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 _____	R-C 01/07/2026

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

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{N 000}	Initial Comments On 12/19/2025, with information obtained through 01/07/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation and verification visits for Statement of Deficiency (SOD) 3WK911, dated 09/03/2025, and SOD BKSP12, dated 12/03/2024. As a result of the survey, 3 deficiencies were identified. One deficiency is a repeat deficiency. See Statement of Deficiency (SOD) IIF411, dated 04/20/2023, and SOD IIF412, dated 09/13/2023. The complaint was substantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 38	{N 000}		
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.	N 389		

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

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This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 2's individual service plan (ISP) was updated to reflect accurate information regarding his/her grooming services.

This is a repeat deficiency. See Statement of Deficiency (SOD) IIF411, dated 04/20/2023, and SOD IIF412, dated 09/13/2023.

Findings include:

On 12/19/2025, Surveyor conducted an investigation into allegations that residents' ISPs did not accurately reflect the services they received.

On 12/19/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 11/27/2024 where s/he resided until 09/11/2025. Resident 2's diagnoses included advanced dementia with behavioral disturbance. Resident 2 was documented as having an activated power of attorney (POA) for healthcare throughout his/her admission. Resident 2's first ISP, dated as signed by his/her legal representative on 12/05/2024, documented the following grooming need:

"Service Type: Grooming: Nail Care Non-Diab[etic]...Caregiver to monitor nail length and cleanliness, assist as needed...trim finger and toenails on showers/bath days..."

Assessments for Resident 2 dated 03/17/2025 and 07/31/2025 documented the following with regards to nail care: "Weekly nail care needed? Includes nail care provided by caregiver. Does not include nail care provided by nurse or

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podiatrist. B. Yes - non-diabetic nail care is needed. Provided by caregiver. Includes filing and/or trimming."

An updated ISP for Resident 2, dated 09/05/2025, documented the following with regards to nail care: "POA responsible [sic] to scheudule [sic] foot care with Podiatry or outside provider."

At approximately 12:20 p.m., Surveyor interviewed Executive Director A and Health and Wellness Director B regarding the provider's process for conducting resident nail care. Executive Director A reported that toenail trimming had always been conducted by podiatry providers and not by the provider's staff. Executive Director A reported that podiatry services were an outside, separate service that residents had to separately contract with outside of the provider's services. When reviewing the ISP for Resident 2 from 12/05/2024 that detailed that caregiving staff would trim toenails, Executive Director A reported that s/he had began working with the provider around this time and was not sure why Resident 2's ISP would have directed for caregiving staff to conduct toenail care.

On 12/30/2025, at approximately 10:26 a.m., Surveyor interviewed Family Member G, who became the activated POA for Resident 2 on 07/21/2025 (the last several weeks before Resident 2's discharge from the facility). Family Member G reported that s/he had been involved in Resident 2's health care management and coordination throughout his/her admission with the provider. Family Member G reported that him/herself, Family Member H, and Family Member I (the latter two being family members that had also served as Resident 2's activated

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N 389	Continued From page 3 POA at times encompassing his/her admission), had all been under the impression that toenail care was part of the services Resident 2 had been receiving throughout his/her admission. Family Member G confirmed that Resident 2's toenails were not trimmed by the provider's staff throughout his/her admission. Family Member G reported that s/he had communicated with the provider's staff via e-mails regarding this concern. On 12/30/2025, Surveyor reviewed e-mail correspondence provided by Family Member G, regarding Resident 2's toenail trimming, which included the following: - E-mail from Family Member G to Former Care Team Manager J, sent 05/11/2025 (5:08 p.m.): "...I was wondering if someone could please trim [Resident 2]'s toenails? [Family Member I] said they are getting really long and I think they are starting to make [his/her] feet hurt when [s/he] walks..." - E-mail from Family Member G to Executive Director A, sent 05/19/2025 (3:00 p.m.): "...I'm reaching out because we continue to have serious concerns about aspects of [Resident 2]'s care that are not being followed, despite being clearly outlined in [his/her] care plan...I e-mailed [Former Care Team Manager J] more than a week ago about [Resident 2]'s toenails, which had become so overgrown that [s/he] was in pain while walking. [Family Member I]...ended up trimming them [him/herself]. - E-mail reply from Executive Director A to Family Member G, sent 05/20/2025 (12:28 p.m.): "...Have you discussed signing onto our podiatry services?...Our staff, including nurses, are not able to cut resident toenails as it requires a	N 389		

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podiatrist to do so. I attached the document for your review. Residents are seen every 60 days."

