STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/10/2024 with information gathered through 05/28/2024, Surveyor conducted 3 complaint investigations at Luther Manor at River Oaks. Five deficiencies were identified. Three of 3 complaints were substantiated. Census: 8	N 000		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report a serious injury resulting in emergency room treatment to the Department within 3 days. Resident 7 fractured his/her left sacral after a fall on 06/17/2023. Findings include: On 11/30/2023, the Department received a complaint alleging concerns following a resident fall. On 05/10/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 admitted to the facility on 01/17/2023 with a diagnosis of dementia. Resident 1 had an	N 165		

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
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 165	Continued From page 1	N 165		

activated healthcare power of attorney. Resident 1 was hospitalized from 06/17/2024-06/28/2024 following his/her fall.

Resident 1's individual service plan (ISP) dated 03/15/2023 documented:
"The resident is at risk for falls r/t balance problems, gait problems, hx of falls, impaired mobility. Approaches: Encourage participation in activities that will increase strength and mobility. Encourage resident to stay in common areas to promote more supervision. Encourage resident to wear hearing aid and ensure that it is clean and functional."

Resident 1's incident report dated 06/17/2023 at 4:35 PM documented:
"Staff to check on [Resident 1] to get ready for dinner, and [s/he] did not want to. Staff left to get [him/her] dinner to [him/her], but 5 mins later [his/her] light was on and [s/he] was yelling and screaming. [S/he] was on the floor."

Resident 1's progress notes documented:
"06/19/2024: Late entry: Res was found in [his/her] room on the floor sitting upright on the side of [his/her] bed by the caregiver. The root cause of the fall is r/t increased confusion and self-transferring. The call light was within reach. Res used call light to call for assistance after falling. The intervention is res was sent out to hospital and be referred to hospice upon return. 06/17/2024: [Resident 1] complained of back pain during the assessment it was decided to transfer [him/her] to the hospital for further evaluation."

Resident 1's hospital discharge summary dated 06/17/2023-06/28/2023 documented:
"Patient was brought into outside ED, with activated POA. POA felt that patient slid out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 165	Continued From page 2 bed and landed on [his/her] tailbone. POA found patient on the floor .....Per ED provider, patient had just left rehab recently and returned home ...Prior to admission the patient was noted to have failure to thrive for several weeks. Comfort cares were initiated while inpatient and plan was made for hospice on discharge. Discharge diagnoses: acute left sacral fracture, recent fall." On 05/23/2024, Surveyor reviewed Department records, which indicated no self-reports were submitted regarding Resident 1's left sacral fracture. On 05/23/2024 at 9:02 AM, Surveyor interviewed Administrator A and Director of Nursing (DON) B. Administrator A confirmed s/he was aware of Resident 1's fall on 06/17/2023. Administrator A acknowledged Resident 1's serious injury that required hospitalization should have been reported to the Department. Administrator A did not comment why the self-report was not submitted.	N 165		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by:	N 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 169	Continued From page 3 Based on record review and interview, the provider did not ensure the resident's legal representative was notified when there was an incident to the resident. Resident 1's legal representative was not notified timely following a fall on 05/12/2023. Findings include: On 11/30/2023, the Department received a complaint alleging concerns following a resident fall. On 05/10/2024, Surveyor reviewed Resident 1's record and identified the following: Resident 1 admitted to the facility on 01/17/2023 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney. Resident 1 was hospitalized from 06/17/2023-06/28/2023 following his/her fall. Resident 1's individual service plan (ISP) dated 03/15/2023 documented: "The resident is at risk for falls r/t balance problems, gait problems, hx of falls, impaired mobility. Approaches: Encourage participation in activities that will increase strength and mobility. Encourage resident to stay in common areas to promote more supervision. Encourage resident to wear hearing aid and ensure that it is clean and functional." Resident 1's incident report dated 05/12/2024 at 7:15 AM documented: "Resident was found on the floor by med passer. Asked [him/her] what happened, [s/he] stated [s/he] does not know. No bruising, no complaints of pain. Family notified: 05/16/2023 at 12:30 PM."	N 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 169	Continued From page 4 Resident 1's progress notes documented: "05/12/2023: Caregiver went to room to get res for breakfast and found res sitting upright on floor on side of bed. When asked how [s/he] fell res informed caregiver that [s/he] did not know how [s/he] fell. Res asked if [s/he] was laying in bed or sitting up on side of bed. Res informed staff that [s/he] was not sure. Res doe not have any apparent injuries. ROM WNL. Res denied pain and discomfort. Res assisted off floor with assist of caregiver without difficulty. 05/15/2023: IDT reviewed and root cause of fall r/t res potentially rolling out of bed while sleep. Res does not recall sitting up on side of bed. Staff will make sure bed is in lowest position when resident in bed. 05/16/2023: Res [son/daughter] was updated on fall res had on 5/12/23." On 05/23/2024 at 9:02 AM, Surveyor interviewed Administrator A and Director of Nursing (DON) B. Surveyor asked why Resident 1's legal representative was not contacted after his/her fall on 05/12/2023. Administrator A noted if the fall occurred on a Friday, sometimes legal representatives are not notified until the following Monday. Surveyor stated Resident 1's fall was on the morning of 05/12/2023 and the following Monday would had been 05/15/2023. Administrator A acknowledged Resident 1's legal representative should have been notified sooner and did not respond further.	N 169		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights:	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 5 Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 3 of 3 residents received prescribed medications in the dosage and at intervals prescribed by a practitioner. Findings include: On 12/08/2023, the Department received a complaint alleging concerns residents were not getting their medications. On 05/10/2024, Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 admitted to the facility on 01/17/2023 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney. Resident 1's individual service plan (ISP) dated 03/15/2023 documented: "The resident has pain and receiving pain medication. Approaches: Administer analgesia scheduled tramadol and PRN Tylenol as per orders." Resident 1's physician orders included: "1) Ensure with meals. Give 1can/carton three times a day with each meals, start date 03/31/2023." Surveyor reviewed Resident 1's record including his/her medication administration record (MAR)	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 6	N 352		

