STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	**831 PINE BEACH RD MARINETTE, WI 54143**

(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 07/18/2025, Surveyor conducted 1 complaint investigation at Luther Manor. Additional information was collected through 08/05/2025. The complaint was substantiated, and 1 deficient practice was identified. Census: 34	N 000		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review, and interview the provider did not ensure Resident 1 received care to meet his/her needs. After Resident 1 had a documented change in condition, the provider did not follow through with adequate interventions or physician orders to meet Resident 1's safety needs.	Y3244		

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
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	**831 PINE BEACH RD MARINETTE, WI 54143**

(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
Y3244	Continued From page 1 Resident 1 had increased frequency in falls and increased confusion, including hallucinations. After Resident 1's physician ordered continual assistance during ambulation, the family requested an alarm for the resident to notify the staff when the resident was ambulating. The intervention was not put into place by the provider nor were all caregivers made aware of the new order on 02/19/2025 to assist the resident with ambulation at all times. The resident was not assessed by the provider for the use of a wander guard bracelet. On 02/21/2025, Resident 1 was seen by a caregiver ambulating and was not assisted as was ordered. Resident 1 subsequently exited the facility and fell. Approximately 20 minutes later the resident was found outside in snow with significant injury to his/her right eye that resulted in partial blindness for greater than five months. The provider is licensed to care for up to 55 resident who may be of advanced age, terminally ill, or have irreversible dementia/ Alzheimer's Disease. Findings include: On 03/05/2025, the Department received a complaint alleging the provider did not provide adequate care to meet resident needs. On 07/18/2025, Surveyor reviewed Resident 1's record including his/her admission assessment and notes to the primary care provider. Resident 1 was admitted on 06/06/2018 with diagnosis including craniopharyngioma and noted memory lapse/ confusion. Resident 1 was discharged on 02/21/2025. Surveyor reviewed Resident 1 had a history of falls with a reported increase in falls from October 2024 through 02/21/2025 and an	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	831 PINE BEACH RD MARINETTE, WI 54143

(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
Y3244	Continued From page 2	Y3244		

increase in confusion in December 2024 through 02/21/2025 with visual and auditory hallucinations noted beginning on 02/09/2025. Resident 1 had an incident report dated 02/21/2025 that noted an injury to his/her right eye from a fall where s/he was found laying face down on the ground outside in the snow for up to 21 minutes.

On 07/18/2025 at 1:20 PM, Surveyor observed the sitting lounge that was near Resident 1's former room while interviewing Caregiver E. The lounge had a door that led outside to a gazebo and further on to other buildings on campus across a grass lawn. The door was openable to passersby. Caregiver E stated and Surveyor observed, the door was fitted with a wander guard system that would alert staff if any resident with a wander guard device on attempted to exit the facility. Caregiver E pointed to across the lawn to the corner of anther campus building and stated that was approximately where Resident 1 was found during an incident that occurred on 02/21/2025.

On 07/18/2025, Surveyor reviewed documentation from Resident 1's medical record including "Face to Face Encounter: Assessment and Plan" electronic note/ order from Neurology APNP D written on 02/19/2025 at 12:40 PM that noted, "... a message to the facility was made that [s/he] should be assisted during ambulation at all times to help minimize the frequency of falls ..."

On 07/18/2025, Surveyor reviewed a self-report submitted to the Department on 02/24/2025 by Director B regarding an incident that occurred on 02/21/2025 involving Resident 1. The report noted Resident 1 had a history of falls and a recent change in condition including visual and auditory hallucinations and increased confusion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	831 PINE BEACH RD MARINETTE, WI 54143

(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
Y3244	Continued From page 3	Y3244		

The report included a timeline between 02/09/2025-02/19/2025 of falls, increased confusion, and the provider updating the family and Resident 1's physician. The timeline noted the resident had a neurology appointment on 02/19/2025 and included the change of medication order but did not include notation about the order to assist Resident 1 at all times during ambulation. The report included a description of the incident that occurred on 02/21/2025 via a written statement from Caregiver C:

"... At (around) 5:35 PM I noticed [Resident 1] get up from the dinner table with another resident who [s/he] frequently walks with after dinner as they are neighbors. I stepped away for a brief moment to go give another resident their medication. When I returned to my Med [sic] cart I did not see [Resident 1] or the resident [s/he] usually walks with and assumed [s/he] had gone back to [his/her] room. At 5:50 PM my relief came in ... (about 6 minutes had passed since [s/he] arrived) just then a resident ... starts yelling down the hallway that there's someone outside in the snow and they look hurt ... [unnamed staff] came back [s/he] stated 'It's [Resident 1!] Call 911." ... I ran outside to assess the situation. A resident assistant and I got [him/her] off the ground and brought [him/her] inside as it was cold and [s/he] had no coat or any winter attire on. When we got [Resident 1] back inside we quickly took vitals, got [him/her] blankets to warm [him/her] and we cleaned [his/her] face the best we could and covered the laceration on [his/her] right eyebrow. Around 6:15 PM the ambulance arrived ..."