- E-mail reply from Family Member G to Executive Director A, sent 05/20/2025 (1:38 p.m.): "...According to the documentation (attached), it states that caregivers are to file and trim fingernails and toenails on shower days. Given the condition of [his/her] toenails recently, it appears this hasn't been happening for quite some time. Also, [Registered Nurse (RN) K, a former employee] had mentioned that [s/he] was arranging for [Resident 2] to be seen by the podiatrist, and that was just before [his/her] departure. I remember seeing the podiatrist at the facility around that time, so we had assumed [s/he] had been seen. It wasn't until recently that we realized that may not have been the case..."

- E-mail reply from Former Care Team Manager J to Family Member G, sent 05/20/2025 (7:30 p.m.): "...I have reiterated to care staff during our crossover meeting that [Resident 2]'s nails should be trimmed on [his/her] scheduled shower days, as outlined in [his/her] care plan."

- E-mail from Family Member G to Executive Director A, sent 07/24/2025 (8:57 a.m.): "...And, per [Resident 2]'s care plan, [his/her] finger and toenails should be tended to after each shower, and that clearly is not happening...There seems to be inconsistency with [his/her] care plan. [His/her] original care plan included...with nail care for both hands and feet."

- E-mail reply from Executive Director A to Family Member G, sent 07/25/2025 (10:51 a.m.) in which Executive Director A informed Family Member G that his/her concerns would be discussed via a care conference for Resident 2 with a subsequent

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N 389	Continued From page 5 attempt to schedule a care conference in order to update Resident 2's ISP.	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 2's health was monitored by communicating to his/her physician (and having the communication	N 431		

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documented) when staff were unable to collect his/her urine as ordered by his/her medical provider, in order to assist in the evaluation of a potential urinary tract infection (UTI).

Findings include:

On 12/19/2025, Surveyor conducted a complaint investigation into concerns that medical provider orders related to residents' health changes were not followed.

On 12/19/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 11/27/2024 where s/he resided until 09/11/2025. Resident 2's diagnoses included advanced dementia with behavioral disturbance. Resident 2 was documented as having an activated power of attorney (POA) for healthcare throughout his/her admission.

On 12/19/2025, Surveyor reviewed e-mail correspondence between Health and Wellness Director B and Resident 2's medical provider, Medical Provider L. The first e-mail, from Medical Provider L, dated 08/13/2025 (8:44 a.m.), documented, "[Resident 2]'s [family members] have been asking if the [urinalysis] has been collected yet? Any updates I can give them? Thanks! See you this afternoon." The e-mail reply, from Health and Wellness Director B that same day (8:51 a.m.) documented, "Not happening. [S/he] doesn't use a toilet. We are still trying."

At approximately 12:20 p.m., Surveyor interviewed Executive Director A and Health and Wellness Director B about the potential urinalysis for Resident 2 around 08/13/2025. Health and Wellness Director B confirmed s/he recalled the

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situation and reported that it had boiled down to confusion that Medical Provider L didn't put in an order for Resident 2's urine to be collected. Health and Wellness Director B reported that the first notice s/he was given about Resident 2's urine needing to be collected was the above e-mail from Medical Provider L on 08/13/2025. When Surveyor reported his/her observation that Medical Provider L's e-mail seemed to indicate an existing understanding of Resident 2's urine needing to be collected, as evidenced by the word "yet,", Health and Wellness Director B reported that maybe there was a phone call earlier that morning in which the urine collection was discussed.