from 04/01/2023-06/17/2023. The providers charting codes for MARs indicated "9=Other/See progress notes".

April 2023:
-45 entries in the administration of Ensure from 04/13/2023-04/28/2023, staff indicated "9."
May 2023:
-5 entries in administration of Ensure from 05/11/2023-05/12/2023, staff indicated "9."

Resident 1's progress notes documented: 05/11/2023-05/12/2023, 5 entries of Ensure was "unavailable or not in yet."

The record did not include any other evidence to show the provider followed up with the pharmacy to see the status of Resident 1's above medications.

Example 2: Resident 2

Resident 2 admitted to the facility on 01/29/2024.

Resident 2's ISP dated 01/31/2024 documented: "The resident is unable to self-administer all [his/her] medications r/t resident preference. Approaches: Medications will be administered by licensed or certified team members. The resident has altered cardiovascular status r/t hypertension. Approaches: Apply tubi-grips as ordered. Time on AM; Time off: HS. Change soiled pairs of tubi-grips. Wash and hang to dry."

Resident 2's physician orders included: "Amlodipine 10mg tablet, give 1 tablet by mouth at bedtime for HTN. Hold if SBP less than 100 or HR less than 50, with a start date of 02/09/2024. Metoprolol 50 mg tablet, given 1 tablet by mouth one time a day for HTN. Hold if SBP less than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 7	N 352		

100 or HR less than 55, with a start date of 01/30/2024.
Cephalexin 500mg 4x/daily for 7 days, with a start date of 02/16/2024."

Resident 2's progress notes documented:
"02/14/2024: This writer was informed by the caregiver that the resident called 911. When they asked why, res reported that [s/he] was having numbness and tingling in [his/her] legs. Caregiver and med passer informed writer that Res never informed them that [s/he] was having numbness and tingling to bilateral lower extremities. The ambulance arrived and took res to the ER around 1600. Res returned around 2045 from St Mary's with a diagnoses of Lymphedema and Cellulitis to BLEs. Res has new orders for Cephalexin 500mg 4x/daily for 7 days. Also PRN orders for Tylenol and Ibuprofen.
02/16/2024 at 9:24AM, 12:08, 16:22, 21:10: Keflex Oral Capsule 500mg-"Not in yet, haven't arrived yet"
02/17/2024 at 0900: Keflex Oral Capsule 500mg-"on order"
02/19/2024 at 12:46: "not in yet."

