STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	**4611 N 92ND ST MILWAUKEE, WI 53225**

(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 02/07/2025, Surveyor conducted an abbreviated survey and complaint investigation at Luther Manor Courtyards, a Community-Based Residential Facility (CBRF) in Wauwatosa, WI. Four deficiencies identified. Complaint substantiated. Census: 92	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees (Resident Care Assistant (RCA) B) reviewed obtained all orientation training. RCA B did not have the following orientation training: information regarding assessed needs and individual services for each resident for whom the employee is responsible, and recognizing and responding to	N 230		

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
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	4611 N 92ND ST MILWAUKEE, WI 53225

(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 230	Continued From page 1 resident changes of condition. Findings include: On 02/07/2025, Surveyor reviewed RCA B's record and identified the following: -RCA B was hired on 09/05/2023. RCA B's record did not contain evidence of orientation training in information regarding assessed needs and individual services for each resident for whom the employee is responsible, and recognizing and responding to resident changes of condition. On 02/07/2025, at approximately 3:36 PM, Surveyor interviewed Chief Clinical Officer (CCO) A. CCO A reported s/he was unable to find the 2nd page of employee educational material for RCA B and was unable to confirm RCA B received the training.	N 230		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	4611 N 92ND ST MILWAUKEE, WI 53225

(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 247	Continued From page 2 topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees (Resident Care Assistant (RCA) B) reviewed obtained all task specific training. RCA B who had responsibilities for providing assistance with activities of daily living, did not have training in provision of personal care prior to assuming these duties. Findings include: On 02/07/2025, Surveyor reviewed RCA B's record and identified the following: -RCA B was hired on 09/05/2023. RCA B's record	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	4611 N 92ND ST MILWAUKEE, WI 53225

(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 247	Continued From page 3 did not contain evidence of training or evidence of meeting an exemption for personal care training. On 02/07/2025, at approximately 3:36 PM, Surveyor interviewed Chief Clinical Officer (CCO) A. CCO A confirmed RCA B record did not have evidence RCA B completed or met an exemption for provision of personal care training prior to assuming these job duties. CCO A stated s/he was unable to find the 2nd page of employee educational material for RCA B and was unable to confirm RCA B received the training.	N 247		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not involve 1 of 1 resident (Resident	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	4611 N 92ND ST MILWAUKEE, WI 53225

(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 387	Continued From page 4 1) reviewed, in developing the individual service plan (ISP) and did not have the plan signed acknowledging their involvement in, understanding of, and agreement with the plan. Findings include: On 02/07/2025, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's facility on 04/27/2023 with diagnoses of type 2 diabetes mellitus with diabetic polyneuropathy, long term use of insulin, essential hypertension, immunodeficiency, kidney transplant status, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, abnormalities of gait and mobility, unsteadiness on feet, need for assistance with personal care, weakness, post covid-19 condition, end stage renal disease, anemia, atherosclerotic heart disease of native coronary artery with angina pectoris, hyperlipidemia, generalized anxiety disorder, mood affective disorder, primary generalized osteo arthritis, gastroesophageal reflux disease without esophagitis, retention of urine, and reaction to tuberculin skin test without active tuberculosis. -Resident 1 was his/her own person. -Resident 1's ISP, dated 11/15/2024, had no resident signature. On 02/07/2025, at approximately 11:35 AM, Surveyor interviewed Chief Clinical Officer (CCO) A. CCO A confirmed Resident 1's ISP, dated 11/15/2024, did not contain Resident 1's signature, CCO A stated s/he could not locate the signature page for Resident 1's ISP, dated	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	4611 N 92ND ST MILWAUKEE, WI 53225

