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 _____	R-C 04/30/2025

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 On 04/30/2025, the bureau of assisted living southern regional office conducted 2 complaint investigations, and a verification visit at New Perspectives Sun Prairie a CBRF located in Sun Prairie, WI. As a result of this survey, 2 violations of DHS Chapter 83 were issued. One complaint was substantiated. Census: 32 Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.	{N 000}		
N 205	83.14(2)(j) Not permit a condition of substantial risk. The licensee may not permit the existence or continuation of any condition which is or may create a substantial risk to the health, safety or welfare of any resident. This Rule is not met as evidenced by: Based on record review and interview, the licensee permitted the existence or continuation of a condition which is or may create a substantial risk to the health, safety or welfare of any resident. From 12/06/2025 to 04/01/2025, provider and hospice staff had documented multiple incidents where Resident 2's behaviors towards Resident 1 had required staff re-direction due to concern for Resident 1's health, safety and/or welfare.	N 205		

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

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 _____	R-C 04/30/2025

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 205	Continued From page 1 On 04/02/2025, Nurse J witnessed Resident 2 slapping Resident 1 across the face in the resident dining room. On 04/30/2025, Surveyor found interventions to protect Resident 1's health, safety and/or welfare had not been initiated. 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 04/29/2025, the Department received a complaint regarding abuse. On 04/30/2025, Surveyors arrived at facility for a complaint investigation. RECORD REVIEW: On 04/02/2025, the Department received a self-report from provider which stated the following, "Witnessed altercation between [Resident 2] and [Resident 1] in common area of Memory Care unit ...[Resident 1] immediately removed from area away from [Resident 2]. Family called, Hospice in community witnessed incident, as well as community nurse. PCP updated and no new orders ...No further altercations observed,investigation (sic.) started and reviewed. Care Plan updated. Plan is to have meeting with family [Name Of Hospice Provider], and Ombudsman on 4.7.2025 to discuss ...Resident Name: [Resident 1] ...Diagnosis: chronic metabolic encephalopathy, Major Depressive Disorder ...Current Residence: [Resident 1] currently resides in memory care at	N 205		

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 _____	R-C 04/30/2025

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 205	Continued From page 2	N 205		

[Name Of Facility] with [Resident 2]."

On 04/30/2025, Surveyor reviewed Resident 1's face sheet. Resident 1 was admitted to the facility on 11/25/2022. Resident 1 had an activated power of attorney for healthcare and an activated financial power of attorney. Resident 1 was diagnosed with but not limited to: cerebral infarction, metabolic encephalopathy, history of depressive episode, chronic kidney disease, secondary parkinsonism, and overactive bladder.

On 04/30/2025, Surveyor reviewed Resident 1's individualized service plan (ISP). The ISP was signed by Family Member I on 11/24/2024. The ISP documented the following, "Team members to provide cueing to get meals and toileting help. Caregivers to provide interventions as described and report changes on need for cues to nursing ...Bathing ...Ensure safe water temperature. Observe skin for changes such as redness, bruises, open areas, wounds & report to supervisor. Encourage resident to complete tasks when able. Caregiver must remain with resident entire time ...Assist resident with dressing ...DME assistive equipment ...Has Sit to stand, sling, walker and wheelchair. Assist resident with DME, assistive equipment as instructed ...Team members are to use sit to stand with [Resident 1] ...Resident requires caregiver assist of 2 ...Resident is at risk for falls ...2 caregivers to assist with incontinence care ..."

On 04/30/2025, Surveyor reviewed Resident 1's incident reports:
1.) On 02/06/2025 at 5:52 PM, Nurse K documented an incident which occurred previous on 02/05/2025 at 9:40 AM. Resident 1 experienced a witnessed fall. The fall occurred in Resident 1's bedroom. Resident 2 was the

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 _____	R-C 04/30/2025

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 205	Continued From page 3	N 205		

witness, who stated Resident 1 slid out of bed an onto the floor. No, apparent injuries were documented.

2.) An unsigned incident report documented that on 03/27/2025 at 4:35 PM. Resident 1 experienced a witnessed fall. The fall occurred in Resident 1's bedroom. Resident 2 was the witness, who stated Resident 1 slid out of bed an onto the floor. No, apparent injuries were documented.

3.) On 04/02/2025 at 10:55 AM, Nurse J documented Resident 1 experienced a witnessed fall at approximately 6:15 AM. The fall occurred in the Resident 1's bedroom. Resident 2 was witness to the fall and s/he stated Resident 1, "rolled off the bed onto the floor." Resident 1 was assessed by Nurse J to be free from injury.

4.) On 04/04/2025 at 2:00 PM, Nurse J documented an incident which occurred previous on 04/02/2025 at 1:05 PM. Nurse J documented the following, "Alleged abuse ...COMMON AREA: Dining room ...Resident was repeating "don't touch me' 2-3 times ...4/2/25 @ 1305 Writer was at med cart and heard smacking type noise, (sic.) Writer turned and visually observed [Resident 2] slapping [Resident 1] on the right side of [his/her] face aggressively trying to rouse [him/her] while [s/he] was sitting [his/her] WC (wheelchair) sleeping. [S/he] was in front of [his/her] table after lunch. Writer quickly approached [Resident 2] and [Resident 1], and instructed [Resident 2] to stop slapping immediately. writer (sic.) asked [Resident 2] to please leave (roll away in [his/her] wheelchair), [s/he] did not comply after several requests to leave the area. Writer did not appreciate any redness to [Resident 1's] face. [Name Of Hospice Provider] RN was in the

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 _____	R-C 04/30/2025

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 205	Continued From page 4	N 205		

common area too and saw events. [Resident 1] went on to nap ..."

