STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018236	A. BUILDING: _____ B. WING _____	C 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

(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 09/03/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at New Perspective Waukesha, a community-based residential facility (CBRF) located in Waukesha, WI. As a result of the survey, 1 deficiency was identified. The deficiency is a repeat deficiency. See Statement of Deficiency (SOD) XB9111, dated 02/17/2025. The complaint was substantiated. Census: 29	N 000		
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: 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 record review and interview, the provider did not ensure that Resident 1 received his/her carbidopa/levodopa on 7 occasions or duloxetine on at least 6 occasions as prescribed by his/her practitioner. This is a repeat deficiency. See Statement of Deficiency (SOD) XB9111, dated 02/17/2025. Findings include:	N 352		

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

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N 352	Continued From page 1 On 09/03/2025, Surveyor conducted a complaint investigation into allegations of residents not receiving medications as prescribed. On 09/03/2025, at approximately 9:45 a.m., Surveyor interviewed Caregiver C. Caregiver C reported that to obtain refills of non-automatically refilled resident medications, the provider's process was for medication passers to let Health Wellness Director B, who is a registered nurse, know through verbal report which medications were getting low. Caregiver C reported that Health Wellness Director B then reordered the medication and followed up with the pharmacy as needed. At approximately 9:55 a.m., Surveyor interviewed Caregiver D. Caregiver D also reported that for non-automatically refilled resident medications that medication passers would let Health Wellness Director B know when a medication was getting low. Caregiver D reported that Health Wellness Director B then reordered any needed medications. On 09/03/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 05/30/2025 with diagnoses including Parkinson's disease with dyskinesia. Resident 1 resided with the provider until s/he experienced a fall on 07/17/2025 after which s/he was taken to the emergency department and then later passed away on 07/24/2025. Resident 1's individual service plan (ISP), last reviewed on 06/09/2025, directed for staff to administer his/her medications. Resident 1's medications included the following: - Carbidopa/levodopa 25 mg-100mg tablets,	N 352		

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active as of 06/09/2025, with instructions to, "Take 1 tablet by mouth twice daily as directed."
- Duloxetine 20 mg capsules, active as of 06/10/2025, with instructions to, "Take 1 capsule by mouth once daily."

In reviewing Resident 1's medication administration record (MAR) from 07/01/2025 - 07/24/2025, Surveyor observed the following:

- Carbidopa/levodopa tablets marked as "Med not available" for 7 administrations between the evening of 07/10/2025 through the evening of 07/13/2025
- Duloxetine capsules marked as "Med not available" for 5 administrations on 07/09/2025, 07/11/2025 through 07/13/2025, and 07/15/2025

Resident 1's progress notes contained an entry by Health Wellness Director B, dated 07/14/2025 at 11:50 a.m. The entry documented, "Writer faxed a communication form to neurologist due to not having the carb/levo and duloxtine [sic] for a week. Waiting for a response or order to be sent to [pharmacy]."

At approximately 11:30 a.m., Surveyor interviewed Health Wellness Director B and Executive Director A about the above incident. Executive Director A reported that depending on where residents admitted from, they maybe only came with either a 14-day or 30-day supply of medications. Executive Director A reported that Resident 1 moved in a couple of days after his/her admission date, and so his/her medications running out may have coincided with his/her initial 30-day supply having run out. Health Wellness Director B reported s/he had been out of the office for an extended period until 07/08/2025 (approximately 1-2 days before

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Resident 1's carbidopa/levodopa and duloxetine had run out). Health Wellness Director B reported that Health Wellness Director E had filled in while s/he was away and s/he was unsure if Health Wellness Director E had been notified by medication passers of Resident 1's medications running low or if s/he had requested any sort of medication refill. Health Wellness Director B reported that s/he thought s/he faxed a note to Resident 1's neurologist on 07/11/2025 to request medication refills and then followed up again on 07/14/2025.

