STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013625	A. BUILDING: _____ B. WING _____	R-C 04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE-WEST BEND	2130 CONTINENTAL DR WEST BEND, WI 53095

(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 04/06/2026, Surveyor conducted a verification visit at New Perspective West Bend, a Community-Based Residential Facility (CBRF) in West Bend, WI. One of four previous deficiencies was corrected. Three deficiencies identified. Three of three are repeat deficiencies. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 39	{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 residents received all prescribed medications in the dosage and at intervals prescribed by a practitioner for 1 of 2 residents reviewed. Resident 4 did not receive five doses of his/her medications. This is a repeat deficiency. See Statement of Deficiency (SOD) IC9Q11, dated 05/09/2024 and SOD 5YVF11, dated 11/10/2025. 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 04/06/2026, Surveyor reviewed Resident 4's records. Resident 4 was admitted on 01/06/2020, with diagnoses including Major neuorcognitive disorder, tonic clonic seizures, epilepsy, unspecified dementia and acute metabolic encephalopathy. On 04/06/2026, Surveyor reviewed Resident 4's record and identified the following: -Individual Service Plan (ISP), dated 10/14/2025, stated, "Service Type: Med and Treatment Plan-Community manages and administers medications/treatments. Resident receives medication and treatment administration and management services. See service agreement and medication and/or treatment assistance assessment for plan descriptions and medication and treatment orders." -Active Orders As of 01/17/2026, identified Resident 4 was prescribed "Nitrofurantoin Macrocrystal 50 MG cap: Give one capsule by mouth daily for 5 days." -Resident 4's January MAR 2026 (date range 01/01/2026 through 01/31/2026) Medication Administration Records (MARs) identified the following: Nitrofurantoin Macrocrystal 50 MG caps not available on 01/17/2026, 01/18/2026 and 01/20/2026. Resident 4 missed 3 doses. Active Orders as of 06/13/2025, identified Resident 4 was prescribed "Lorazepam Tab 0.5 MG: Give 1 tablet by mouth twice daily for anxiety." -Resident 4's March MAR 2026 (date range 03/01/2026 through 03/31/2026) Medication Administrator Records (MAR) identified the following: Lorazepam 0.5 MG tab not available on 03/07/2026 at 8:00 AM and 03/07/2026 at 5:00 PM. Resident 4 missed two doses. -Resident 4's progress notes dated 03/10/2026 at	{N 352}		

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{N 352}	Continued From page 2 2:50 PM: "Writer notified PCP via fax regarding both missed does of Lorazepam 0.5 mg on 03/07/2026." On 04/06/2026 at approximately 11:30 AM, Surveyor interviewed Nurse D. Nurse D stated based on the MAR, it looks like Resident 4 did not receive his/her additional Nitrofurantoin Macrocrystal 50 MG cap since it was prescribed for 5 days and staff signed out stating it was not available. Resident 4 missed 3 doses of it. Nurse D stated Resident 4's Lorazepam was out but the medication was in the other med cart and staff did not look in there, so Resident 4 missed two does of his/her Lorazepam.	{N 352}		
{N 381}	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not assess resident's needs, abilities, and physical and mental condition for 1 of 1 resident (Resident 3) reviewed when there was a	{N 381}		

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{N 381}	Continued From page 3 change in needs, abilities or condition. Resident 3 had a total of 11 falls from 01/11/2026-04/04/2026 and had only 7 assessments/post fall evaluations. This is a repeat deficiency. See Statement of Deficiency (SOD) 5YVF11, dated 11/10/2025. Findings include: On 04/06/2026, Surveyor reviewed resident records and identified the following: -Resident 3 was admitted to the provider's facility on 04/14/2025. -Resident 3 had a total of 11 falls from 01/11/2026-04/04/2026. -Resident 3's ISP dated 04/14/2025 indicated the following: -"Falls Management, PRN (as needed): [Resident 3] is at a high risk for falls. Resident 3 has had a number of recent falls due to poor safely awareness, impulsive behavior, and unsteady gait. Team members will update a member of the clinical team with decline in ability to ambulate. Resident is at risk for falls. Encourage resident to wear properly fitting foot ware or non-slip socks; keep walkways within apartment free of clutter; participate in community exercise activities to support physical endurance and strength; keep call pendant, if in use, within reach; place pull cord, if available, within reach when in their bedroom; and drink fluids in between meals and at mealtime. Promptly report to nursing any changes in cognitive status, such as confusion, increased confusion from baseline, or impulsiveness; symptoms of UTI including, but not limited to frequency (feeling the urge to urinate), burning with urination, foul smelling urine; or changes in mobility such as changes in gait or unsafe-self transfers.	{N 381}		