Surveyor reviewed Resident 2's record including his/her MAR from 02/01/2024-04/30/2024. Surveyor observed that staff who administered Resident 2's Amlodipine and Metoprolol did not document blood pressure readings across 73 days the medications were administered.

February 2024:
-8 entries in the administration of Keflex Oral Capsule 500mg from 02/16/2024-02/19/2024, staff indicated "9."

The record did not include any other evidence to show the provider followed up with the pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 8 to see the status of Resident 2's above medications. Example 3: Resident 3 Resident 3 was admitted to the facility on 09/21/2022. Resident 3 is their own legal decision maker. Resident 3's ISP with an unknown dated documented: "the resident has impaired visual function r/t infection (shingles in the eye) and has been prescribed Moxifloxacin and valtrex. Approaches: ensure appropriate visual aids are available to support resident's participation in activities. Monitor/document/report PRN any s/sx of acute eye problems: change in ability to perform ADLs, decline in mobility, sudden visual loss, pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. Tell resident where your are placing their items. Be consistent." Resident 3's physician orders included: "Oxybutynin 5mg tablet give by mouth at bedtime for for nocturia, with a start date of 05/26/2023. Difluprednate Ophthalmic Emulsion 0.05%, instill 1 drop in left eye 4x/daily for eye infections, with a start date of 01/01/2024. Atorvastatin 20mg tablet, given by mouth in evening for cholesterol, with a start date 04/12/2023. Prednisolone Acetate Ophthalmic 1%, instill 1 drip in left eye 3x/daily for corneal perforation to left eye, with a start date of 04/01/2024. Surveyor reviewed Resident 3's record including his/her MAR from 11/01/2023-04/30/2024:	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 9 November 2023: -6 entries in administration of Oxybutynin from 11/01/2023-11/06/2023, staff indicated "9." January 2024: -Surveyor observed 92 of 120 entries in administration of Difluprednate Ophthalmic Emulsion, staff indicated "9." February 2024: -8 entries in administration of Atorvastatin from 02/04/2024-02/06/2024, 02/10/2024, 02/11/2024, 02/14/2024, 02/15/2024, and 02/28/2024, staff indicated "9." -Surveyor observed 80 of 112 entries in administration of Difluprednate Ophthalmic Emulsion, staff indicated "9." March 2024: -15 entries in administration of Atorvastatin from 03/01/2024-03/04/2024, 03/07/2024, 03/09/2024, 03/09/2024, 03/11/2024-03/13/2024, 03/15/2024, 03/19/2024-03/21/2024, 03/24/2024, 03/29/2024, staff indicated "9." -Surveyor observed 98 of 120 entries in administration of Difluprednate Ophthalmic Emulsion, staff indicated "9." April 2024: 18 entries in administration of Atorvastatin from 04/01/2024-04/04/2024, 04/06/2024-04/09/2024, 04/12/2024, 04/16/2024-04/18/202404/20/2024-04/24/202404/28/2024, staff indicated "9." -Surveyor observed 91 of 116 entries in administration of Difluprednate Ophthalmic Emulsion, staff indicated "9." -11 entries in administration of Prednisolone	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 10 Acetate Ophthalmic 1%, staff indicated "9.' Resident 3's progress notes documented: "11/02/2023-11/04/2023, 3 entries Oxybutynin was "on order." 1/8/2024-1/29/2024, 18 entries Difluprednate Ophthalmic Emulsion was "not in yet or haven't arrived yet." 02/03/2024-02/27/2024, 19 entries Difluprednate Ophthalmic Emulsion was "on order, out for order, or medication not available." 02/05/2024-02/27/2024, 12 entries Atorvastatin was "not in yet, on order, med not on cart." 03/01/2024-03/31/2024, 44 entries Difluprednate Ophthalmic Emulsion was "on order, out for order, or medication not available." 03/01/2024-03/29/2024, 12 entries Atorvastatin was "not in yet, on order, med not on cart." 04/01/2024-04/30/2024, 16 entries Atorvastatin was "not in yet, on order, med not on cart." 04/01/2024-04/30/2024, 57 entries Difluprednate Ophthalmic Emulsion was "on order, out for order, or medication not available." The record did not include any other evidence to show the provider followed up with the pharmacy to see the status of Resident 3's above medications. On 05/10/2024 at 10:34 AM, Surveyor interviewed Resident 3. Resident 3 stated every month the facility will run out of his/her medications especially eye drops. Resident 3 stated s/he was supposed to be on this one set of eye drops that is required 4x/day, but the facility cannot give an answer to why it had not started. On 05/23/2024 at 9:02 AM, Surveyor interviewed Administrator A and Director of Nursing (DON) B. Surveyor expressed concern for the ongoing	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 11 systems issues related to reordering or getting medications filled by the pharmacy. Surveyor noted 3 of 3 resident records showed from at least November 2023 until day of survey 05/10/2024, ongoing issues with medications not being available to residents. Administrator A stated Resident 3 continued to have many eye drops and at times insurance will not cover. Administrator A acknowledged the facility should have completed more follow up on above medications. Administrator A stated staff retraining is ongoing with reordering resident medications.	