STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015199	A. BUILDING: _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

(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 11/01/2024 to 11/15/2024, the bureau of assisted living southern regional office conducted a complaint investigation & self-report review at New Perspectives a CBRF located in Sun Prairie, WI. As a result of this survey, 8 violations from DHS Chapter 83 were identified. Complaint was substantiated. Census: 32	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate an injury that was not observed by any person to a resident who could not adequately explain the source of the injury. On 10/09/2024, Resident 1 suffered from an unwitnessed fall. Caregiver B documented Resident 1 was found with a cut to the back of the head with dried blood, and Resident 1 could not remember how s/he had cut his/her head. Resident 1 was sent to an emergency room where s/he received first aide treatment including staples to suture the cut on the back of his/her	N 161		

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

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N 161	Continued From page 1	N 161		

head before they were discharged back to facility.

On 11/01/2024, Surveyors reviewed Resident 1's facility record. No, investigation related to Resident 1's unwitnessed fall on 10/09/2024 was documented.

FINDINGS INCLUDE:

On 11/01/2024, Surveyors arrived at facility for a complaint investigation.

On 11/01/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 07/01/2024. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: Alzheimer's disease.

On 11/01/2024, Surveyor reviewed a document titled, "Resident Incident/Accident Report Worksheet." On 10/09/2024, Caregiver B documented Resident 1 suffered an unwitnessed fall. In the narrative section of the document, Caregiver B documented the following, "Resident c/o (complaint of) chest pain. Doesn't remember anything happening to head. Back of head has cut and dried blood."

On 11/01/2024, Surveyor reviewed Resident 1's progress notes from 08/01/2024 to 11/01/2024. The following entries were reviewed:
1.) Documented by Triage Nurse C on 10/09/2024 at 5:05 AM, "TRIAGE CALL - resident had dried blood and a laceration on the back of [his/her] head. Resident is complaining of chest discomfort and has refused VS (vital signs) per staff. Writer instructs staff to call 911 and notify triage of transfer."
2.) Documented by Nurse D on 10/09/2024 at

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N 161	Continued From page 2 4:25 PM, "Follow/up/After Visti (sic.) Summary: [Resident 1] was seen at [Hospital Name] for fall and laceration to scalp. CT imaging did not reveal and acute injuries. The laceration was repaired with staples, to be removed in 7-10 days." On 11/01/2024, Surveyor reviewed Resident 1's after visit summary from his/her emergency room admission on 10/09/2024. The after-visit summary documented Resident 1 was treated for head injury related to a fall. On 11/01/2024 at 2:00 PM, Surveyor discussed the above concern with Administrator A, Nurse E and Regional F. Administrator A stated s/he had not been made aware of Resident 1's unwitnessed head injury and emergency room treatment. Administrator A stated s/he did not investigate Resident 1's unwitnessed fall and head laceration that occurred on 10/09/2024. Administrator A acknowledged Resident 1 was not provided a comprehensive assessment upon return to facility from hospital. CROSS REFERENCE: N0214 DHS CHAPTER 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 161		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the	N 163		

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N 163	Continued From page 3 local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department within 3 working days after Resident 1's whereabout were unknown. On 09/05/2024, Resident 1's whereabouts were unknown. Family Member O arrived at the facility and could not find Resident 1. Staff could not find Resident 1 on the unit. Staff located Resident 1 in a garage outside of the facility. On 11/01/2024, Surveyors reviewed Department records. No, self-reports related to Resident 1's elopement on 09/05/2024 were sent to the Department. FINDINGS INCLUDE: On 11/01/2024, Surveyors arrived at facility for a complaint investigation. On 11/01/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 07/01/2024. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: Alzheimer's disease. On 11/01/2024, Surveyor reviewed Resident 1's individualized Service Plan (ISP) dated 07/22/2024.	N 163		

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N 163	Continued From page 4 On 11/01/2024, Surveyor reviewed Resident 1's progress notes from 08/01/2024 to 11/01/2024. The following entry was reviewed: 1.) On 09/05/2024 at 11:13 AM, Previous Nurse G documented the following, "[Resident 1's] wife in unit this morning and unable to find resident. Staff unable to locate resident within unit. A staff member outside saw a resident in the garage and brought him back inside the building. No apparent injuries...Updated on increase in exit seeking and unobserved elopement from memory care unit...". On 11/01/2024, Surveyor reviewed the facility self-reports filed with the Department. No, self-report related to the Resident 1's elopement on 09/05/2024 was on file. On 11/02/2024 at 2:00 PM, Surveyor discussed the above concern with Administrator A, Nurse E and Director F. Administrator A stated Previous Nurse G would have been the individual to file the self-report related to Resident 1's elopement on 09/05/2024 to the Department. Administrator A acknowledged a self-report regarding Resident 1's elopement on 09/05/2024 was not filed with the Department within 3 working days of the incident. Administrator A acknowledged an investigation related to Resident 1's elopement had not been documented and Resident 1 had not been provided a comprehensive assessment upon return to the unit from the garage on 09/05/2024. CROSS REFERENCE: N0164 DHS CHAPTER 83.12(4)(b) Reporting When Law Enforcement Is Called CROSS REFERENCE: N0214 DHS CHAPTER 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 163	Continued From page 5 CROSS REFERENCE: N0426 DHS CHAPTER 83.38(1)(b) Supervision	N 163		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department within 3 working days after law enforcement personnel was called to the facility because of an incident that jeopardizes the health, safety, or welfare of residents or employees. On 09/14/2024, police responded to the facility due to an incident involving the de-escalation of a resident who was being combative towards care staff and eloped from the facility. On 11/01/2024, Surveyors reviewed Department records. No written reports involving the 09/14/2024 requiring police being summoned to the facility was on file. This is a repeat violation. See statement of deficiency (SOD) LHXR11, dated 08/30/2022.	N 164		