While still conducting the above interview, Surveyor continued to review Resident 2's record. Surveyor observed an order from Medical Provider L for "UTI-[Polymerase Chain Reaction (PCR) - a test method used to assess for a UTI]." The order was dated 08/07/2025. Surveyor noted that this was approximately 6 days prior to the above communication. Surveyor reviewed the order with Health and Wellness Director B. Health and Wellness Director B reported that the order was sent on 08/08/2025. When Surveyor reported his/her observation that the order was dated 08/07/2025, Health and Wellness Director B replied that s/he believed the order was sent the night of 08/07/2025. When asked if there was any communication staff had with Medical Provider L to alert him/her of the urine collection difficulties and/or inability prior to being asked by Medical Provider L about the collection's status on 08/13/2025, Health and Wellness Director B reported that the only other communication would have been verbally with Medical Provider L on the afternoon of 08/13/2025. Health and Wellness Director B reported s/he did not believe Resident

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N 431	Continued From page 8 2 was displaying symptoms of having a UTI. On 12/30/2025, Surveyor reviewed e-mail correspondence between Medical Provider L, Person G, and Person H, provided by Person G. Resident 2's record indicated that at this time Person G was the activated POA for him/her. The correspondence included the following: - E-mail from Person G to Medical Provider L (with Person H copied), dated 08/06/2025 (10:35 p.m.): "...I wanted to reach out with a concern [Person H] and I have about [Resident 2]. [S/he]'s been grabbing at [his/her] groin area recently - something [s/he] typically does when [s/he] needs to use the bathroom or has already gone. However, we've noticed that [s/he]'s continuing to do this even after [s/he]'s been changed or has used the restroom, which feels a bit out of the ordinary. Do you think this could be a behavioral symptom related to [his/her] dementia, or might [s/he] be experiencing some discomfort or irritation - possibly even a urinary tract infection? Given that [s/he] only has one kidney, we're especially cautious, since an infection could pose a serious risk to [his/her] health. Would you be able to see [him/her] or advise us on how best to proceed?..." - E-mail reply from Medical Provider L to Person G and Person H, dated 08/07/2025 (10:24 a.m.): "...I have sent the facility an order to obtain a urine sample to test for UTI..." - E-mail from Person G to Medical Provider L and Person G dated 08/13/2025 (8:13 a.m.): "...I just wanted to follow up to see if there were any results from the urine test you were planning to do last week for [Resident 2] to rule out a UTI."	N 431		

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N 431	Continued From page 9 - E-mail reply from Medical Provider L to Person G and Person H, dated 08/13/2025 (8:43 a.m.): "Hello, I will be going to the facility today but will send [Health and Wellness Director B] an email right now asking if this has been collected. I will keep you updated." - E-mail reply from Person G to Medical Provider L and Person H, dated 08/13/2025 (8:54 a.m.): "...I am concerned about how much time has passed since we first discussed this test a week ago. As I mentioned previously, [Resident 2] only has one kidney, so any delay in identifying and treating a possible UTI could put [him/her] at serious risk..." - E-mail reply from Medical Provider L to Person G and Person H, dated 08/13/2025 (9:23 a.m.): "I completely understand. Would you or [Person H] be able to assist in getting the urine sample? I guess staff over at [New Perspective] are having a hard time getting [Resident 2] to urinate in the hat. [S/he] said they are still trying. I do not like to treat with antibiotics unless it is absolutely necessary and I am able to see results. (antibiotic stewardship) Do you feel [s/he] is still symptomatic?" - E-mail reply from Person G to Medical Provider L and Person H, dated 08/13/2025 (11:30 a.m.): "...I'll check in with [Person H] about whether [s/he] feels [Resident 2] is still showing signs of discomfort...What's especially concerning to me is that the facility has not communicated with us that there were any difficulties obtaining the sample we inquired about a week ago...This is especially puzzling since we've had reports that [Resident 2] has been using the toilet without issue since [his/her] medication changes."	N 431		