5.) On 04/14/2025 at 4:34, Nurse J documented an incident which occurred pervious on 04/11/2025 at 10:15 AM. Resident 1 experienced a witnessed fall. The fall occurred in Resident 1's bedroom. Resident 2 was the witness, who stated Resident 1 slid out of bed an onto the floor. No, apparent injuries were documented.

On 04/30/2025, Surveyor reviewed Resident 1's observation notes:
1.) On 02/25/2025 at 12:36 PM, Triage Nurse L documented the following, "resident had an unwitnessed fall from bed to floor. Laceration present to right elbow 3 inches in length...Writer instructs caller to call 911. EMS arrives (sic.) and took resident to TAC. Resident uses hospice services."

2.) On 2/25/2025 at 12:38 PM, Nurse B documented the following, "received call from UW-TAC and resident is returning to facility with [Family Member]. Received 8 internal stitches and 10 external stitches."

3.) On 03/21/2025 at 10:44 AM, Nurse J documented the following, "Writer met with [Nurse G] and [Social Worker F] from [Name Of Hospice Provider], (just met with resident),they (sic.) Informed writer that resident has been reporting on going hitting. Per Caregivers reported historically that they have observed [Resident 2], open hand slapping [Resident 1] on his/her back, unsure of all occasions. [Resident 1] reported to [Name Of Hospice Provider] staff This am, that [Resident 2] hits him/her mostly in their shared room. Currently, [Resident 1] has no bruising or signs of physical strikes, per [Hospice

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 _____	R-C 04/30/2025

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 205	Continued From page 5	N 205		

Staff]. [Hospice Staff] informed writer that they are following up with the Exec. Dir and HWD, now and have called the Ombudsman. Additionally, they have called family ..."

4.) On 04/02/2025 at 4:46 PM, Nurse J documented the following, "1615 (4:15 PM) called [Name Of Hospice Provider] as a resident is yelling out that [his/her] arm hurts on the right side/guarding arm up against chest. Writer explained events of the day starting with fall early am and episode this afternoon with RUE (right upper extremity) pain and the lump on right side of head. Writer has transferred to Triage RN and writer reported all events. Writer told would receive callback from Hospice RN after speaking with [Family Member I]."

5.) On 04/03/2025 at 10:01 AM, Nurse J documented the following, "Late entry: 4/2/2025, Resident returned from UW East ED via [Family Member M] circa 2300 (11:00 PM). Residents exam and Ed per AVS was negative for any fractures or UTI ... After earlier talk with [Family Member I], writer will f/u on Safely You, with Exec Director..."

6.) On 04/27/2025 at 9:24 PM, Nurse N documented the following, " TRIAGE CALL: resident had a witness fall in his/her room, [Resident 2] informed caregiver [s/he] fell while [s/he] was helping [him/her]. SafelyYou fall detection also captured fall. Resident is a Hospice patient with history of cerebral infarctions, CKD, and falls. Video footage reviewed, [Resident 2] was attempting to assist [him/her] into [his/her] recliner when [s/he] pushed [his/her] wheelchair with [his/her] foot to scoot it back. Resident was leaning forward so [s/he] fell out of the chair onto[his/her] knees. No

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 _____	R-C 04/30/2025

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 205	Continued From page 6	N 205		

apparent injuries noted, no head impact, resident denies pain..."

7.) On 04/29/2025 at 6:30 AM, Nurse L documented the following, "4/29/2025 2:25 TRIAGE CALL - resident had an unwitnessed fall from bed to floor. No apparent injury ..."

On 04/30/2025, Surveyor reviewed Resident 1's hospice record:
1.) On 12/06/2024 at 10:02 AM, Nurse G documented the following, "Focused visit performed d/t: Fall. [Resident 1] on the floor upon arrival. Per [Facility Caregiver] the [Resident 1] was calling out saying "no, no stop" and when staff came around the corner [Resident 1] was on the floor next to [his/her] chair and [Resident 2] who was doing a puzzle. Per staff [Resident 1] and [Resident 2] came out to the dining room to eat breakfast and after breakfast [Resident 2] who is in a wc puched (sic.) [Resident 1] back to the room with [his/her] in [his/her] wc as [s/he] puts [his/her] feet on the back of [his/her] wc and uses [his/her] arms to self propel. Per staff [Resident 1] is not able to hold [his/her] feet up and may have put them down. Per staff [Resident 2] often gets frustrated with [him/her] and may have continued to push causing [Resident 1] to fall to the floor. Fall was not witnessed by staff ..."