On 07/18/2025 at 1:30 PM, Surveyor interviewed Caregiver C. Caregiver C stated prior to the elopement and fall on 02/21/2025 s/he believed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	831 PINE BEACH RD MARINETTE, WI 54143

(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
Y3244	Continued From page 4 Resident 1 required "assisted ambulation to the bathroom but not all the time." Caregiver C stated s/he was unaware that Resident 1 had an order entered on 02/19/2025 to be assisted at all times during ambulation. Caregiver C stated Resident 1 had a history of falls and, prior to the fall on 02/21/2025, it was communicated by Director B that Resident 1 was having increased falls, increased confusion including hallucinations, and the staff were directed to provide increased "monitoring" for Resident 1. Caregiver C stated s/he could not recall any other interventions provided. Caregiver C stated new orders are communicated verbally between shifts and could be found on the front of the Medication Administration Record (MAR) or added to the Treatment Administration Record (TAR.) Caregiver C stated to his/her knowledge Resident 1 did not have a bed alarm, chair alarm, or wander guard and was uncertain if [s/he] had been assessed for one after a change in condition was noted. Regarding the order on 02/19/2025 to assist the resident at all times during ambulation, Caregiver C was unable to state how the caregivers would know if Resident 1 was up in his/her room or exited his/her room other than providing frequent visual checks and reminding the resident to use the call light. Caregiver C acknowledged asking a resident with confusion to remember to use a call light was not an effective or reliable intervention. Caregiver C reviewed and confirmed his/her statement written in the self-report regarding the incident on 02/21/2025. Caregiver C stated at the time s/he was "newer to the role" and did not realize Resident 1 had a new order to be assisted with ambulation all times. Caregiver C confirmed seeing Resident 1 ambulate away from the dining room with his/her neighbor as s/he frequently did and not intervening to assist as Caregiver C was	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	831 PINE BEACH RD MARINETTE, WI 54143

(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
Y3244	Continued From page 5 unaware of the new order. On 07/18/2025 At 2:46 PM, Surveyor interviewed Director B. Director B stated Resident 1 frequently liked to exit the building and go for walks in the immediate campus vicinity. Director B acknowledged Resident 1 had a history of falling and had recently had a change in condition with increased confusion and hallucinations but stated that Resident 1 did not have a history of wandering or elopement. Despite the change in condition, Director B stated Resident 1 was not assessed for the use of a wander guard and s/he could not recall if Resident 1 had been assessed for use of a bed or chair alarm. Director B could not recall if the order to assist the resident at all times during ambulation had been placed in the resident record at the time it was ordered on 02/19/2025 or if it had been communicated verbally to staff. On 07/18/2025, Surveyor reviewed Resident 1's Individual Service Plan dated 12/06/2024 had a hand written note under "Mobility" dated 02/19/2025, "SBA of 1 with ambulation." Surveyor reviewed handwritten notes under the fall assessment category for 'Fall Risk" that occurred on 02/13/2025, 02/18/2025 and 02/21/2025 and interventions including visual monitoring, the use of grab bars, and a wheeled walker for ambulation. No notation under "Fall Risk" was made to indicate on or after 02/19/2025 that the resident required staff assistance with ambulation. On 07/24/2025 at 4:50 PM, Surveyor interviewed Family Member D (FM D.) FM D stated Resident 1's family was aware of his/her history of falls and a change in condition in the months prior to 02/21/2025 that included an increase in falls and,	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	831 PINE BEACH RD MARINETTE, WI 54143

(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
Y3244	Continued From page 6	Y3244		

in the weeks prior to 02/21/2025, an increase in confusion, including hallucinations. FM D stated the family was very concerned about the resident's changing condition and had requested multiple times for Director B to provide a bed or chair alarm so the staff would be aware when Resident 1 was getting up, as Resident 1 was unable to remember to use the call light. FM D stated s/he was told since Resident 1 was in an assisted living they could not have bed or chair alarms. Regarding if the resident had been assessed for use of a wander guard after sustaining increased confusion, FM D stated, "I don't even know what that is." FM D was unaware the facility was equipped with a wander guard system and stated had s/he known the intervention was available s/he would have requested it due to Resident 1's increased confusion and hallucinations. FM D stated Resident 1 had been found outside in the snow. FM D stated how fortunate the family felt that Resident 1 had been found, however reiterated the potential for harm could have included death had s/he not been seen by a resident. FM D stated Resident 1 was admitted to the hospital with a laceration above his/her right eye and a hematoma. FM D stated Resident 1 suffered a "bleed in the back of (his/her) retina" which resulted in partial blindness for the past 5 months. FM D stated Resident's vision was slowly improving but s/he "could only see about the size of a dime amount" since the fall on 02/21/2025.

On 08/05/2025 Surveyor reviewed Resident 1's medical documentation pertinent to the injury sustained on 02/21/2025 via Resident 1's provider's records. Physician F's note dated 05/28/2025 noted Resident 1 had an new diagnosis of "Contusion of eyeball and orbital tissue, right eye, subsequent encounter" and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008721	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MANOR	**831 PINE BEACH RD MARINETTE, WI 54143**

(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
Y3244	Continued From page 7 noted, "Vitreous hemorrhage right eye partially clearing. Vision still significantly impaired but risks with surgery outweigh benefit. Continue to observe for spontaneous resolution." On 08/05/2025 at 1:00 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he had a "poor short term memory" and that s/he sustained an injury "a little while back" that caused his/her right eye to be mostly blind. Resident 1 stated s/he was told s/he had a fall and stated his/her vision has not been the same since. Resident 1 recalled s/he had use of both eyes prior to the injury. Resident 1 expressed difficulty performing daily tasks "when you only have one eye that works" and commented on his/her loss of depth perception. Resident 1 stated his/her vision had slowly returned in the right eye and it had been a small circle of vision but reported it has recently been diminished and stated the limited vision that had been recovered in the right eye was "starting to go."	Y3244		