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N 164	Continued From page 6 Findings include: On 11/01/2024, Surveyors arrived at facility for a complaint investigation. On 11/01/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 07/01/2024. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: Alzheimer's disease. On 11/01/2024 at approximately 10:00 am, Surveyors interviewed Caregiver J who stated they were in work status when police were called to the facility due to Resident 1 being combative with caregivers, eloping and refusing to come back into the facility. Caregiver J recalled the officer speaking to Resident 1 about "things they had in common" and eventually the officer was able to persuade Resident 1 to enter the facility and remain calm. Surveyor reviewed Resident 1's progress notes and incident reports. The record did not include any details of the incident on 11/01/2024. On 11/01/2024 at 2:00 PM, Surveyor discussed the above concern with Administrator A, Nurse E and Regional F. Administrator A stated s/he was not aware of Resident 1's elopement or police being summoned to the facility. Surveyor then asked Administrator A why the department had not received any sort of incident report from them since 07/2024. Administrator A stated that a different staff member who was no longer with the facility was tasked with submitting all self-reports. On 11/15/2024 Surveyor reviewed requested	N 164		

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N 164	Continued From page 7 reports from the Sun Prairie Police Department that detailed their involvement with the provider on 09/14/2024. An officer was called to the facility to assist with Resident 1 who according to the responding officer's report was, "Hitting the workers and pulling on the worker's arms ...in the parking lot pulling on car door handles ...being very combative and eloping from the building ..." CROSS REFERENCE: N0163 DHS CHAPTER 83.12(4)(a) Reporting When Resident Whereabouts Unknown CROSS REFERENCE: N0214 DHS CHAPTER 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE: N0426 DHS CHAPTER 83.38(1)(b) Supervision	N 164		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, Administrator A did not provide the supervision necessary to ensure that the residents receive	N 214		

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N 214	Continued From page 8	N 214		

proper care and treatment, that their health and safety were protected and promoted and that their rights are respected.

The requirement was not met as evidenced by 8 deficiencies identified on 11/01/2024.

FINDINGS INCLUDE:

Facility is a Class CNA non-ambulatory facility. Has a capacity of 50 residents and serves advanced aged, irreversible dementia & Alzheimer's.

On 11/01/2024, Surveyors arrived at facility for a complaint investigation.

On 11/01/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 07/01/2024. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: Alzheimer's disease.

On 11/01/2024, Surveyor reviewed a document titled, "Resident Incident/Accident Report Worksheet." On 10/09/2024, Caregiver B documented Resident 1 suffered an unwitnessed fall. In the narrative section of the document, Caregiver B documented the following, "Resident c/o (complaint of) chest pain. Doesn't remember anything happening to head. Back of head has cut and dried blood."

On 11/01/2024, Surveyor reviewed Resident 1's progress note from 08/01/2024 to 11/01/2024. The following entries were reviewed:
1.) Documented by Previous Nurse G on 09/05/2024 at 11:13 AM, "[Family Member O] in unit this morning and unable to find resident. Staff

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N 214	Continued From page 9	N 214		

unable to locate resident within unit. A staff member outside saw a resident in the garage and brought [him/her] back inside the building. No apparent injuries...Updated on increase in exit seeking and unobserved elopement from memory care unit...".
2.) Documented by Triage Nurse C on 10/09/2024 at 5:05 AM, "TRIAGE CALL - resident had dried blood and a laceration on the back of [his/her] head. Resident is complaining of chest discomfort and has refused VS (vital signs) per staff. Writer instructs staff to call 911 and notify triage of transfer."
3.) Documented by Nurse D on 10/09/2024 at 4:25 PM, "Follow/up/After Visti (sic.) Summary: [Resident 1] was seen at [Hospital Name] for fall and laceration to scalp. CT imaging did not reveal and acute injuries. The laceration was repaired with staples, to be removed in 7-10 days."

On 11/01/2024, Surveyor reviewed Resident 1's after visit summary from his/her emergency room admission on 10/09/2024. The after-visit summary documented Resident 1 was treated for head injury related to a fall.