2.) On 01/08/2025 at 5:13 PM, Nurse G documented, " visit made to determine what wc [Resident 1] is using as [s/he] is to be in [Name Of Hospice Provider] high back but at visit earlier this week writer noted this was not the wc [s/he] was in ...[Resident 2] was not too sure about the switch but [Resident 1] was very happy voicing that [s/he] may even fall asleep in it, it was so comfortable. regular wc removed from room to help prevent [Resident 2] from encouraging

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 _____	R-C 04/30/2025

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 205	Continued From page 7	N 205		

[him/her] to use this as [s/he] likes to push [Resident 1] in wc that has resulted in falls and [Resident 1] is often sliding out of the standard wc causing falls ..."

3.) On 02/17/2025 at 12:35 PM, Social Worker F documented the following, "[Nurse G]. On arrival, noted [Resident 1] to be resting in [his/her] w/c at the dining room table. [Resident 1] sitting in standard [Name Of Hospice Provider] w/c as opposed to high-back w/c. [Resident 2] who resides in shared room often takes high-back part off of [his/her] chair or does not wish for [Resident 1] to sit in the high-back w/c d/t feeling [s/he] isn't comfortable, however [Resident 1] will state [s/he] is comfortable when sitting in high-back w/c ... [Resident 1] oriented to self; stated thinking [s/he] was at a "rescue center" in [Name Of City] and that it was December. Oriented [Resident 1] to place and month ...."

4.) 03/03/2025 at 12:47 PM, Social Worker F documented the following, " ...Writer asked [Resident 1] if [s/he] is having any pain or discomfort and [s/he] stated no, and then stated "sometimes". [Resident 1] stated, "I don't want to be more comfortable". Writer asked [Resident 1] where the discomfort is and [s/he] voiced not wanting to answer that question. Writer asked [Resident 1] if [s/he] feels safe and [s/he] stated, "not all the time". Asked [Resident 1] what makes [him/her] feel unsafe and [s/he] voiced not wanting to answer that question. [Resident 1] verbalized if [s/he] doesn't feel safe, [s/he] will "just punch [him/her]". Asked [Resident 1] who [s/he] would punch and [s/he] declined wishing to answer this question. [Resident 1] voiced having to punch [Resident 2] at times stating, "but [s/he] wouldn't think I would do anything". Asked [Resident 1] why [s/he] has had to punch

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 _____	R-C 04/30/2025

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 205	Continued From page 8 [him/her] and [s/he] declined to answer the question. [Social Worker Q] asked [Resident 1] when the last time was that [s/he] had to punch [Resident 2] and [s/he] stated, "I don't like that one", meaning [s/he] did not like that question and declined to answer. Team reassured [Resident 1] that we are here to help [him/her] and ensure [s/he] is safe and comfortable, letting [Resident 1] know that [s/he] can talk to team any time if [s/he] has concerns or needs; [Resident 1] smiled ...[Nurse G] spoke w/ [Resident 1] about incident last week during [his/her] visit when [Resident 1] voiced wanting to eat lunch in the dining room but [Resident 2] voicing wanting [Resident 1] to eat lunch in their room, and how [Resident 1] had eventually given in to [Resident 2's] wishes, however [Nurse G] intervened and [Resident 1] ultimately chose to eat [his/her] lunch in the dining room. [Resident 1] stated, "sometimes you just gotta get along"; [Nurse G] validated [Resident 1's] feelings and reassured [Resident 1] that [s/he] has a voice and capacity to decide things on [his/her] own vs feeling [s/he] has to do what [Resident 2] wants [him/her] to do; [Resident 1] smiled and did not verbally respond at this point. During the visit, [Nurse G] assessed [Resident 1] stitches to R arm; [Resident 1] was able to state [s/he] had 18 stitches placed and that [s/he] fell against the door in [his/her] room which "bit" [him/her]. [Resident 1] able to recall being the ER ... Provided detailed updates on conversation held w/ [Resident 1] during the visit and concerns regarding [Resident 1's] statements surrounding punching [Resident 2]. Facility staff will continue monitoring [Resident 1] and [Resident 2's] interactions, communicating [Nurse B] and [Name Of Hospice Provider] any concerns ..." 5.) On 03/17/2025 at 1:40 PM, Nurse G	N 205		

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 _____	R-C 04/30/2025

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 205	Continued From page 9	N 205		

documented the following, " ...[Resident 1] was in [his/her] room being assisted with a shower by [Hospice Caregiver]. Pt was cooperative and pleasant with visit assessment. When asked if the [Resident 1] had pain [s/he] reported "only when [Resident 2] hits me". When asked where [s/he] hits [him/her], [s/he] said "typically my kiester". When asked if [s/he] hurt anywhere else [s/he] denied pain. [S/he] denied current pain ... Collaboration during this visit: [Resident 1], and floor staff. [Nurse J] updated ..."

6.) On 04/02/2025 at 2:42 PM, Nurse G documented the following, "Writer was in the building seeing other patients when a few slaps were heard by writer and other staff members including [CNA R] who was present. [Resident 2] approached the [Resident 1] as [s/he] was not initially in the kitchen area and was seen slapping [his/her] face and when asked what [s/he] was doing by [Nurse J] [Resident 2] responded that [s/he] was trying to wake [him/her] up. [Nurse J] told [him/her] [s/he] was not allowed to put hands on [him/her] and that this was not acceptable ..."

