STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019637	A. BUILDING: _____ B. WING _____	C 07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT LUTHER MANOR (THE)	**4603 N 92ND STREET WAUWATOSA, 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 07/02/2024, Surveyor concluded a complaint investigation at Gardens at Luther Manor (The). As a result, 1 deficiency was identified. The complaint was substantiated. Census: 15	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident received prompt and adequate treatment appropriate to their needs. On 03/01/2024, Resident 1 sustained an unwitnessed fall and had lacerations to his/her left arm and left eye area. On 03/03/2024, Resident 1's family visited and identified Resident 1 was exhibiting signs of pain and had a bruise on his/her face and requested staff to send Resident 1 to the hospital for evaluation. Resident 1 was diagnosed with a fracture to his/her left hip and required surgery. Findings include: On 05/23/2024, the department received a complaint alleging a resident had an unwitnessed fall and did not go to the hospital for evaluation for 2 days. The fall resulted in a fractured hip which required surgery to repair.	N 353		

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

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N 353	Continued From page 1 On 07/02/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 02/22/2024, with diagnoses including cognitive communication deficit, degenerative disc disease, osteoarthritis, prior history of right hip fracture (femoral head), and dementia. The following was identified: - Fall report, dated 03/01/2024 (no time reported), identified a caregiver entered Resident 1's room and found him/her sitting on the floor near his/her bed. The caregiver called for Registered Nurse (RN) Supervisor C. RN C assessed Resident 1. Resident 1 had "2 small skin tears to left arm and small skin tear above left eye." - Progress note, dated 03/01/2024 timestamped 6:10 AM, written by RN C, stated, "Writer called to residents [sic] room. upon [sic] arrival observed resident sitting upright in [his/her] room in front of chair. ROM (range of motion) good to all extremities. @ [sic] small skin tears noted to left arm, both measure 1.0cm (centimeter) x (by) 0.1 cm,areas [sic] cleaned with mild soap and water,steri [sic] strips applied. Small lacerations to left eye 0.1x0.1,area [sic] cleaned with mild soap and water,left [sic] open to air." - Progress notes between 03/01/2024 through 03/03/2024 did not identify any staff assessments of pain, as needed pain medication administration, or monitoring post unwitnessed fall. - Progress note, dated 03/03/2024 timestamped 7:04 PM, written by Nurse Supervisor D, stated, "Resident is complaining of pain to LUE (left upper extremity) and RUE (right upper extremity). While [family member]/POA (power of attorney) and [family member], visited they expressed concerns regarding pain and possibly injuries with Friday's fall. POA requested that resident be sent out to acute care and evaluation. NP (nurse practitioner), DON (director of nursing) and	N 353		

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N 353	Continued From page 2	N 353		

manager notified..."
- Resident 1's hospital document titled, "Orthopaedic Trauma H&P (history and physical)," dated 03/03/2024, identified Resident 1 was diagnosed with a left femoral neck fracture. The document stated, "History of Present Illness: [Resident 1]....sustained the hip fracture after sustaining ground-level fall while at [his/her] memory care facility on Friday (3/1/2024). Patient with bruising on [his/her] face, suspected to hit [his/her] head. Unknown loss of consciousness. [S/He] has been endorsing left hip pain and face pain after [his/her] fall. Patient's family requested [s/he] be evaluated and was sent to [named hospital] ED (emergency department) for further evaluation/management. Workup significant for above injuries. Of note, patient with recent history of right femoral neck fracture sustained in December 2023 after a mechanical fall...[S/He underwent a right hip hemiarthroplasty...Review of Systems:...Left Upper Extremity: Inspection/Palpation: Tenderness to palpation over lateral elbow, superficial abrasions with soft bandages in place...Left Lower Extremity: Inspection/Palpation: leg shortened, externally rotated, hip tender....Plan: Will require surgical intervention, tentative plan for OR (operating room) on ¾ pending medical risk assessment."
- Resident 1's Fall Assessments, dated 02/26/2024 and 03/01/2024, identified Resident 1 was at high risk for falling. Resident 1 used crutches, cane, or walker. Resident 1's gait was described as "weak, stooped but able to lift head without losing balance, steps are short, resident may shuffle."
- Resident 1's Initial Assessment Record, dated 01/06/2024, identified Resident 1 was independent with ambulation and transfers and required a walker and wheelchair (did not specify when these were to be utilized).