On 11/01/2024, Surveyors identified the following violations of DHS Chapter 83 and DHS Chapter 50:
1.) 83.12(3)(a) Investigate Injuries of Unknown Source
2.) 83.12(4)(a) Reporting When Resident Whereabouts Unknown
3.) 83.12(4)(b) Reporting When Law Enforcement Is Called
4.) 83.15(3)(a) Administrator Shall Supervise Daily Operation
5.) 83.37(1)(i) PRN Psychotropic Medication
6.) 83.38(1)(b) Supervision
7.) 83.38(1)(h) Medication Management

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N 214	Continued From page 10 8.) 83.38(1)(i) Behavior Management On 11/01/2024 at 2:00 PM, Surveyors discussed the above concerns with Administrator A, Nurse E and Regional F. Administrator A stated s/he did not investigate Resident 1's head injury because s/he had not been made aware of the incident. Administrator A stated s/he had not filed self-reports with the Department regarding Resident 1's elopement and/or head injury secondary to unwitnessed fall because Previous Nurse E had been filing self-reports for the facility before his/her position ended. Administrator A acknowledged Resident 1 had not received adequate supervision and behavioral management program services. On 11/08/2024 at 12:45 PM, Surveyor spoke with Resident 1's primary care provider (PCP) Doctor Q. Doctor Q identified themselves as Resident 1's PCP. Doctor Q reported s/he had been notified of Resident 1's elopements on 09/05/2024 and 11/03/2024. Doctor Q stated s/he had not been notified Resident 1 had been banging on doors during night time hours. Doctor Q stated s/he had not been notified Resident 1 had gone into other residents living spaces without permission. Doctor Q stated s/he had not been notified of Resident 1 being combative with staff. Doctor Q stated s/he had not been notified that Resident 2's psychotropic PRN Risperidone 0.25 mg prescribed for agitation had not been administered from 09/01/2024 to 11/01/2024. On 11/15/2024 Surveyor reviewed requested reports from the Sun Prairie Police Department that detailed their involvement with the provider on 09/14/2024. An officer was called to the facility to assist with Resident 1 who according to the responding officer's report was, "Hitting the	N 214		

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N 214	Continued From page 11 workers and pulling on the worker's arms ...in the parking lot pulling on car door handles ...being very combative and eloping from the building ..."	N 214		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given. This Rule is not met as evidenced by: Based on record review and interview, the provider did not add a detailed description of the behaviors which indicate the need for administration of PRN (as needed) psychotropic medication in Resident 1's individualized service plan (ISP). FINDINGS INCLUDE:	N 408		

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N 408	Continued From page 12 On 11/01/2024, Surveyors arrived at facility for a complaint investigation. On 11/01/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 07/01/2024. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: Alzheimer's disease. On 11/01/2024, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 07/22/2024. Zero, documentation of PRN (as needed) psychotropic medication was reviewed. On 11/01/2024, Surveyor reviewed Resident 1's October 2024 medication administration record (MAR). The following psychotropic as needed (PRN) medication orders were listed: 1.) Lorazepam 1 mg - 1 tablet three-time daily (TID) PRN for anxiety - order start date: 07/16/2024 2.) Risperidone 0.25 mg - 1 tablet twice daily (BID) PRN for anxiety/agitation - order start date: 07/01/2024 On 11/06/2024 at 9:29 AM, Surveyor emailed Administrator A and Nurse E the above information. On 11/06/2024 at 9:58 AM, Administrator A emailed Surveyor to report the above findings would be shared with care team. CROSS REFERENCE: N0214 DHS CHAPTER 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE: N0432 DHS CHAPTER 83.38(1)(h) Medication Administration CROSS REFERENCE: N0433 DHS CHAPTER	N 408		

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N 408	Continued From page 13 83.38(1)(i) Behavior Management	N 408		
N 426	83.38(1)(b) Supervision. 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: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not arrange adequate supervision appropriate to meet Resident 1's needs. On 09/05/2024, Resident 1 eloped from the facility to an outside garage. On 11/03/2024, Resident 1 eloped from facility. Staff reported Resident 1's whereabouts were unknown to Administrator A. Administrator A called the local police department. Local police department reported Resident 1 had been found at a local coffee shop. FINDINGS INCLUDE: On 11/01/2024, Surveyors arrived at facility for a complaint investigation.	N 426		

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N 426	Continued From page 14 OBSERVATION: On 11/01/2024 at 9:15 AM, Surveyors toured the secured memory care unit. Surveyors observed Resident 1's apartment was located on the secured section of the unit. The main entrance to the secured memory care unit could only be unlocked with a facility issued key fob. The emergency exits had delayed egress which were in working order. RECORD REVIEW: On 11/01/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 07/01/2024. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: Alzheimer's disease. On 11/01/2024, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 07/22/2024. Under the subsection titled, "Vulnerable Adult: Behavior: susceptible to be abused by others...[Resident 1] is a vulnerable adult due to diagnosis of Alzheimer's disease. Resident 1's ISP documented him/her as a fall risk. On 11/01/2024, Surveyor reviewed Resident 1's progress notes from 08/01/2024 to 11/01/2024. The following entries were reviewed: 1.) On 09/05/2024 at 11:13 AM, Previous Nurse G documented the following, "[Resident 1's] [spouse] in unit this morning and unable to find resident. Staff unable to locate resident within unit. A staff member outside saw a resident in the garage and brought [him/her] back inside the building. No apparent injuries...Updated on increase in exit seeking and unobserved	N 426		