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{N 381}	Continued From page 4 Resident 3's progress notes from 01/12/2026-04/01/2026 stated the following: -"01/11/2026 at 12:47 AM, TRIAGE NOTE 1215: Caregivers found [Resident 3] sitting in [his/her] chair with multiple skin tears from alleged fall. [Resident 3] has a skin tear on right elbow, 2 skin tears on left arm, small abrasion on left eyebrow, an abrasion on right cheek. ROM WNL. Instructed caregivers to wash wounds, VS every 2 hours for 24 hours. Notified Horizon Hospice who is sending nurse to assess [Resident 3] and notify family." -"01/16/2026 at 8:27 AM, late entry from 01/15/2026 at 2015. Resident was being assisted to bathroom and getting ready for bed when [s/he] lost [his/her] balance and fell. [S/he] did have a head strike. No visible injury noted. Resident assisted to bed and hospice was notified." -"01/17/2026 at 4:21 PM, Triage Call @ 1600 for unwitnessed fall. Resident got up and out of [his/her] broda chair in the dining room and had a fall. Resident was found by caregiver lying on [his/her] back. Resident c/o left knee pain. Hospice and POA notified." -"01/29/2026 at 6:05 PM, Writer notified of resident fall. Resident was in the dining area and tried to get out of [his/her] broda and fell. Resident assisted from floor with 2 assist and gait belt. Hospice updated and will make visit tonight." -"02/03/2026 at 5:27 PM, 1700: Client had an unwitnessed fall, [s/he] was found sitting on buttock next to [his/her] chair in [his/her] bedroom. Skin tears noted to L arm. Areas cleansed, dried, steri strips applied and Hospice/POA notified, will be sending in nurse tonight." -"03/03/2026 at 11:20 PM, Call received from	{N 381}		

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{N 381}	Continued From page 5	{N 381}		

team that resident had a fall. Found on floor with multiple skin tears. Resident assisted back to bed. Hospice called to update. Nursing to follow up with resident in the AM."
-"03/27/2026 at 7:31 AM, at 07:24 Resident had an unwitnessed fall in [his/her] room. When called entered room [s/he] found resident sitting on floor in front of [his/her] electric recliner with the electric recliner raised as high as it could go, appeared that [s/he] slid out of chair. Writer instructed caller to assist resident off floor per care plan, continue vitals every 2 hours for the next 24 hours and updated nursing with any changes. Community nurse to follow up with PCP and resident in morning."
-"03/28/2026 at 6:57 PM, med passer called writer at 1845 to report an unwitnessed fall. Med passer stated that resident got done eating in the dining room and fell out of [his/her] chair. Resident c/o mild back pain with no other complaints or noted injuries at this time. Writer instructed med passer to give PRN pain medication. Hospice notified. POA notified."
-"03/31/2026 at 9:47 AM, team member notified of resident fall. Resident found kneeling on floor next to [his/her] bed. Denies pain. No obvious injury noted. Resident assisted off floor with 2 assist and gait belt. Hospice and POA updated, MD updated."
-"04/01/2026 at 5:18 AM, call received at 12 a that resident walked out of [his/her] room and fell. No obvious injury. Resident assisted back to room and back to bed. Notifications to be made in AM."
-"04/04/2026 at 7:02 AM, call received at 0415 that resident was found on floor of [his/her] room. Resident is moving normally and smiling. [S/he] has no visible injury. Team instructed to assist resident from floor. Calls placed to POA and hospice."

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{N 381}	Continued From page 6 On 04/06/2026 , Surveyor reviewed Resident 3's post fall evaluations from 01/11/2026-04/04/2026 . Resident 3 had post fall evaluations on 01/12/2026, 01/19/2026, 01/30/2026, 02/04/2026, 03/27/2026, 03/30/2026 and 04/04/2026. There were a total of 11 falls and a total of 7 assessments/post fall evaluations. On 04/026/2026 at approximately 12:30 PM, Surveyor interviewed Executive Director A and RN D. RN D stated multiple nurses would be responsible for conducting a post fall assessment for Resident 3. It would just depend who was on call or if s/he is at a different building. Executive Director A and RN D acknowledged there was not an assessment after each fall Resident 3 had from 01/11/2026-04/04/2026 and stated nobody had reviewed the information since the last survey and they will be working on a new system for post fall assessments.	{N 381}		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	{N 386}		

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{N 386}	Continued From page 7	{N 386}		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 individual service plans (ISP) reviewed included all the resident's needs. Resident 3's ISP did not include his/her needs regarding his/her broda chair, wound care and being on hospice. Resident 4's ISP's did not include their needs regarding their risk of seizures and being on hospice.

This is a repeat deficiency from Statement of Deficiency (SOD) 5YVF11, dated 11/10/2025.

