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 07/30/2024

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 From 07/29/2024 to 07/30/2024, Surveyor conducted 2 complaint investigations at New Perspective Waukesha, a CBRF in Waukesha. Two deficiencies were identified. One deficiency is a repeat deficiency - See Statement of Deficiency (SOD) IIF411, dated 04/20/2023. Two of two complaints were substantiated. Census: 23	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were safeguarded from environmental hazards. Resident 1's bed was left in a raised position resulting in injuries leading to death when s/he fell from bed. Findings include: On 07/29/2024, Surveyor conducted a complaint investigation regarding a resident's fall.	N 358		

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

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N 358	Continued From page 1 On 07/29/2024 at approximately 9:00 a.m., Surveyor interviewed Caregiver C. Caregiver C stated s/he worked the morning when Resident 1 sustained a fall. Caregiver C stated s/he responded to Resident 1's room after his/her coworker had heard a "crash" and summoned assistance to Resident 1's room. Caregiver C stated Resident 1 had fallen from bed. Caregiver C stated Resident 1 hit his/her head on a glass lamp/table when s/he fell, resulting in "a lot of blood." Caregiver C stated Resident 1's bed was left in a raised position by the overnight shift. On 07/29/2024 at approximately 9:30 a.m., Surveyor reviewed Resident 1's record, provided by Nurse B. Resident 1 was admitted to the provider's facility on 05/20/2024 with diagnosis of left-sided hemiplegia. Resident 1's individual service plan (ISP), dated 05/20/2024, indicated Resident 1 required assistance of 2 for bed mobility, a hoyer lift for transfers and was a fall risk. Resident 1's record included an incident report, dated 07/05/2024, that stated Resident 1 was found lying facedown, visibly bleeding from his/her face and with a bedside table that had a glass top shattered under the resident. The report stated EMS was called and Resident 1 was transferred to the hospital. On 07/29/2024 at approximately 10:00 a.m., Surveyor interviewed Nurse B. Surveyor shared report that Resident 1's bed was left in a raised position and that would be consistent with injuries sustained from bedside table with a shattered glass top. Nurse B stated s/he was out of the facility on 07/05/2024, but agreed that Resident 1's bed would have been elevated based on caregiver report and injuries sustained. Nurse B stated it was facility policy for all hospital beds to be kept lowered. Nurse B then provided the	N 358		

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N 358	Continued From page 2	N 358		

"Caregiver - New Team Member Checklist," which indicated policies and procedures were reviewed upon hire and the "Bed Mobility Procedure," which stated "Bed mobility devices (e.g., hospital beds) will be kept in the lowest position when not in use by team members)." Nurse B stated this policy would have been reviewed with all caregivers upon hire and the expectation would have been that Resident 1's bed was in the lowest position when occupied.

On 07/29/2024 at approximately 10:30 a.m., Surveyor reviewed hospice notes, dated 06/05/2024 to 07/08/2024, and obtained by Surveyor. Each hospice note documented "Bed to be in lowest position when not receiving cares." Surveyor then reviewed a hospital "Death Summary," dated 07/08/2024 and obtained by Surveyor, that stated Resident 1 passed away with cause of death being aspiration pneumonia due to acute metabolic encephalopathy due to head trauma with suspected concussion.

On 07/29/2024 at approximately 12:00 p.m., Surveyor interviewed Administrator A. Administrator A confirmed s/he was contacted by caregivers when Resident 1 fell on 07/05/2024. Administrator A stated s/he responded to Resident 1's room before EMS transported Resident 1 to the hospital. Surveyor shared concern that Resident 1's bed was left in an elevated position while occupied which contributed the injuries sustained. Administrator A stated s/he did not pay attention to the height of the bed, but that s/he thought hospice had provided too small of a bed for Resident 1.