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N 426	Continued From page 15 elopement from memory care unit...". On 11/07/2024, Surveyor reviewed a self-report sent to the Department on 11/06/2024. The reason documented for the self-report was, "Law Enforcement Intervention + Elopement." The date and time of the incident was 11/03/2024 at 8:00 AM. Administrator A reported the following, "Incident Description... [Resident 1] moved into our memory care unit on 7/1/24 with diagnoses of Alzheimer's Disease and Hyperlipidemia. On Sunday, November 3rd at 8:00am [Resident 1] eloped from our secure memory care by pressing on our delayed egress crash bar until the door alarmed and the lock released...Incident Outcome...Community's Caregivers responded to the alarm within three minutes, reset the system and began to conduct a head count of all the memory care residents. Upon realizing that [Resident 1] was unaccounted for, the Community's Caregivers reported the elopement to [Administrator A]. [Administrator A] then called the [Local Police Department] to report the elopement. The operator informed [Administrator A] that [Name of Coffee Shop] had already found [Resident 1] and that an Officer was with [him/her]. [Administrator A] coordinated for Community Caregivers to meet [Resident 1] at [Name of Coffee Shop] and escort [him/her] back to the secured memory care. In total, the resident was outside of the community for 45mins and walked 0.3miles to [Name of Coffee Shop]. The temperature in [Name of Town] was 50 degrees at this time and [Resident 1] was appropriately dressed for the conditions. At 8:55am [Administrator A] updated [Family Member H] about the elopement and scheduled a care conference for 11/8/24...Action Taken to Ensure Resident's Health, Safety and Wellbeing...The Resident PCP and [Family	N 426		

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Member H] were notified of the 11/3/24 elopement. The Resident PCP is reviewing the medication regime and did not give any further orders. A comprehensive assessment was completed (sic.) and the ISP (individualized service plan) and care plan were updated to include new interventions on how to redirect [Resident 1]. [Resident 1] is on a PRN and a scheduled anxiolytic (anti-anxiety medication), and we will continue to monitor the effectiveness of these."

INTERVIEWS:

On 11/01/2024 at 9:50 AM, Surveyors discussed Resident 1's behavior with Caregiver I. Caregiver I reported for approximately 2 months, Resident 1's behaviors had become more difficult for caregivers to manage. Caregiver I reported Resident 1 would attempt to elope from the unit, enter other resident rooms. bang on doors and would attempt to strike staff for re-directing the behavior. Caregiver I reported facility had to call local police on multiple occasions to keep Resident 1 safe. Caregiver I stated Resident 1 could be re-directed with a calm approach, favorite foods and connecting with family. Caregiver I stated staff had administered PRN Lorazepam multiple times, but it had not always been effective. Caregiver I stated Resident 1 had attempted to enter Resident 4's room, and Resident 4 told staff if Resident 1 entered his/her room again Resident 4 would defend himself/herself. Caregiver I stated Resident 1 would bang on the other resident doors. Caregiver I stated Resident 1 would bang on Resident 2 and Resident 3's door during night shift hours. Caregiver I stated staff reported Resident 1's behaviors during cross shift reports. Caregiver I denied being instructed to utilize new

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N 426	Continued From page 17 behavioral interventions when the PRN Lorazepam was reported as not effective. On 11/01/2024 at 10:06 AM, Surveyors discussed Resident 1's behavior with Caregiver J. Caregiver J reported Resident 1 had attempted to elope, strike staff, enter other residents' rooms without permission, and bang on doors. Caregiver J reported Resident 1 required very close staff supervision to manage potentially harmful behaviors. Caregiver J reported police intervention had been required when Resident 1 had refused to re-enter the facility. Caregiver J reported Resident 1 was found in another resident's bed. Caregiver J reported Resident 1 would bang on Resident 3's door during all hours. Caregiver J could not recall being given new behavioral interventions to utilize after police presence had been required to get Resident 1 to re-enter the facility. On 11/01/2024 at 2:00 PM, Surveyor discussed the above concern with Administrator A, Nurse E and Regional F. Administrator A acknowledged Resident 1 had eloped from the facility on 09/05/2024. Administrator A reported Resident 1 was on hospice service from an outside provider. CROSS REFERENCE: N0163 DHS CHAPTER 83.12(4)(a) Reporting When Resident Whereabouts Unknown CROSS REFERENCE: N0214 DHS CHAPTER 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE: N0433 DHS CHAPTER 83.38(1)(i) Behavior Management	N 426		
N 432	83.38(1)(h) Medication administration.	N 432		

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N 432	Continued From page 18 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: Medication administration. The CBRF shall provide medication administration 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 Resident 2 was provided medication administration services appropriate to meet his/her needs. From 09/01/2024 to 10/31/2024, Resident 2 was not administered 33 doses of medication at intervals prescribed by their practitioner. During that period, Resident 2 received 3 doses of Bactrim DS-Septra DS 800-160 mg without an active practitioner's order. This is a repeat violation of statement of deficiency (SOD) 5DNC11 dated 07/24/2019 & SOD ZZI812 dated 05/15/2024. FINDINGS INCLUDE: On 11/01/2024, Surveyors arrived at facility for a complaint investigation. RECORD REVIEW: On 11/01/2024, Surveyor reviewed Resident 2's facesheet. Resident 2 was admitted to the facility	N 432		

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on 04/17/2023. Resident 2 had an activated power of attorney (APOA). Resident 2 was diagnosed with but not limited to: unspecified dementia & amnesia.