N 352		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an assessment was completed for 2 of 2 residents reviewed. Resident 1's record did not include a pre-admission assessment or change of condition assessment following a fall on 01/27/2023. Resident 2's record did not include a change of condition assessment	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 381	Continued From page 12 following a hospitalization in April 2024. Findings include: On 05/10/2024, Surveyor reviewed resident records and identified the following: Example 1: Resident 1 Resident 1 admitted to the facility on 01/17/2023 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney. Resident 1's record did not include a pre-admission assessment. Resident 1's incident report dated 01/27/2023 documented: "Resident was in the restroom getting washed up for lunch when the staff went to check on the resident and found the resident laying on the floor on [his/her] back. Staff stated that resident was bleeding from [his/her] head. Resident stated [s/he] misjudged grabbing [his/her] walker and fell backwards." Resident 1's progress notes documented: "02/07/2024: Writer spoke with [Family Member C] to discuss ED visit. Per [Family Member C] they are still in the ED and awaiting info. Writer updated [Family Member C] that I am aware that a fracture was discovered during the ED visit. Per [Family Member C] they found a pelvic fracture and possibly a sacral fracture, nut [s/he] is awaiting speaking with ortho. When writer was attempting to revive the current injuries [Family Member C] stated that the fracture could be a result of the fall from 1/27/23 as no imaging was completed when sent to the ED and [Resident 1] was having pain since. Writer explained the self-reporting process for the new injuries noted.	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 381	Continued From page 13 [Family Member C] upset that [Resident 1] had an injury noted from the previous fall, writer explained that we are aware of the previous injuries, but since [s/he] now is discovered to have new injuries we will include those injuries as well." Resident 1 discharged to the provider's skilled nursing facility for rehab from 02/10/2023-02/27/2023. Resident 1 admitted back to the facility from 02/28/2023-06/01/2023. The record did not contain an assessment following Resident 1's sacral fracture. Resident 1's record did not include a pre-admission assessment. Example 2: On 04/22/2024, the Department received a complaint alleging concerns residents were not being assisted with transfers. Resident 2 admitted to the facility on 01/29/2024. Resident 2's individual service plan (ISP) dated 01/31/2024 documented: "Resident is at risk for falls r/t balance problems. Approaches: become familiar with the resident's daily routine and attempt to anticipate and meet the resident's needs daily. Remind resident to use assistive devices and to use call deice pull cord for assistance as needed. Remind resident to use assistive devices walker and wheelchair." Resident 2's self-report dated 04/03/2024 documented: "[Resident 2] had an unwitnessed fall with complaints of pain in head and knee. [Resident 2] was sent out to the emergency room for further assessment, evaluation, and treatment. [Resident 2] was last seen laying down in bed. [Resident 2]	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 381	Continued From page 14 waited patiently for the ambulance to come. When observing resident and environment it was noticed that [Resident 2] was in [his/her] pajamas and socks while watching t.v. [Resident 2] reported [s/he] was trying to turn [his/her] hip and [s/he] had a fall out the bed. Upon return back to the facility, IDT will be working to put interventions in place. [Resident 2] will continue to utilize durable medical equipment and pendant for assistance when needed. While in the ED was noted that [Resident 2] has a hematoma left knee and right hip pain. [Resident 2] was admitted and discharged back to Assisted Living." Resident 2's hospital discharge report dated 04/03/2024-04/10/2024 documented: "Discharge diagnoses: Weakness, Secondary diagnoses: fall, hematoma of left knee region ..history of hypertension as well as chronic cellulitis with lower extremity lymphedema. Residing in assisted living presenting to emergency room brought in by EMS after falling from bed. [S/he] had discomfort in [his/her] right hip while lying in bed then. But that to get to a comfortable position however fell from bed sustain injury to left knee also hit [his/her] head to the floor. [His/her] main complaint is that of left knee pain denies any hip pain and was brought in for evaluation. Prior to the fall the day prior patient has had no physical complaints ....negative and ct knee without fracture, head ct also negative, patient not able to ambulate and being admitted ....Hospital course: Fall, R frontal scalp hematoma, L knee hematoma, appears mechanical in nature." Resident 2's progress notes document:	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 381	Continued From page 15 "04/11/2024: Late entry-Writer and [Administrator A] met with the [son/daughter] in regards to resident care level change at this time. [Son/daughter/POA] acknowledged. 04/27/2024: Late entry-Res not returning to facility. Res's [son/daughter] moved all resident personal belongings out." Resident 2's record did not contain an assessment following his/her hospitalization from 04/03/2024-04/10/2024. On 05/23/2024 at 9:02 AM, Surveyor interviewed Administrator A and Director of Nursing (DON) B. Administrator A acknowledged after looking over Resident 1's and Resident 2's records no other assessments could be located. Administrator A noted the provider should have completed assessments for the above occurrences. Administrator A and DON B did not comment any further.	N 381		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the CBRF implemented and followed the individual service plan (ISP) for 1 of 1 resident reviewed. Resident 1's ISP directed staff to obtain Resident 1's blood pressure readings. From 04/01/2023-06/01/2023 and 06/15/2023-06/17/2023, there was no evidence that staff obtained 2x daily blood pressure	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 388	Continued From page 16	N 388		