On 07/30/2024 at approximately 1:55 p.m., Surveyor interviewed Caregiver E. Caregiver E stated s/he responded to Resident 1's room with

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N 358	Continued From page 3 Caregiver C. When asked if Resident 1's bed was lowered to the ground at the time of his/her fall, Caregiver E replied, "Bed was up." Caregiver E stated the bed should have been lowered to the ground.	N 358		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure personal care services were provided to Resident 1. Resident 1's requests for assistance were not responded to for greater than 60 minutes. This is a repeat deficiency. See Statement of Deficiency (SOD) IIF411, dated 04/20/2023. Findings include:	N 425		

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N 425	Continued From page 4 On 07/29/2024, Surveyor conducted a complaint investigation regarding care concerns. On 07/29/2024 at approximately 9:15 a.m., Surveyor interviewed Caregiver D regarding the facility's call light system. Caregiver D explained that the facility had a call light system that reported to phones, which all caregivers carried. Caregiver D explained that when caregivers received an alert on their phone that a resident called for assistance, caregivers click "Take" on the phone to indicate they are responding and then click "Complete" once cares are completed. Caregiver D explained that residents continuing to push their call light while a call from that same resident was still pending would not re-alert caregiver phones (E.g. If resident's call light at 10:00 a.m. was not "completed" by the caregiver, the resident would be unable to call again until "Completed"). On 07/29/2024 at approximately 9:30 a.m., Surveyor reviewed Resident 1's record, provided by Nurse B. Resident 1 was admitted to the provider's facility on 05/20/2024 with diagnosis of left-sided hemiplegia. Resident 1's individual service plan (ISP), dated 05/20/2024, stated, "Encourage resident to use call pendant when assistance is needed. Resident has a call response pendant." On 07/29/2024 at approximately 10:30 a.m., Surveyor reviewed hospice notes, dated 06/05/2024 to 07/08/2024, and obtained by Surveyor. The following concerns regarding the facility's assistance were documented: - 06/11/2024: "[Resident 1] verbalized frustration that [s/he] had trouble getting assistance from staff last night and ended up calling [his/her	N 425		

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N 425	Continued From page 5	N 425		

family member] about the problem. [His/her family member] called the facility and a caregiver came to [Resident 1]'s room to provide cares.
- 07/04/2024 at 1:36 a.m.: [Family member] called hospice stating Resident 1 was having issues with his/her oxygen and no one at the facility was answering Resident 1's call pendant. Hospice called the facility multiple times with no answer. Hospice arrived to the facility.

On 07/29/2024 at approximately 11:00 a.m., Surveyor interviewed Administrator A regarding long responses to call lights. Surveyor shared concern that hospice notes documented concerns with long wait times, including hospice responding to the facility due to lack of response. Administrator A denied allegations of long wait times and stated call light response times were routinely audited. Administrator A then provided Surveyor with Resident 1's call light response times, dated 07/03/2024 to 07/05/2024. The following responses with a wait time greater than 60 minutes were documented:

- 07/03/2024: Call light activated at 7:22 a.m. and responded to at 8:49 a.m. (86 minute duration). Resident 1 continued to push the call pendant 17 times while waiting for a response.
- 07/03/2024: Call light activated at 8:53 p.m. and responded to at 9:56 p.m. (63 minute duration). Resident 1 continued to push the call pendant 15 times while waiting for a response.
- 07/03/2024: Call light activated at 10:03 p.m. and responded to at 10:55 p.m. (52 minute duration). Resident 1 continued to push the call pendant 26 times while waiting for a response.
- 07/04/2024: Call light activated at 7:13 a.m. and responded to at 9:09 a.m. (115 minute duration). Resident 1 continued to push the call pendant 6 times while waiting for a response.

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N 425	Continued From page 6 - 07/05/2024: Call light activated at 6:03 a.m. and responded to at 8:45 a.m. (162 minute duration). Resident 1 continued to push the call pendant 47 times while waiting for a response. *On 07/29/2024 at 9:15 a.m., Surveyor interviewed Caregiver D and on 07/30/2024 at 1:55 p.m., Surveyor interviewed Caregiver E. Both Caregiver D and Caregiver E clarified that Resident 1's call light had been marked as "taken" during the 07/05/2024 call time, so the initial request for assistance may have been provided as Resident 1 was observed sleeping during rounds; however, request was not cleared so Resident 1's repeat pushes of the call light system did not alert staff. On 07/29/2024 at approximately 11:15 a.m., Surveyor reviewed the above response times, which were greater than 60 minutes, with Administrator A. Administrator A replied, "That is not acceptable." Administrator A explained the expectation was for call lights to be answered within 20 minutes and that call light response times were to be audited by Care Team Manager F. Administrator A stated egregious wait times were supposed to be discussed during management's morning meeting, but s/he was unaware of the long wait times reviewed by Surveyor.	N 425		