7.) On 04/07/2025 at 5:40 PM, Social Worker F documented the following, "Discussed options for intervention including splitting [Resident 1] and [Resident 2] up into separate rooms [Name Of Facility Memory Care Unit]; family disagreeable to this idea. [Family Member M] voiced feeling interactions b/t [Resident 1] and [Resident 2] are being taken out of context; they feel splitting them up into different rooms would be detrimental to their relationship at this point in their life. Family expressed the dynamics being discussed and observed last week are consistent w/ the dynamics [Resident 1] and [Resident 2] have had throughout their entire relationship. Family understands [Name Of Hospice Provider], facility

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 _____	R-C 04/30/2025

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 205	Continued From page 10 obligations to make reports w/ suspected abuse and also continue discussions of interventions to ensure both [Resident 1] and [Resident 2's] safety and well-being. They feel reminders to [Resident 2] are sufficient in situations where [s/he] is attempting to control where [s/he] is, what [s/he] does ... Discussed interventions of staff providing increased oversight to both [Resident 1] and [Resident 2], encouraging/reminding [Resident 2] that it is okay for [Resident 1] to have space to do what [s/he] wants to do. [Resident 2] consistently voiced throughout the meeting that [Resident 1] is the love of [his/her] life and [s/he] voiced not recalling hitting [Resident 1] in the face last week. [Resident 2] agreed that [s/he] does feel anxious at times when [s/he] is away from [Resident 1]. Family also inquired about resources for marital counseling; [APS Dementia Specialist S] will be emailing [Family Member I] and [Family Member M] f/u on resources for marital counseling. [APS Dementia Specialist S] will continue gathering psychosocial hx information w/ [Resident 1], [Resident 2], and family as well as identifying possible options for facility staff training opportunities; [s/he] voiced being open to working w/ [Name Of Hospice Provider] on joint facility dementia training ... Discussed w/ [Resident 2] that [Resident 1] needs more help than [s/he] does, and that [s/he] needs to allow facility caregiving staff to provide [Resident 1] w/ personal cares such as changing briefs, dressing, getting [Resident 1] up in the AM and going to bed in the PM ... Family inquired about the fall alert camera as well as landline in [Resident 1's] room based on the reate (sic.) they are paying; facility confirmed [Resident 1's] fall alert camera is on and will be working on turning on the landline, however there is no operator at this time so facility will be following up w/ family in the future ...."	N 205		

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 _____	R-C 04/30/2025

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 205	Continued From page 11 8.) On 04/08/2025 at 3:00 PM, Nurse G documented the following, " ...[Resident 1] was pushing another wheelchair in front of [him/her] while in [his/her] wheelchair. [Resident 2] was then pushing [him/her] while [s/he] was pushing the other wheelchair. The 1st wheelchair was hitting the wall as [Resident 2] was attempting to push the [Resident 1] and [Resident 1] would not let go of it. [Resident 2] was shaking and jerking [his/her] wheelchair telling [him/her] to "drop it". Writer noticed this happening and asked [Resident 1] to let go of the wheelchair [s/he] was pushing and asked where [s/he] wanted to go. Initially [s/he] stated "where do you want me". Writer voiced that [s/he] can be in the common area or [his/her] apt. [S/He] stated [s/he] wanted to go to [his/her] apt. Writer voiced that [s/he] needed to turn the corner and [Resident 2] assisted [him/her] to get to the apt. [Nurse J] was updated on need to redirect [Resident 2] and [s/he] was encouraged to have staff watch the pair. Writer also reviewed with staff that NOC shift was to get [Resident 1] up to help prevent [Resident 2] from getting [him/her] up or assisting. They voiced not being updated on meeting or new suggestions from 4/7. [Resident 1] was in [his/her] room upon arrival ..." On 04/24/2025, Surveyor reviewed electronic conversations between Resident 1 care team members: 1.) On 03/18/2025 at 3:22 PM, Social Worker F sent an email to Family Member I, Family Member M, Administrator A, and Nurse G. Social Worker F wrote the following,"...the statements [Resident 1] made to [Nurse G] and I during out last handful of visits as well as the instance of [Resident 1] verbalizing wanting to eat lunch in the dining room on the day [s/he] returned from	N 205		

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 _____	R-C 04/30/2025

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 205	Continued From page 12	N 205		

the ED, but [Resident 2] was pretty insistent that [s/he] go back to their room to eat and ultimately [Nurse G] intervening to advocate for [Resident 1's] wishes ...Ultimately, mine and [Nurse G's] job as [Resident 1's] primary hospice team is to ensure [his/her] safety and well-being. I understand that it sounds like there may be some long-standing dynamics between [Resident 1] and [Resident 2], however we wouldn't be doing our jobs if we didn't put interventions in place to promote [his/her] safety ...This situation is tricky given seemingly long-standing dynamics between [Resident 1 & Resident 2] and there being a fine line between family dynamics and concerns for elder abuse ...Please, let us know what your thoughts are about splitting them up into different rooms and if this will be financially feasible."