Findings include:

On 04/06/2026 at approximately 10:30 AM, Surveyor reviewed resident records and identified the following concerns:

Example 1 - Resident 3
Resident 3 was admitted to the provider's facility on 04/14/2025. Resident 3's ISP dated 04/14/2025 indicated the following:
-"Service Type: Skin check. Times: PRN. Notes: Team members will report any newly identified concerns related to skin impairment to a member of the clinical team. Promptly report to a nurse any observed skin issues or changes in skin condition."
-Service Type: DME, Assistive Equipment. Times: PRN. Notes: [Resident 3] uses a 2 wheeled walker for ambulation needs. [Resident 3] also has a manual wheelchair, shower chair/bench, and grab bars in the bathrooms and shower. Notify nurse for changes in resident condition, and if resident has new DME or

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{N 386}	Continued From page 8 equipment." Resident 3's progress notes stated the following: -"01/17/2026 at 4:21 PM: Triage Call @ 1600 for unwitnessed fall. Resident got up and out of [his/her] broda chair in the dining room and had a fall. Resident was found by caregiver lying on [his/her] back. Resident c/o left knee pain. No injuries noted at this time. Caregivers instructed to take vitals q2h and update nursing with any changes. Medpasser instructed to give PRN pain medication. Hospice and POA notified." -"01/19/2026 at 10:45 AM: Hospice RN present this AM. Resident was mostly unresponsive for cares. Not eating much. Appears to be declining." -"01/29/2026 at 6:05 PM: Writer notified of resident fall. Resident was in dining room and tried to get out of [his/her] broda chair and fell. Resident assisted from floor with 2 assist and gait belt. Hospice updated and will make visit tonight." -"02/03/2026 at 5:27 PM: 1700: client had an unwitnessed fall, [s/he] was found sitting on buttocks next to [his/her] chair in [his/her] bedroom. Skin tears noted to L arm. Areas cleansed, dried, steri strips applied and Hospice/POA notified, will be sending in nurse tonight." -"02/09/2026 at 4:08 PM: Hospice in today for a visit and wound care." -"02/12/2026 at 11:46 AM: Hospice in for visit-wounds to arm dressings change. Nurse to revisit on Monday and change wounds dressing." -"02/19/2026 at 12:25 PM: Hospice in for visit: wounds improving, re-wrapped R elbow, no other concerns." -"02/23/2026 at 3:58 PM: Hospice in for visit: wounds to both arms healed/scabbed. No dressings on today."	{N 386}		

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{N 386}	Continued From page 9 -"03/03/2026 at 11:20 PM: Call received from team that resident had fall. found on floor with multiple skin tears. Resident assisted back to bed. Hospice called to update. Nursing to follow up with resident in the AM." -"03/05/2026 at 10:39 AM: Hospice in for visit, skin tear to L elbow was changed today." -"03/11/2026 at 11:23 AM: Hospice nurse in for visit: L elbow dressing changed and improving. Alert, pleasant with no pain." On 04/06/2026 at approximately 12:00 PM, Surveyor interviewed RN D. RN D stated Resident 3's ISP has not been updated since 04/14/2025 so the information regarding Resident 3's wound care, broda chair and frequency of hospice services was not in his/her ISP. Example 2 - Resident 4 Resident 4 was admitted to the provider's facility on 01/06/2020. Resident 4's progress note stated the following: -"01/14/2026 at 11:46 AM, Staff noted resident hard to arouse with eyes closed. Writer noted client not responsive to verbal stimuli. Skin warm and dry. Refused breakfast and was barely able to take in AM pills (scheduled Lorazepam was administered). Hospice team updated." -"01/14/2026 at 6:46 PM, writer notified that resident had seizure lasting 3-4 minutes. [S/he] has stopped seizing. Instructed staff to administer rectal 2mg Lorazepam as ordered. Hospice updated who stated they will update family and schedule a visit for tomorrow if not already scheduled. Resident is resting in bed at this time." -"03/27/2026 at 4:19 PM, resident discharged from hospice 03/26/2026. Team and community care attempting to get new DME in order."	{N 386}		

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{N 386}	Continued From page 10 Resident 4's ISP dated 10/31/2025 indicated s/he was at a high risk for falls. Resident 4's ISP stated the following: -"Diagnoses: Acute Metabolilc Encephalopathy, Metabolic Encephalopathy, Other seizures: Tonic Cloinc seizures 10/09/2023, and Epilepsy Resident 4's ISP, dated 10/31/2025, did not address Resident 4's cognitive ability/needs related to having a history of seizures and Resident 4's seizure that occurred on 01/14/2026 and staff are to administer rectal 2mg Lorazepam for the seizures. On 04/06/2026 at approximately 12:00 PM, Surveyor reviewed concern with Executive Director A and RN D that 2 of 2 ISP's did not address resident needs regarding their risks. Resident 3's ISP did not include his/her needs regarding his/her broda chair, wound care and frequency of hospice services and Resident 4's ISP did not include their needs regarding their risk of seizures. Executive Director A and RN D acknowledged neither of the ISP's were corrected from the last survey and stated they would be reviewing all resident records to make sure all ISP's are up to date for each resident.	{N 386}		