat belt was not in use at the time of the fall because the intervention reads that staff need to locate it. On 12/10/2025 at 1:25 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-H. Surveyor asked if there was a time that R6 did not have a seat belt in place. LPN-H stated that the wheelchair with the seat belt was missing for about 2 to 3 months. On 12/15/2025 at 8:41 AM, Surveyor interviewed CNA-E. Surveyor asked how long R6 has had a seat belt in the wheelchair. CNA-E stated that CNA-E was not sure. CNA-E stated that CNA-E works with R6 occasionally. CNA-E stated that R6 always has a wheelchair but does not always have a seatbelt in place. CNA-E acknowledged that there was a time that the seatbelt was missing but did not know how long it was gone. On 12/16/25 at 9:10 AM, Surveyor interviewed DON-B. Surveyor asked if R6's wheelchair and seatbelt were missing for a period of time. DON-B stated that the wheelchair and seatbelt were not missing but they were out for repair. Surveyor asked when the wheelchair was being serviced and for how long it was not in repair. DON-B stated that DON-B could not find that time frame. Surveyor asked about the intervention placed on 10/29/25 as a result of R6's fall on 10/24/25 at the dining room table. DON-B agreed that the intervention for locating R6's wheelchair with seatbelt would not have (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been added if the wheelchair with seatbelt was in place at the time of R6's fall on 10/24/25. On 12/10/2025 at 11:18 AM, Surveyor observed R6's room. R6 was not in the room or bathroom. R6's door was open and there was not a stop sign noted across R6's entry way door per R6's care plan interventions. On 12/10/2025 at 1:18 PM, Surveyor observed R6's room. R6 was not in the room or bathroom. R6's door was open and there was not a stop sign noted across R6's entry way door per R6's care plan interventions. On 12/10/2025 at 1:20 PM, Surveyor observed R6 at the common dining room table. R6 is not wearing a seatbelt. On 12/10/25 at 1:25 PM, Surveyor interviewed LPN-H. Surveyor asked if R6 was wearing a seatbelt. LPN-H stated that R6 is not wearing a seatbelt. On 12/16/25 at 9:15 PM, Surveyor informed DON-B of the concerns that after R6's falls, the care plan was not updated timely. On 10/24/25, R6's seatbelt was not in place at the time of R6's fall per R6's care plan intervention. In addition, through interviews, Surveyor found that R6's wheelchair with seatbelt was not in place for an unknown period of time while the wheelchair was being serviced. Surveyor had observations of care plan interventions not in place while on survey. DON-B understood the concerns. On 12/26/25 at 10:06 AM, Surveyor informed Nursing Home Administrator (NHA)-A of the above concerns. No additional information was provided as to why R6's fall care plan interventions not in place during survey. 2.) R5 was admitted to the facility on [DATE] with pertinent diagnoses that include hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (hemiplegia refers to paralysis on one side, while hemiparesis refers to weakness on one side, both occurring after a stroke to affect the left side) and history of falling. R5's Quarterly Minimum Data Set (MDS) with an assessment reference date of 11/19/2025 indicates R5 had a Brief Interview for Mental Status score of 15 (cognitively intact). R5 is coded to have adequate hearing and clear speech and is able to make self understood and understands others. R5's care plan documents The resident had an actual fall 8/2/25 no injury. Date Initiated: 08/06/2025. Pertinent interventions added after the fall include: Continue interventions on the at-risk plan. Date Initiated: 08/06/2025 Encourage resident and spouse to sit in the common area when spouse is visiting. Date Initiated: 08/07/2025 Family/caregiver or resident education on fall safety protocol. Date Initiated: 08/06/2025 Follow toileting plan and ensure to toilet before and after meals. Date Initiated: 08/06/2025 (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	12/16/2025

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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Remind resident and spouse will request for assistance related to add ADLS and transfers. Date Initiated: 08/07/2025 R5's unwitnessed fall report dated 8/2/25 documents resident husband put her in the bathroom and she tried to use restroom by herself and fell. R5's progress note written 8/2/2025, at 4:49 PM, documents: Staff alerted writer that resident was found on the floor. Upon arrival, writer found resident with head under the sink lying supine. Resident had neck brace in place. Resident is alert and verbal. Surveyor noted that R5's fall occurred on 8/2/25 and interventions to prevent future falls were not added to R5's care plan until 4 and 5 days later. On 12/16/25, at 9:07 AM, Surveyor interviewed (Director of Nursing) DON-B and informed of concern that R5 fell on 8/2/25 and R5's care plan was not updated until 8/6/25 and 8/7/25 which is a delay and safety concern for R5. On 12/16/25, at 10:04 AM, Surveyor informed Nursing Home Administrator (NHA)-A of concern related to delay in R5's care plan being updated after fall. Surveyor noted no additional information on why R5's care plan was delayed in being updated was provided.