2.) On 03/21/2025 at 2:23 PM, Social Worker F sent an email to Administrator A, Nurse B, Nurse J, and Nurse K. Social Worker F wrote the following, "[Family Member I] said the [Family] have been discussing the current concerns and their thoughts/interventions are as followed - they plan to meet with [Resident 1] and [Resident 2] as a family To discuss the concerns with their interactions/dynamics, and family has decided to turn on the fall camera (I'm not sure if they have reached out to you about this?). [Family Member I] voiced feeling [Resident 2's] interactions with [Resident 1] are not of malicious intent, but consistent with long-standing dynamics. [S/He] gave the example of their term of endearment to each other for several years has been calling each other "you asshole". (sic.) I voiced understanding that they may have long-standing dynamics, however they are now aging and [Resident 1] is not able to make informed decisions for [himself/herself] so the statements [s/he] has made are concerning, and we wouldn't

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 _____	R-C 04/30/2025

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 205	Continued From page 13	N 205		

be doing our jobs if we didn't provide updates and offer interventions for [Resident 1's] safety ..."

3.) On 03/31/2025 at 12:27 PM, Nurse B sent an email to Administrator A. Nurse B wrote the following, "I didn't answer because I thought you had been working on this? We also would like to open safely you for [Resident 1] with all [his/her] falls, as we feel that it possibly could be [him/her] doing this ..."

4.) On 04/03/2025 at 7:51 AM, Social Worker F sent an email to Administrator A, Nurse B, Nurse J, and Nurse K. Social Worker F wrote the following, "[Nurse G] updated me on [Resident 2] slapping [Resident 1] in the face yesterday and I wanted to let you all know that after collaborating with our manager, I made an APS report at the end of the day yesterday regarding this concern, as well as the ongoing concerns of the statements [Resident 1] has made to us over the last several weeks... [S/He] let me know that we should know by 4-7 or 4-8 whether a case is going to be opened, and [s/he] anticipates that a case will be opened ..."

On 04/30/2025, Surveyor reviewed Resident 2's face sheet. Resident 2 was admitted to the facility on 11/25/2022. Resident 2 had an active power of attorney. Resident 2 was diagnosed with but not limited to: coronary artery disease, chronic obstructive pulmonary disease, diabetes insipidus, type II diabetes mellitus, and other amnesia.

On 04/30/2025, Surveyor reviewed Resident 2's ISP. Resident 2's ISP was signed on 04/18/2024. The following was documented, "Dining: Assist/Cueing ...Assist with proper sitting position ...DME, Assistive Equipment ...Assist resident

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 _____	R-C 04/30/2025

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 205	Continued From page 14	N 205		

with DME, assistive equipment as instructed ...Mobility: Assist ...Resident needs an assist of one to all meals with walker and W/C following behind ...Falls Management ...Resident is at risk for falls ...". Zero, documentation related to history of behaviors and/or behavior management in ISP.

On 04/30/2025, Surveyor reviewed Resident 2's incident report dated 04/02/2025. Nurse J documented the following, "Aggressive behavior ...COMMON AREA: Dining room ...Resident said, "I was trying to wake [him/her] up" "I was just doing this", Resident demonstrated gently taping (sic.) [Resident 1's] right cheek ...Writer was a med cart and heard a smacking type of noise. Writer (sic.) turned and visually observed [Resident 2] slapping [Resident 1] on the right side of [his/her] face aggressively trying to rouse [him/her] while [s/he] was sitting in [his/her] WC sleeping ..."

On 04/30/2025, Surveyor reviewed Resident 2's progress notes from 01/03/2025 to 04/25/2025. Zero, documentation related to his/her behavior's reported by Resident 1's hospice provider in progress notes.

INTERVIEWS:

On 04/30/2025 at 9:00 AM, Surveyor interviewed, Hospice Nurse G. Hospice Nurse G stated that s/he was made aware of concerns regarding how Resident 2 treats Resident 1 in 11/2024. Hospice Nurse G stated that s/he made Former Administrator X aware immediately but nothing seemed to have been done about it. Hospice Nurse G stated that s/he also made Administrator A aware in 3/2025 but things have not changed much. Hospice Nurse G stated that Resident 1 has had multiple falls due to Resident 2 trying to

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 _____	R-C 04/30/2025

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 205	Continued From page 15	N 205		

help Resident 1, but would rush him/her causing Resident 1 to fall. Resident 2 would not say anything to staff or Hospice Nurse G. Hospice Nurse G stated that s/he had witnessed Resident 2 being confronted by staff about Resident 2 slapping Resident 1 and pushing Resident 1's wheelchair with his/her feet. Hospice Nurse G stated, "Resident 2 stated "s/he is my spouse and I will do what I want!" Hospice Nurse G stated, "I do not think that this is a safe environment just due to the fact that both Resident 1 and Resident 2 have dementia and Resident 2 forces Resident 1 to do things and s/he is getting hurt because of it. Nothing seems to be done about it."