readings for 64 days. Hospital records identified a historic concern for Resident 1's hypertension.

Findings include:

On 05/10/2024, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 admitted to the facility on 01/17/2023 with a diagnosis of dementia. Resident 1 had an activated healthcare power of attorney.

Resident 1's physician orders included:
"Metoprolol Tartrate 25 MG, take 1 tablet 2 times a day for HTN hold if SBP less than 100 or HR less than 50. Amlodipine 5 MG, take 1 tablet by mouth 1 time a day for HTN, hold if SBP less than 100 or HR less than 50."

Resident 1's individual service plan (ISP) dated 03/15/2023 documented:
"Resident has an active diagnosis of hypertension. Approaches: Obtain blood pressure readings per MD. Take blood pressure readings under the same conditions each time. For example resident is sitting, use right arm."

Surveyor reviewed Resident 1's record including his/her medication administration record (MAR) from 04/01/2023-06/17/2023 and observed 128 missing entries across 64 days. Surveyor observed that staff who administered Resident 1's Metoprolol and Amlodipine did not document blood pressure readings across 64 days the medications were administered.

On 05/23/2024 at 9:02 AM, Surveyor interviewed Administrator A and Director of Nursing (DON) B. Administrator A and DON B stated after reviewing Resident 1's MARs, staff should have recorded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009128	A. BUILDING: _____ B. WING _____	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR AT RIVER OAKS	11340 N CEDARBURG RD MEQUON, WI 53092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 388	Continued From page 17 blood pressure readings in the facilities' electronic health record. DON B stated if staff had recorded blood pressure readings the value would have displayed on the residents monthly MAR. Administrator A acknowledged the concern and stated staff would be retrained.	N 388		