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services, and ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments was received for 1 (R51) of 1 residents reviewed.Findings include:The facility's Hemodialysis policy implemented 9/21 and revised 8/24 documents:Policy: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the person-centered care plan and the residents' goals and preferences to meet the special medical, nursing, mental and psychosocial needs of residents receiving hemodialysis.Purpose: The facility will ensure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments. monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices; and ongoing communication of collaboration with the dialysis facility regarding dialysis care and services. 4. The facility will monitor and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner and dialysis facility of the changes.5. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form that will include, but not limit itself to:b. Physician/treatment orders, laboratory values, and vital signs.e. Dialysis treatment provided and resident's response, including declines in functional status, falls and the identification of symptoms that may interfere with treatments.f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site.R51 admitted to the facility on [DATE] and has diagnoses that include Venous insufficiency and Hypertensive Chronic Kidney Disease stage 5 or end state renal disease. R51 receives dialysis every Tuesday, Thursday and Saturday. R51's December 2025 Treatment Administration Record (TAR) documents:Monitor hemodialysis access device for bleeding, infection and pain. If profuse bleeding, apply tourniquet above fistula site and call MD (medical doctor) every shift. Monitor hemodialysis access site for Bruit/Thrill every shift for CKD (chronic kidney disease). If absent, notify MD. Surveyor noted this was signed out as completed with a + sign, indicating the bruit/thrill present. (Bruit is the sound heard with a stethoscope over an atrioventricular fistula. Thrill is the vibration felt over an atrioventricular fistula. This indicates good blood flow).Surveyor noted R51 does not have an atrioventricular fistula, instead R51 has an access port in the upper right chest.On 12/11/25 at 11:43 AM, Surveyor asked Licensed Practical Nurse (LPN)-F how the facility communicates with the dialysis center. LPN-F reported they do nurse to nurse report every shift and R51 has a binder in a bag on the back of his wheelchair for facility to dialysis communication. LPN-F stated, We look at the binder when he returns to see if there are new orders or anything abnormal. We are supposed to do vital signs before and after dialysis. He has an access site in his chest, but we don't do anything with it, we don't change the dressing, just make sure it's clean and dry. The communication forms are kept in the binder.Surveyor reviewed the facility/dialysis communication forms in the binder, noting only 2 forms dated 12/2/25 and 12/4/25. Both forms contained pre-dialysis vital signs only. There was no documentation from the dialysis center staff and no assessment or vital signs documented from facility staff upon return from dialysis. On 12/11/25 at 11:47 AM, Surveyor spoke with LPN Manager-J who reported the facility (continued on next page)

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	525588	A. Building B. Wing	12/16/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicates with dialysis with the binder on the back of his wheelchair. Surveyor asked what the expectation regarding assessment is. LPN Manager-J stated, We monitor his dialysis site for bleeding and such every shift. We should be doing vital signs before and when he returns from dialysis. They should be documenting on the form. Surveyor reviewed the dialysis communication forms in R51's binder with LPN Manager-J, noting there were only 2 forms dated 12/2 and 12/4 with pre dialysis vitals only, no other documentation from dialysis and no assessment or vital signs documented from facility staff after dialysis. Surveyor asked where the communication forms for 11/29, 12/6 and 12/9 are. LPN Manager-J stated. I don't know, let me look into this. I don't want to mis-speak on the process.Surveyor review of R51's medical record and nursing progress notes revealed no evidence or documentation an assessment or vital signs are completed after dialysis.On 12/15/25 at 9:51 AM, Surveyor spoke with LPN Manager-J and asked if she had any additional information. LPN Manager-J stated, No, it's the same as I told you. The expectation is that vital signs be done before dialysis, they should document on the form, dialysis should document on the form any of their information or new orders and we should be doing an assessment and vital signs when he returns from dialysis. LPN Manager-J reported she has not been able to locate any other forms completed. She stated, The expectation is that all the communication forms should stay in his binder until he discharges, then we will scan them in. We should be looking at the forms to see if there are any new orders or changes from dialysis and document our assessment and vital signs on the form.Surveyor advised LPN Manager-J that R51 has a dialysis port in his chest and asked if she was aware staff was signing in the TAR that they are assessing bruit/thrill for atrioventricular fistula, which R51 does not have. LPN-J stated, I thought he had a shunt in his arm. Surveyor advised he does not. LPN-J stated, I don't know why they would be documenting that then. The only explanation I have is that they enter standard orders for dialysis and maybe that got entered, but it should have been discontinued if he doesn't have the shunt. On 12/15/25 at 3:13 PM, during the daily exit meeting, Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were notified of concern regarding communication between the facility and dialysis center and concern the facility is not completing a post-dialysis assessment or vital signs.No additional information was provided.