On 04/30/2025 at 10:00 AM, Surveyor interviewed Caregiver H. Caregiver H stated s/he had witnessed Resident 2 aggressively pushing Resident 1's wheelchair with his/her wheelchair. Caregiver H stated Resident 2 should not be alone with Resident 1 because Resident 2 thinks s/he can take care of Resident 1. Caregiver H specified Resident 2 instead of calling staff with attempt to change Resident 1's clothing, depends, or give them a shower. Caregiver H stated s/he is very concerned Resident 2 is going to let Resident 1 fall and get really hurt. Caregiver H reported Resident 1 had severe dementia and was on hospice, but Resident 2 didn't have a dementia diagnosis listed on his/her record.. Caregiver H stated this had been going on for about 2 months. Caregiver H denied witnessing Resident 2 hit, slap, or kick Resident 1.

On 04/30/2025 at 10:20 AM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 will be relaxing in his/her wheelchair after a meal and then Resident 2 will come up behind them locking his/her wheelchair to

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 _____	R-C 04/30/2025

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 205	Continued From page 16	N 205		

Resident 1 and then will try to push Resident 1 back into their room. Caregiver D stated it had been explained to Resident 2 multiple times that s/he was not to move Resident 1 in this manner. Caregiver D stated s/he just verbally redirected Resident 2 that morning after breakfast for moving Resident 1's wheelchair, and Resident 2 verbally 'angerly snapped' back at Caregiver D telling him/her to 'mind their own business'. Caregiver D stated Resident 2 had been observed pushing Resident 1 back in their shared room, when it was apparent Resident 1 wanted to be in the common area. Caregiver D reported not feeling like Resident 1 was safe alone in a room with Resident 2. Caregiver D reported Resident 1 had many unwitnessed falls, and so a fall camera was installed in the room. Caregiver D stated Resident 1 just had a fall and the staff found the camera had been unplugged. Caregiver D stated Resident 2 will attempt to shower Resident 1 and that it put Resident 1 at a high risk of a fall injury. Caregiver D stated the situation was 'heartbreaking,' and had 'kept him/her up at night.' Caregiver D stated floor staff had been reporting these situations to administration for months and nothing had been done in keep Resident 1 safe from Resident 2. Caregiver D stated Resident 2 was seen slapping Resident 1 across the face to make them wake up, and the police weren't even called. Caregiver D stated Resident 1 had a severe dementia diagnosis, but Resident 2 didn't seem to have issues with his/her memory.

On 04/30/2025 at 10:30 AM, Surveyor interviewed Resident 2. Resident 2 stated that everything was going well. Resident 2 stated that, "Resident 1 needs more help than I do, and I try to help him/her as much as I can. I like it here, but staff need to mind their business." Surveyor asked Resident 2 what s/he meant by that

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 _____	R-C 04/30/2025

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 205	Continued From page 17	N 205		

statement. Resident 2 stated, "There are things that they should just stay out of, but I am not going to discuss that with you."

On 04/30/2025 at 3:00 PM, Surveyor discussed the above concerns with Administrator A, Nurse B, and Director C. Administrator A stated on 04/02/2025 s/he had Resident 1 and Resident 2 separated for awhile after Resident 2 had been observed slapping Resident 1 in the dining room. Administrator A stated s/he immediately notified Resident 1's hospice provider, Family Member I, and Family Member M of the incident. Administrator A reported Family Member I nor Family Member M seemed concerned about Resident 1 and Resident 2 cohabitating with a fall camera. Administrator A stated the fall camera did not provide continuous monitoring it merely recorded the second(s) before, during, and after a fall occurs. Administrator A acknowledged prior to the incident on 04/02/2025, staff and hospice had voiced concerns Resident 2 was: isolating Resident 1, moving Resident 1 without permission, and performing personal cares on Resident 1 which increased his/her risk of falls. Administrator A, Nurse B, and Director C stated they did not feel Resident 1 was safe sharing an unsupervised private living space with Resident 2. Administrator A acknowledged since Resident 2 had been observed slapping Resident 1 a common area, facility hadn't obtained objective evidence Resident 1 was safe while sharing a private space with Resident 2. Administrator A stated s/he would not allow unrelated residents to reside in an unsupervised private living space if one of the residents had been observed slapping the other. Administrator A, Nurse B, and Director C acknowledged Resident 2's behaviors which required staff to verbally re-direct him/her from engaging in: moving Resident 1's wheelchair

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 _____	R-C 04/30/2025

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 205	Continued From page 18	N 205		

without permission, honoring Resident 1's verbally expressed wants, removing the high-back from Resident 1's wheelchair, and providing personal cares which increased Resident 1's risk of fall. Administrator A, Nurse B, and Director C acknowledged Resident 2's ISP did not contain a described behavioral plan instructing caregivers on how to manage Resident 2's behaviors. Administrator A, Nurse B, and Director C acknowledged Resident 1's co-habitation with Resident 2 after 04/02/2025 without continuous supervision had put Resident 1's safety at substantial risk. Administrator A reported it was very difficult to interview Resident 1 without Resident 2 being involved, and that staff were encouraged to engage Resident 1 in as many activities as possible to give his/her space.