On 11/01/2024, Surveyor reviewed Resident 2's individualized service plan (ISP). Resident 2's ISP was last signed by Legal Representative S on 04/11/2024. under the subsection titled, "Medications/Treatment," the following was documented, "Medications: will accept/receive all medications/treatments as ordered by MD/pharmacy without ill effect through next review."

On 11/01/2024, Surveyor reviewed Resident 2's October 2024 MAR. The following antibiotic therapies were documented:
1.) Ciprofloxacin HCL 500 mg - twice daily (BID) - order start date:10/21/2024 - order end date: 10/26/2024 - Resident 2 was administered all 11 doses.
2.) SMZ/TMP 800 mg - 160 mg (Bactrim DS) - BID for 10 days - order start date: 10/22/2024 - order end date: 10/24/2024 - Resident 2 was administered 4 doses total.

On 11/01/2024, Surveyor reviewed Resident 2's grievances. On 10/26/2024, Family Member L wrote the following grievance, "Thursday morning 10/17/24 [Name of Facility] staff took a urine sample from my [Resident 2]. I took a urine sample to my [Physician Assistant P]. The sample came back positive for a UTI. Friday afternoon I contacted [his/her] primary and was told it was being cultured to be sure to use the correct antibiotic. Saturday morning, the on-call doctor called in a prescription to Walgreens that I picked up.
Saturday afternoon and Sunday morning I gave

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[Resident 2] the antibiotic. Sunday 10/20/24, I gave the bottle to the staff and explained the story. Monday evening, I was told a new prescription was being sent in. Tuesday morning, I spoke to [Nurse D]. [S/He] assured me that [s/he] would follow up and verify with [his/her] primary if [s/he] should get one or both antibiotics...Wednesday morning [s/he] was still getting both. I sent [Nurse D] a text asking him to verify what [s/he] should be getting. I sent [him/her] a copy of what the doctor had sent me, that the second dose was cancelled. Wednesday I was told [Nurse D] was gone. I was concerned if [s/he] had followed up so Wednesday I sent [Administrator A] a text explaining the situation asking if [s/he] could follow up...Thursday morning [s/he] was still getting both. I spoke to [Nurse E], [s/he] said [s/he] did not think [s/he] should be getting both and would contact the primary to verify. Within 30 minutes [Nurse E] told me [s/he] was NOT to be getting both. I sent [Administrator A] a text explaining this. Friday morning, [s/he] was still getting both, I spoke to [Nurse M] and [s/he] said [s/he] was not to be getting both and [s/he] would contact the primary to verify what antibiotic was ordered." Under the subsection titled, "Findings of investigation," Administrator A documented the following, "[Nurse D's] last day was 10/22/24 and [his/her] calls and emails forwarded to me since [Family Member L] texted we did not receive (sic.) [his/her] message."

On 11/01/2024, Surveyor reviewed test message sent from Family Member L to Administrator A and Nurse D.
-On 10/23/2024 at 9: 07 AM, Family Member L sent Nurse D a screen shot of Resident 2's electronic clinical record (mychart). The screen shot showed the following message from

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Physician Assistant P on 10/22/2024 at 8:36 PM, "Sorry for the confusion, I didn't see [Name of Prescriber] was on-call this weekend and prescribed Cipro which is also a good antibiotic for UTIs. I will cancel my order." Family Member L then sent as second message, "I was told today [s/he] is getting both antibiotics? But I did not see the orders."
-On 10/23/2024 at 4:04 PM, Family Member L sent Administrator A a screen shot of the messages s/he had sent to Nurse D at 9:07 AM. Family Member L then sent a second message, "I sent this to [Nurse D] this morning. Please make sure to verify [Resident 2] should NOT be taking 2 antibiotics."
-On 10/24/2024 at 8:56 AM, Family Member L sent Administrator A the following message, "[Resident 2] is still getting both Let me ask the primary to see the issue."

On 11/01/2024, Surveyor reviewed a fax sent from Resident 2's primary care clinic to facility on 10/24/2024. The fax contained Physician Assistant P's order for Bactrim DS-Septra DS 800-160 mg. The order was started on 10/21/2024 at 11:28 AM. The order was discontinued on 10/22/2024 at 8:26 PM due to, "Reason:Clinical Decision."