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N 431	Continued From page 10 On 12/30/2025, at approximately 11:03 a.m., Surveyor interviewed Medical Provider L regarding Resident 2's urine collection difficulties. Medical Provider L reported s/he could not recall if any communication took place from the provider's staff from the time s/he placed his/her order for the urine collection on 08/07/2025 - 08/13/2025. Medical Provider L reported s/he would look at his/her notes and send any additional information s/he had from that timeframe, if there was any, by the end of the day. Nothing further was received.	N 431		
N 446	83.41(1)(b) Equipment. Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all equipment and utensils were stored in a clean manner and in good repair. The exterior of the fryer, stove, oven, steamer, warming box, garbage can and ice cream freezer were soiled. Half of the ice cream freezer's door was broken and missing resulting in a heavy frost buildup. This is a repeat deficiency. See Statement of Deficiency (SOD) IIF413, dated 02/07/2024 and SOD IF414, dated 05/28/2024.	N 446		

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Findings include:

On 12/19/2025 at 10:09 AM, while inspecting the kitchen with Culinary Director F during a complaint investigation, Surveyor observed the following:

Fryer- The fryer's back splash, and front/side surfaces were covered with dried grease. A heavy accumulation of dried amber colored grease with dirt and debris in the grease was on the floor under and on both sides of the fryer. The fryer was on wheels (Photo 1).

Range/stove- Back splash was covered with white, amber, brown and black dried speckles and drips; burners were covered with a white powdery substance; drip pans were heavily soiled with burnt food debris; dried orange, brown, and black substances were dried onto the burner knobs and stainless-steel surfaces. Under the stove top were 2 stainless steel shelves. A large area of dried powdery white substance was on the surface of the top shelf. Cooking oils, etc. were stored on the bottom shelf and a thick layer of amber colored grease was dried to the left front corner of the shelf. A shallow baking pan was set on the bottom shelf and in the pan was a dirty kitchen rag, clumps of dried yellow food, and amber colored dried grease. Areas of dried grease, dirt and debris were on the floor under and on both sides of the range. The range was on wheels (Photos 2 and 3).

Oven and steamer- A steamer was set on top of an oven. The top surface of the oven (under the steamer) was heavily soiled with a white, amber, brown and food particles. The surfaces of the steamer and oven were heavily soiled with white, amber, brown and black drips and dried

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substances. The oven and steamer were on wheels (Photo 4).

Warming box- The door of the warming box was covered with white and gray streaks, and orange, amber and white spots and streaks of varying sizes were observed on the outer surfaces. A thick substance under the left front corner of the warming box was dried to the floor. The warming box was on wheels (Photo 5).

Garbage can- A tall black garbage can was located between a prep table and left of stainless-steel wall. The surfaces of the garbage can were heavily soiled with dried drips and speckles of various colors. The white drips and speckles were dried onto the wall. A flat top griddle was located on the right side of the stainless-steel wall. The white and gray drips and speckles covered the black splash and surfaces of the flat top's surfaces and backsplash. A dishtowel, soiled with amber, brown and black dirt was placed under flat top (Photo 6).

Ice cream freezer- The chest-style ice cream freezer had a glass top consisting of 2 sliding glass panels. In place of 1 of the missing glass panels, a baking pan was placed on the top of the freezer. The interior walls of the freezer were covered with frost approximately 4 inches thick and the frost extended up to the glass panel. The frost was soiled with areas of pink, brown and yellow ice cream. Brown debris sat in the corners of the rim holding the glass panel. White and gray blotches covered the surface of the glass panel (Photos 7 and 8).

On 12/19/ 2025 at approximately 10:30 AM, Surveyor interviewed Culinary Director F who stated a grease overflow occurred a week prior to

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 _____	R-C 01/07/2026

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 446	Continued From page 13 12/19/2025. Culinary Director F stated kitchen floors were swept and mopped daily, and staff had not kept up on the weekly deep cleaning under the appliances. Culinary Director F stated a new staff person was starting on 12/20/2025 and would deep clean the floor and appliances on 12/20/2025. Culinary Director F stated 1 of the ice cream freezer's glass panels broke causing the frost build-up. On 12/19/2025 at 4:48 PM, Surveyors discussed concern regarding kitchen equipment with Executive Director A and Health and Wellness Director B. Executive Director A stated the kitchen would be thoroughly cleaned right away.	N 446		