On 05/01/2025 at 9:12AM, Surveyor spoke with Ombudsman E over the phone. Ombudsman E stated s/he had been asked to approach Resident 1 by his/her hospice care team. Ombudsman E reported s/he entered facility and was able to find Resident 1 alone in a common area . Ombudsman E reported Resident 1 refused Ombudsman E's offer of assistance with navigating allegations of abuse against Resident 2. Ombudsman E reported within a few minutes of speaking to Resident 1, Resident 2 rolled up next to Resident 1 in his/her wheelchair. Ombudsman E observed Resident 1's posture become guarded/ridged. Ombudsman E stated s/he ended the interview. Ombudsman E stated adult protective services (APS) had been notified of the 04/02/2025 incident. Ombudsman E stated s/he had not attended the 04/07/2025 care team meeting between Resident 1, Resident 2, Administrator A, Nurse B, Family Member I, Family Member M, and Dementia Specialist S. Ombudsman E had been updated that Dementia

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 _____	R-C 04/30/2025

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 205	Continued From page 19	N 205		

Specialist S had assessed Resident 2's behaviors weren't being managed appropriately and provided a list of resources for facility to utilize.

On 05/01/2025 at 4:15 PM, Nurse J responded to Surveyor's email request. Nurse J wrote the following, "You and I discussed over the phone [Resident 1] And (sic.) [Resident 2] MC (memory care) situation of hitting by [Resident 2] to [Resident 1]. I was not made aware until caregivers and med passers told me mid-March and I looked into it. The LPN [Nurse K] said [s/he] never documented it as was Here Say (sic.). I explained that [s/he] could document and report what was being endorsed to [him/her]. Apparently, it has been going on for a long time . I spoke With (sic.) [Name Of Hospice Provider], as [Resident 1] is in hospice. Their SW (social worker) contacted the Ombudsman. And then I actually saw [Resident 2] open handed slapping, loud enough to be heard by me 200 ft away. [S/He] was striking [him/her] in the face in order to wake [him/her] up as [s/he] sat in [his/her] WC (wheelchair) napping. I made [him/her] stop immediately. I documented and followed the chain of command. Eventually APS SW [Dementia Specialist S] visited facility 2x. Then there was a family meeting, with no changes. Except Safely You consented for by HCPOAS. [Resident 1] has had many falls OOB (out of bed), as [s/he] and [Resident 2] sleep in queen bedtogether. Last fall the camera was unplugged? That fall [s/he] was sent to the ED with left sided head hematoma ...Often reported that [Resident 2] gets [Resident 1] up and puts [his/her] in the shower w/out staff, and [s/he] is mod assist of 1-2 depending on the day, and a huge fall risk ..."

On 05/02/2025 at 8:20 AM, Surveyor spoke with

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 _____	R-C 04/30/2025

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 205	Continued From page 20	N 205		

Social Worker F. Social Worker F stated Resident 1's APOA paperwork isn't currently valid due to Resident 2 being a signed witness. Social Worker F stated s/he had difficulty with maintaining communication with Family Member I and Family Member M. Social Worker F stated there had been many concerns related to Resident 2's treatment of Resident 1. Social Worker F reported these concerns to the facility and no interventions would be implemented. Social Worker F stated s/he had reported the 04/02/2025 incident to APS along with his/her list of previous concerns related to alleged elder abuse. Social Worker F reported s/he did not feel APS had adequately kept Resident 1 safe from Resident 2. Social Worker F stated Dementia Specialist S stated a list of interventions like facility staff training, collaboration with hospice, and marriage counseling. Social Worker F stated Dementia Specialist S had not contacted hospice to organize these interventions since the original care team meeting on 04/07/2025. Social Worker F stated s/he directly asked Dementia Specialist S how Resident 1 was to be protected from Resident 2's behavior of performing showers without staff assistance. Dementia Specialist S suggested turning the water off in Resident 1 and Resident 2's apartment. Social Worker F stated s/he asked how turning off the water would stop Resident 1 from experiencing a fall. Social Worker F had not been provided an answer.

On 05/06/2025 at 3:30 PM, Surveyor spoke with APS Case Manager P. APS Case Manager P stated Resident 2 had been diagnosed with dementia prior to 2023. APS Case Manager P stated Resident 2's activated power of attorney had been activated by statement of incapacitation in 2023. APS Case Manager P stated Resident 1 had a recent series of falls which left injuries on

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 _____	R-C 04/30/2025

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 205	Continued From page 21 his/her face. On 05/08/2025 at 9:00 AM, Surveyor discussed above concerns with APS Case Manager T and APS Case Manager P. APS Case Manager T stated Dementia Specialist S had not been acting as an APS investigator. APS Case Manager T stated an investigation had been recently initiated into the alleged domestic abuse between Resident 1 and Resident 2. CROSS REFERENCE N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 205		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's Individual service plan review occurred when there was a change in a Resident 1's needs, abilities or	N 389		

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 _____	R-C 04/30/2025

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 389	Continued From page 22	N 389		

physical or mental condition.

From 01/07/2025 to 04/29/2025, Resident 1 experienced 7 falls.

On 04/30/2025, Surveyor reviewed Resident 1's fall management plan in his/her ISP. The fall management plan hadn't been updated since 11/25/2022. Facility had recently installed a fall camera monitoring system in Resident 1's room called SafelyYou. The SafelyYou camera system had not been documented in Resident 1's ISP.