On 11/01/2024 at 11:30 AM, Surveyor discussed the above concern with Nurse E. Nurse E reported s/he is a regional nurse and s/he started an interim role as a facility nurse on 10/24/2024. Nurse E stated that when Family Member L reported this issue to them. S/He contacted Resident 2's primary care clinic and obtained the discontinuation order for the Bactrim DS-Septra DS 800-160 mg tablets. Nurse E stated s/he discontinued the Bactrim DS-Septra DS 800-160 mg tablet from the facility MAR upon receipt of

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the discontinuation order. Nurse E acknowledged the Bactrim DS-Septra DS 800-160 mg tablet had been discontinued by Nurse E on 10/22/2024 at 8:36 PM. Nurse E acknowledged on from 10/23/2024 to 10/24/2024, Resident 2 received 3 doses of Bactrim DS-Septra DS 800-160 mg tablet without an active practitioner's order.

On 11/01/2024, Surveyor reviewed the last page of Resident 2's September 2024 MAR. The following doses of medication were documented as, "Out of building."
1.) 09/17/2024 at 8:00 AM, Cetirizine 10 mg
2.) 09/17/2024 at 8:00 AM, Duloxetine 20 mg
3.) 09/17/2024 at 8:00 AM, Ferosul 325 mg
4.) 09/17/2024 at 8:00 AM, Memantine HCL 10 mg
5.) 09/17/2024 at 8:00 AM, Multivitamin tablet
6.) 09/17/2024 at 8:00 AM, Nitrofurantoin mono 100 mg
7.) 09/17/2024 at 8:00 AM, Bactrim DS-Septra DS 800-160 mg
8.) 09/17/2024 at 8:00 AM, Vitamin D3 1,000 international units (IU)
9.) 09/21/2024 at 8:00 AM, Amlodipine 5 mg
10.) 09/21/2024 at 8:00 AM, Cetirizine 10 mg
11.) 09/21/2024 at 8:00 AM, Duloxetine 20 mg
12.) 09/21/2024 at 8:00 AM, Ferosul 325 mg
13.) 09/21/2024 at 8:00 AM, Memantine HCL 10 mg
14.) 09/21/2024 at 8:00 AM, Multivitamin tablet
15.) 09/21/2024 at 8:00 AM, Bactrim DS-Septra DS 800-160 mg
16.) 09/21/2024 at 8:00 AM, Vitamin D3 1,000 IU

On 11/01/2024, Surveyor reviewed the last page of Resident 2's October 2024 MAR. The following doses of medication were documented as, "Out of building."
1.) 10/19/2024 at 5:39 PM, Super B-Comp Tablet

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N 432	Continued From page 23 2.) 10/19/2024 at 8:00 AM, Amlodipine 5 mg 3.) 09/17/2024 at 8:00 AM, Cetirizine 10 mg 4.) 10/19/2024 at 8:00 AM, Duloxetine 20 mg 5.) 10/19/2024 at 8:00 AM, Ferosul 325 mg 6.) 10/19/2024 at 8:00 AM, Memantine HCL 10 mg 7.) 10/19/2024 at 8:00 AM, Multivitamin tablet 8.) 10/19/2024 at 8:00 AM, Vitamin D3 1,000 international units (IU) 9.) 10/19/2024 at 5:59 PM, Memantine HCL 10 mg 10.) 10/31/2024 at 5:59 PM, Super B-Comp Tablet 11.) 10/31/2024 at 8:00 AM, Amlodipine 5 mg 12.) 10/31/2024 at 8:00 AM, Cetirizine 10 mg 13.) 10/31/2024 at 8:00 AM, Duloxetine 20 mg 14.) 10/31/2024 at 8:00 AM, Memantine HCL 10 mg 15.) 10/31/2024 at 8:00 AM, Multivitamin tablet 16.) 10/31/2024 at 8:00 AM, Vitamin D3 1,000 international units (IU) 17.) 10/31/2024 at 5:59 PM, Memantine HCL 10 mg On 11/01/2024 at 11:30 AM, Surveyor discussed documentation with Nurse E. Nurse E reported Resident 2 was out with family when staff documented s/he was "Out of building". Nurse E denied medical orders given to withhold medications on the intervals Resident 2 had been documented as "Out of building." Nurse E denied a system for Resident 2 to be administered his/her medications while outside of the facility. Nurse E provided Surveyor with the visitor logs for 09/17/2024, 09/21/2024, 10/19/2024 & 10/31/2024. Resident 2 was documented as out with family all 4 days. On 11/01/2024 at 2:00 PM, Surveyor discussed the above concern with Administrator A, Nurse E	N 432		

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N 432	Continued From page 24 and Regional F. Administrator A acknowledged facility was responsible for administering Resident 2's medication as prescribed by their practitioner. Administrator A stated facility had not been notified Resident 2's medication had been discontinued on 10/22/2024 and Administrator A reported s/he did not see Family Member L's text messages before 10/24/2024. Administrator A acknowledged the facility to responsible for creating a method of communication with Resident 2's primary care clinic to provide adequate medication administration service. Administrator A acknowledged Resident 2 should have been provided his/her medications during outings with family on 09/17/2024, 09/21/2024, 10/19/2024 & 10/31/2024. CROSS REFERENCE: N0214 DHS CHAPTER 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE: N0408 DHS CHAPTER 83.37(1)(i) PRN Psychotropic Medication CROSS REFERENCE: N0432 DHS CHAPTER 83.38(1)(h) Medication Administration	N 432		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others.	N 433		

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This Rule is not met as evidenced by:
Based on record review and interview the provider did not arrange behavior management services adequate to manage Resident 1's behavior(s) which may be harmful to themselves or others.