When asked if Health Wellness Director B had any evidence of his/her faxes to Resident 1's neurologist, s/he provided Surveyor a document titled "Provider Communication Form." The form had a handwritten date of 07/11/2025, indicated that it was regarding Resident 1, and had a handwritten note that stated, "Need refills for Carb/levo. [S/he] is out completely. Need refill for Duloxetine. [S/he] is out. Please fax back order. Thanks." (Of note, Surveyor noted that Resident 1's duloxetine having been out was inconsistent with staff having documented in his/her MAR administering it to him/her on 07/14/2025.) There was nothing on the note indicating that it had been faxed.

As part of the same interview, Surveyor asked if Health Wellness Director B had any evidence of the fax s/he reportedly thought s/he sent on 07/11/2025. Health Wellness Director B then provided Surveyor a fax confirmation dated 07/14/2025 at 8:50 a.m. When asked about the date discrepancy, Health Wellness Director B confirmed s/he had no evidence of his/her fax sent on 07/11/2025 and s/he wasn't sure if s/he had received any sort of confirmation that the fax at that time was sent successfully.

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N 352	Continued From page 4 As part of the same interview, Health Wellness Director B and Executive Director A reported understanding of Surveyor's concerns that Resident 1 did not receive his/her carbidopa/levodopa or duloxetine as prescribed. According to the National Institute of Health (NIH) and Parkinson's Foundation, carbidopa-levodopa, a drug combination prescribed to treat Parkinson's symptoms such as tremors, stiffness, and slowed movement, should be taken exactly as directed by the prescribing practitioner around the same times every day in order to appropriately manage symptoms. Patients with Parkinson's disease are typically prescribed "antiparkinsonian agents" (such as carbidopa-levodopa), and medications not administered in accordance with a patient's schedule can cause a patient to feel an "immediate" increase in their Parkinson's disease symptoms, such as worsening tremors, increased rigidity, loss of balance, and confusion. Suddenly stopping carbidopa-levodopa, without tapering, can put a patient at risk for Parkinsonism Hyperpyrexia Syndrome, a condition caused by the sudden withdrawal of antiparkinsonian agents which can cause fever, rigid muscles, unusual body movements, and confusion. (Sources: NIH: National Library of Medicine, Levodopa and Carbidopa, June 20, 2024, https://medlineplus.gov/druginfo/meds/a601068.html (retrieval date - September 03, 2025); Parkinson's Foundation, Levodopa, no date, https://www.parkinson.org/living-with-parkinsons/treatment/prescription-medications/levodopa (retrieval date - September 03, 2025); Grissinger, M. (2018). Delayed administration and contraindicated drugs place hospitalized Parkinson's disease patients at risk. Pharmacy &	N 352		

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Therapeutics 43(1): 10-11, 39); and Cleveland Clinic, Parkinson's Disease Medications, November 9, 2023, https://my.clevelandclinic.org/health/treatments/parkinsons-disease-medications (retrieval date - September 03, 2025).).

According to the National Alliance on Mental Illness (NAMI), "Stopping duloxetine [an antidepressant medication] abruptly may result in one or more of the following withdrawal symptoms: irritability, nausea, feeling dizzy, vomiting..." (NAMI, Duloxetine (Cymbalta), December 2024, https://www.nami.org/about-mental-illness/treatments/mental-health-medications/types-of-medication/duloxetine-cymbalta/ (retrieval date - September 03, 2025).).

Of note, in having reviewed the progress notes for Resident 1, Surveyor observed the following entries made after his/her carbidopa/levodopa and duloxetine ran out:

- 07/11/2025 (8:28 p.m.): "Staff report that resident seems more confused and agitated with staff tonight. Resident not as willing to participate in cares."
- 07/11/2025 (10:31 p.m.): "Staff report that resident won't stand with them now, has increased lethargy and is drooling. Instructed staff to call 911. Resident transported to [local emergency department]..."
- 07/12/2025 (11:24 a.m.): "Resident had a safely you witnessed fall. Resident was walking in room without walker. Resident lost [his/her] balance falling to [his/her] right side, head impact with floor. Resident got self up off floor prior to staff arriving..."