This is a repeat violation from previous statement of deficiency (SOD) 9PKX12 dated 09/05/2023, SOD ZZI811 dated 10/12/2023, SOD ZZI812 dated 05/15/2024, and SOD ZZI813 dated 08/28/2024.

FINDINGS INCLUDE:

On 04/29/2025, the Department received a complaint regarding behavior management at facility.

On 04/30/2025, Surveyor arrived at facility for a complaint investigation.

RECORD REVIEW:

On 04/30/2025, Surveyor reviewed Resident 1's face sheet. Resident 1 was admitted to the facility on 11/25/2022. Resident 1 had an activated power of attorney for healthcare. Resident 1 was diagnosed with but not limited to: cerebral infarction and metabolic encephalopathy.

On 04/30/2025, Surveyor reviewed Resident 1's incident reports:
1.) On 01/27/2025 at 4:28 PM, Nurse B

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 _____	R-C 04/30/2025

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 389	Continued From page 23	N 389		

documented an incident which occurred pervious on 01/07/2025 at 5:15 PM, Resident 1 was witnessed by staff sliding out of recliner in the common area.

2.) On 02/06/2025 at 5:52 PM, Nurse K documented an incident which occurred pervious on 02/05/2025 at 9:40 AM. Resident 1 experienced a witnessed fall. The fall occurred in Resident 1's bedroom. Resident 2 was the witness, who stated Resident 1 slid out of bed an onto the floor. No, apparent injuries were documented.

3.) An unsigned incident report documented that on 03/27/2025 at 4:35 PM. Resident 1 experienced a witnessed fall. The fall occurred in Resident 1's bedroom. Resident 2 was the witness, who stated Resident 1 slid out of bed an onto the floor. No, apparent injuries were documented.

4.) On 04/02/2025 at 10:55 AM, Nurse J documented Resident 1 experienced a witnessed fall at approximately 6:15 AM. The fall occurred in the Resident 1's bedroom. Resident 2 was witness to the fall and s/he stated that Resident 1, "rolled off the bed onto the floor." Resident 1 was assessed by Nurse J to be free from injury.

5.) On 04/14/2025 at 4:34, Nurse J documented an incident which occurred pervious on 04/11/2025 at 10:15 AM. Resident 1 experienced a witnessed fall. The fall occurred in Resident 1's bedroom. Resident 2 was the witness, who stated Resident 1 slid out of bed an onto the floor. No, apparent injuries were documented.

On 04/30/2025, Surveyor reviewed Resident 1's observation notes:

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 _____	R-C 04/30/2025

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 389	Continued From page 24 1.) On 02/25/2025 at 12:36 PM, Triage Nurse L documented the following, "resident had an unwitnessed fall from bed to floor. Laceration present to right elbow 3 inches in length...Writer instructs caller to call 911. EMS arrives (sic.) and took resident to TAC. Resident uses hospice services." 2.) On 04/27/2025 at 9:24 PM, Nurse N documented the following, " TRIAGE CALL: resident had a witness fall in his/her room, [Resident 2] informed caregiver [s/he] fell while [s/he] was helping [him/her]. SafelyYou fall detection also captured fall. Resident is a Hospice patient with history of cerebral infarctions, CKD, and falls. Video footage reviewed, [Resident 2] was attempting to assist [him/her] into [his/her] recliner when [s/he] pushed [his/her] wheelchair with [his/her] foot to scoot it back. Resident was leaning forward so [s/he] fell out of the chair onto[his/her] knees. No apparent injuries noted, no head impact, resident denies pain..." 3.) On 04/29/2025 at 6:30 AM, Nurse L documented the following, "4/29/2025 2:25 TRIAGE CALL - resident had an unwitnessed fall from bed to floor. No apparent injury ..." On 04/30/2025, Surveyor reviewed Resident 1's individualized service plan (ISP). The ISP was signed by Family Member I on 11/24/2024. Under the subsection titled "Falls Management" it was documented that it was last updated on 11/25/2022. The falls which occurred on 01/07/2025, 02/05/2025, 02/25/2025, 03/27/2025, 04/02/2025, 04/11/2025, 04/27/2025 and 04/29/2025 were not documented in the ISP. The SafelyYou camera that was installed after 04/02/2025 was not documented as a fall	N 389		

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 _____	R-C 04/30/2025

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 389	Continued From page 25 monitoring system in Resident 1's ISP. INTERVIEWS: On 04/30/2025 at 3:00 PM, Surveyor discussed the above concerns with Administrator A, Nurse B, and Director C. Nurse B and Director C reviewed Resident 1's ISP with Surveyor. Nurse B and Director C acknowledged Resident 1 had experienced a series of falls which were not documented in the ISP with preventative interventions. Director C acknowledged that the ISP Resident 1's caregivers had access to did not describe the fall monitoring camera system recently installed in Resident 1's room. Nurse B and Director C stated they would update Resident 1's fall management plan in his/her ISP to reflect all the interventions being utilized for fall prevention. CROSS REFERENCE N0205 DHS Chapter 83.14(2)(i) Not Permit A Condition Of Substantial Risk	N 389		