From 09/01/2024 to 10/31/2024, Resident 1 had not been administered his/her psychotropic PRN (as needed) Risperidone 0.25 mg tablet prescribed for anxiety/agitation. Resident 1 had been administered his/her psychotropic PRN Lorazepam 1 mg tablet prescribed for anxiety 8 times. Three of the 8 administrations of PRN Lorazepam 1 mg were documented as "Not Effective." During that period, Resident 1 had exhibited the following behaviors: exit seeking, physical aggression towards caregivers and entering other residents' rooms without permission.

FINDINGS INCLUDE:

On 11/01/2024, Surveyors arrived at facility for a complaint investigation.

RECORD REVIEW:

On 11/01/2024, Surveyor reviewed Resident 1's facility facesheet. Resident 1 was admitted to the facility on 07/01/2024. Resident 1 had an activated power of attorney. Resident 1 was diagnosed with but not limited to: Alzheimer's disease.

On 11/01/2024, Surveyor reviewed Resident 1's individualized service plan (ISP) dated 07/22/2024.
Resident 1's was documented as an elopement

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NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

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risk. Resident 1's ISP did not document their prescribed psychotropic PRN (as needed) medications.

On 11/01/2024, Surveyor reviewed Resident 1's September 2024 "Behavioral Expressions Monitoring Log." No, behaviors were documented from 09/01/2024 to 09/30/2024.

On 11/01/2024, Surveyor reviewed Resident 1's October 2024 "Behavioral Expressions Monitoring Log." No, behaviors were documented from 10/01/2024 to 10/31/2024.

On 11/01/2024, Surveyor reviewed Resident 1's September 2024 medication administration record (MAR). The following psychotropic as needed (PRN) medication orders were documented:
1.) Lorazepam 1 mg - 1 tablet three-time daily (TID) PRN for anxiety - order start date: 07/16/2024-Lorazepam 1 mg PRN was administered 4 times during the month of September:
-09/14/2024 at 8:46 PM, Lorazepam 1 mg was administered for anxiety, response was documented as "Effective."
-09/19/2024 at 8:21 AM, Lorazepam 1 mg was administered for anxiety, response was documented as "Effective."
-09/20/2024 at 8:00 AM, Lorazepam 1 mg was administered for anxiety, response was documented as "Effective."
-09/30/2024 at 12:05 AM, Lorazepam 1 mg was administered for anxiety, response was documented as " Not Effective."

2.) Risperidone 0.25 mg - 1 tablet twice daily (BID) PRN for anxiety/agitation - order start date: 07/01/2024 - Risperidone 0.25 mg PRN was not

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administered to Resident 1 during the month of September.

On 11/01/2024, Surveyor reviewed Resident 1's October 2024 MAR. The following psychotropic PRN medication orders were documented:
1.) Lorazepam 1 mg - 1 tablet three-time daily (TID) PRN for anxiety - order start date: 07/16/2024-Lorazepam 1 mg PRN was administered 4 times during the month of October:
- 10/06/2024 at 9:16 AM, Lorazepam 1 mg was administered for anxiety, response was documented as "Not Effective."
- 10/06/2024 at 8:50 PM, Lorazepam 1 mg was administered for anxiety, response was documented as "Effective."
- 10/23/2024 at 7:51 PM, Lorazepam 1 mg was administered for anxiety, response was documented as "Somewhat Effective."
- 10/29/2024 at 8:00 AM, Lorazepam 1 mg was administered for anxiety, response was documented as "Not Effective."

2.) Risperidone 0.25 mg - 1 tablet twice daily (BID) PRN for anxiety/agitation - order start date: 07/01/2024 - Risperidone 0.25 mg PRN was not administered to Resident 1 during the month of October.

On 11/01/2024, Surveyor reviewed Resident 1's progress notes from 08/01/2024 to 11/01/2024. On 10/29/2024 at 11:09 AM, Writer called resident hopsice (sic.) nurse and spoke with [Nurse Name] in regard to resident continuously trying to elope, jump the fence, and agitation. Staff have reported redirecting resident several times, every time being ineffective. PRN Lorazepam was given at 8am which ineffective as well. [Nurse Name] stated to give resident his

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mid-day scheduled lorazepam at 11am and prn can be given every 4 hours. Writer also called pharmacy to get a refill on [his/her] prn risperidone, [s/he] is out of refills so pharmacy stated they will send another request to the doctor... [Nurse M]."

On 11/01/2024, Surveyor reviewed a document titled, "Resident Incident/Accident Report Worksheet." On 10/29/2024, Resident 1 attempted to elope from facility while under staff supervision. Under the narrative section Caregiver I documented the following, "They let [him/her] out to get some fresh air and [s/he] tried to jump the fence."

On 11/01/2024, Surveyor reviewed the "24-Hour Shift Log" dated 10/31/2024. Staff documented that Resident 1, "tried eloping all shift."