(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 387	Continued From page 5 11/15/2024.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's individual service plan (ISP) was updated based on assessments to meet his/her needs for fall prevention. Between 07/25/2024 and 11/14/2024, Resident 1 experienced 4 falls. Resident 1's ISP, dated 11/15/2024, was not updated to identify interventions to mitigate his/her risk of falls. Findings include: On 02/07/2025, Surveyor reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's facility on 04/27/2023 with diagnoses of type 2 diabetes mellitus with diabetic polyneuropathy, long term	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	4611 N 92ND ST MILWAUKEE, WI 53225

(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 389	Continued From page 6	N 389		

use of insulin, essential hypertension, immunodeficiency, kidney transplant status, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, abnormalities of gait and mobility, unsteadiness on feet, need for assistance with personal care, weakness, post covid-19 condition, end stage renal disease, anemia, atherosclerotic heart disease of native coronary artery with angina pectoris, hyperlipidemia, generalized anxiety disorder, mood affective disorder, primary generalized osteo arthritis, gastroesophageal reflux disease without esophagitis, retention of urine, and reaction to tuberculin skin test without active tuberculosis.

-Resident 1's incident report, dated 11/05/2024, stated the following: "Supportive staff reported [Resident 1] trying to back up to bed to fast. Right leg failed due to side with stroke. [Resident 1] slid self to the floor. Per supportive, [Resident 1] did not hit [his/her] head. Upon assessment, [Resident 1] found sitting on floor next to bed, in front of recliner. [Resident 1] at baseline mentation, no apparent to report. [Resident 1] stated, "[s/he] was going to bed, and leg went out on [him/her]. I'm not hurt."

-Resident 1's incident report, dated 11/11/2024, stated the following: "On 11/9/24 supportive staff in bathroom with [Resident 1] assisting with toileting needs. [Resident 1] stood up from the toilet and started walking then started to lean forward stated, "I'm going to fall." [Resident 1] began to fall, and staff guided [Resident 1] to the floor. No apparent injury from began lowered to the floor by staff. Supportive staff reports that [Resident 1] was able to get up off of the floor with supportive staff guiding him back into a sitting position."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	4611 N 92ND ST MILWAUKEE, WI 53225

(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 389	Continued From page 7 -Resident 1's incident report, dated 11/14/2024, stated the following: "Supportive staff helped [Resident 1] get up from [his/her] wheelchair to transfer to [his/her] walker. [Resident 1] stood up all the way and [Resident 1] asked me was I coming back to get [him/her] from the toilet, I said yes and moved [his/her] wheelchair into the hallway, and then [Resident 1] fell backwards. [Resident 1] stated, "ok I just fell", and lost [his/her] balance."Supportive staff called for a lift assist, and when EMT (emergency medical technicians) arrive [Resident 1] was transported to St. Luke's Hospital. No injuries found." -Resident 1's morse fall risk assessment, dated 11/05/2024, 11/11/2024, and 11/15/2024 stated the following: "High Risk for Falling." -Resident 1's ISP, dated 11/15/2024 stated the following: "[Resident 1] is Moderate risk for falls related to gait/balance problems. 7/25/24 witnessed fall with to emergency room visit due to hitting head; CT (computerized tomography scan) Head without contrast negative. [Resident 1] has had an actual fall with (Specify: no injury, minor injury, serious injury) Poor Balance. 11/9/2024 [Resident1] had a fall with no injury. 11/14/2024 [Resident 1] had a fall and transferred to emergency department. On 02/07/2025, at approximately 11:35 AM, Surveyor interviewed Chief Clinical Officer (CCO) A. CCO A confirmed Resident 1's ISP, dated 11/15/2024, was not updated to identify interventions to mitigate his/her risk of falls. CCO A stated the interdisciplinary team (IDT) was responsible for updating residents' ISPs. CCO A stated the IDT failed to update Resident 1's ISP to identify interventions to mitigate his/her risk of	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310087	A. BUILDING: _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR COURTYARDS	**4611 N 92ND ST MILWAUKEE, WI 53225**

(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 389	Continued From page 8 falls. CCO A stated the entire IDT professionals were recently hired.	N 389		