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N 353	Continued From page 3	N 353		

- Resident 1's Pain-Comprehensive Evaluation, dated 03/01/2024 and timestamped 10:34 AM, identified, "Pain Level: Enter pain level for current pain AND/OR enter pain level for when resident does experience pain." The following options were provided to select: "1. Face Scale: No Hurt; Hurts a Little Bit; Hurts a Little More; Hurts Even More; Hurts a Whole Lot; Hurts Worst." 'Hurts a Little More' was the option selected for this post-fall pain assessment. The assessment further stated, "5. Numerical Pain Indicators: Check any indicators that are prominent in the resident...a. Non-verbal sounds (crying, whining, grasping, moaning, or groaning)" was selected. The pain assessment indicated touching the affected areas made the pain worse. Resident 1's Pain Evaluation for Dementia/Cognitively Impaired Residents reported Resident 1 displayed facial grimacing when experiencing discomfort.
- Resident 1's temporary individualized service plan (ISP), dated 02/22/2024, identified Resident 1 required staff assistance with bathing and showering and was able to assist staff with getting into bed. Resident 1 had limited physical mobility and was at risk for falls. Staff were to ensure Resident 1 wore appropriate footwear.

On 07/02/2024, Surveyor reviewed the provider's Incidents and Accidents Policy, dated 2023, provided by Nurse Manager B. The policy stated, "'Accident' refers to any unexpected or unintentional incident, which results in injury or illness to a resident...The following incidents/accidents require an incident/accident report but are not limited to:...falls...Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions. The

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N 353	Continued From page 4	N 353		

supervisor or other designee will be notified of the incident/accident...The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury(ies). In the event of an unwitnessed fall or blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet..."

On 07/02/2024, at approximately 2:40 PM, Surveyor interviewed Administrator A and Nurse Manager B. Administrator A confirmed Resident 1 had an unwitnessed fall on 03/01/2024. Administrator A reported their policy was to have the nurse supervisor assess the resident to determine further action and notify the resident's doctor of the fall. The nurse supervisor would have the ability to send a resident to the hospital for further evaluation. Administrator A reported in the event of an unwitnessed fall, they typically sent a resident to the hospital for evaluation and once they were discharged back to the facility, they would implement neurological checks and complete the flow sheet. Administrator A confirmed they did not initiate neurological checks for Resident 1. Administrator A and Nurse Manager B confirmed due to the injury on Resident 1's left side of face/eye area, and the fall being unwitnessed, Resident 1 should have been sent to the hospital for evaluation immediately after the fall. Administrator A was unsure why Resident 1 was not sent to the hospital for further evaluation. Administrator A confirmed Resident 1 was assessed for pain after the fall on 03/01/2024 but did not have further assessments of pain level for the following days. Nurse Manager B reported the caregivers were to report to the nurse

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N 353	Continued From page 5 supervisor on duty any irregularities in residents' behavior, and the nurse supervisor was responsible for inputting data into progress notes. Administrator A confirmed there were no additional monitoring notes post fall until Resident 1's POA requested s/he be sent to the hospital for evaluation on the evening of 03/03/2024, 2.5 days after the fall occurred. Administrator A confirmed Resident 1 required surgery to repair his/her left hip fracture. Administrator A reported if Resident 1 received an as needed medication for pain relief, there would have been a progress note in his/her record (reviewed above-no notes present). Administrator A and Nurse Manager B confirmed staff were trained on identifying pain in residents with dementia and should have identified Resident 1 was in pain prior to Resident 1's visitors on 03/03/2024. Administrator A reported there had been some turnover in staff and Resident 1 was discharged to another location for a higher level of care after s/he was released from the hospital, so limited information was available. Administrator A reported s/he would begin working on an internal plan of correction to ensure this type of occurrence did not happen again. Surveyor requested Resident 1's Medication Administration Record (MAR) for March 2024. As of 07/03/2024 at 12:00 PM, it was not received.	N 353		