On 11/01/2024, Surveyor reviewed Resident 2's grievance records:
1.) On 10/22/2024, Family Member L wrote a grievance that described Resident 1 entering Resident 2's room without permission.

2.) On 10/26/2024, Family Member L wrote a grievance that described Resident 1 entering Resident 2's room without permission.

INTERVIEWS:

On 11/01/2024 at 9:50 AM, Surveyors discussed Resident 1's behavior with Caregiver I. Caregiver I reported for approximately 2 months, Resident 1's behaviors had become more difficult for caregivers to manage. Caregiver I reported Resident 1 would attempt to elope from the unit, enter other resident rooms. bang on doors and would attempt to strike staff for re-directing the

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behavior. Caregiver I reported facility had to call local police on multiple occasions to keep Resident 1 safe. Caregiver I stated Resident 1 could be re-directed with a calem approach, favorite foods and connecting with family. Caregiver I stated staff had administered PRN Lorazepam multiple times, but it had not always been effective. Caregiver I stated Resident 1 had attempted to enter Resident 4's room, and Resident 4 told staff if Resident 1 entered his/her room again Resident 4 would defend himself/herself. Caregiver I stated Resident 1 would bang on the other resident doors. Caregiver I stated Resident 1 would bang on Resident 2 and Resident 3 door during night shift hours. Caregiver I stated staff reported Resident 1's behaviors during cross shift reports. Caregiver I denied being instructed to utilize new behavioral interventions when the PRN Lorazepam was reported as not effective.

On 11/01/2024 at 10:06 AM, Surveyors discussed Resident 1's behavior with Caregiver J. Caregiver J reported Resident 1 had attempted to elope, strike staff, enter other residents' rooms without permission, and bang on doors. Caregiver J reported Resident 1 required very close staff supervision to manage potentially harmful behaviors. Caregiver J reported police intervention had been required when Resident 1 had refused to re-enter the facility. Caregiver J reported Resident 1 was found in another resident's bed. Caregiver J reported Resident 1 would bang on Resident 3's door during all hours. Caregiver J could not recall being given new behavioral interventions to utilize after police presence had been required to get Resident 1 to re-enter the facility.

On 11/01/2024 at 10:20 AM, Surveyors knocked

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on Resident 3's apartment door. Resident 3 unlocked the door and welcomed Surveyors into his/her apartment. Resident 3 reported s/he had started keeping his/her apartment locked at all times a month ago. Resident 3 stated Resident 1 had started to bang loudly on his/her door at 2:00 AM and in the afternoon. Resident 3 stated s/he was scared to see what would happen if Resident 1 came into the apartment from how they were banging on the door. Resident 3 stated Resident 1 had lived in his/her apartment with their spouse before Resident 3 had moved in and thought Resident 1 maybe confused as to who was inside the apartment. Resident 3 stated Resident 1's banging usually woke him/her up at night and s/he would press his/her call button for staff to escort Resident 1 away from the door.

On 11/01/2024 at 2:00 PM, Surveyor discussed the above concern with Administrator A. Nurse E and Regional F. Administrator A acknowledged Resident 1 had eloped from the facility on 09/05/2024 and had an attempted elopement on 10/29/2024. Administrator A reported, that when agitated, Resident 1 responded well to favorite food(s) and family connection. Administrator A acknowledged Resident 1's ISP did not document Resident 1's history of potentially harmful behaviors nor behavioral interventions. Administrator A acknowledged from 09/01/2024 to 10/31/2024, staff had not documented Resident 1's behaviors in the "Behavioral Expressions Monitoring Log". Administrator A stated Resident 1 had entered Resident 4's room without permission. Administrator A stated s/he had investigated Family Member L's grievances; but had not documented the investigations at this time. Administrator A stated s/he talked to Caregiver K about Resident 1 being found in Resident 2's bed, and Caregiver K reported

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N 433	Continued From page 31 Resident 2 was found crawling on the floor calling out for help and Resident 1 was naked in Resident 2's bed while wrapped in his/her blanket. Administrator A reported a care conference to update Resident 1 ISP had been scheduled with Resident 1's legal representative. On 11/08/2024 at 12:45 PM, Surveyor spoke with Resident 1's primary care provider (PCP) Doctor Q. Doctor Q identified themselves as Resident 2's PCP. Doctor Q reported s/he had been notified of Resident 1's elopements on 09/05/2024 and 11/03/2024. Doctor Q stated s/he had not been notified Resident 1 had been banging on doors during night time hours. Doctor Q stated s/he had not been notified Resident 1 had gone into other residents living spaces without permission. Doctor Q stated s/he had not been notified of Resident 1 being combative with staff. Doctor Q stated s/he had not been notified that Resident 2's psychotropic PRN Risperidone 0.25 mg prescribed for agitation had not been administered from 09/01/2024 to 11/01/2024. CROSS REFERENCE: N0214 DHS CHAPTER 83.15(3)(a) Administrator Shall Supervise Daily Operation CROSS REFERENCE: N0408 DHS CHAPTER 83.37(1)(i) PRN Psychotropic Medication CROSS REFERENCE: N0426 DHS CHAPTER 83.38(1)(b) Supervision	N 433		