STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013625	A. BUILDING: _____ B. WING _____	C 05/09/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 05/09/2024, Surveyor conducted 2 complaint investigations and a self-report review at New Perspective-West Bend. Two deficiencies were identified. One complaint was substantiated. One complaint was unsubstantiated. Self-report review resulted in a deficiency. Census: 30	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 2 received prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 2 missed 4 doses of Guaifenesin during December 2023-January 2024. Findings include: On 02/16/2024, the Department received a complaint alleging concerns with residents not receiving their medications.	N 352		

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

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N 352	Continued From page 1 On 05/01/2024, Surveyor reviewed Resident 2's record and identified the following: Resident 2 was admitted to the facility on 03/02/2013. Resident 2's individual service plan (ISP) dated 11/14/2023 documented: "Med And Treatment Plan: Resident receives medication and treatment administration and management services." Resident 2's physician orders included: "Guaifenesin LIQ 100/5ML, take 3 teaspoonfuls (10ML) by mouth three times daily for 10 days for cough, start dated 12/20/2023. Guaifenesin LIQ 100/5ML, take 3 teaspoonfuls (10ML) by mouth three times daily for cough, start date 01/05/2024." Resident 2's December 2023 Medication Administration Record (MAR) documented: 3 occurrences where his/her medications were not available: "12/28/2023-7:59 AM Guaifenesin LIQ 100/5ML-Med not available 12/28/2023-11AM Guaifenesin LIQ 100/5ML-Med not available Resident 2's January 2024 MAR documented 2 occurrences where his/her medications were not available: 01/16/2024 11am Guaifenesin LIQ 100/5ML-Med not available 01/16/2024 6PM Guaifenesin-Med not available" The record did not include any other evidence to show the provider followed up with the pharmacy to see the status of Resident 2's above medications.	N 352		

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N 352	Continued From page 2 On 05/09/2024 at 3:00 PM, Surveyor interviewed Administrator A and Nurse B. Nurse B acknowledged when printing Resident 2's MAR's s/he saw certain medications were unavailable. Nurse B stated Resident 2 was prescribed cough medication twice within a couple of weeks and was not sure if Resident 2 ran out towards the end of the cycle. Nurse B stated staff retraining is ongoing with reordering medications and selecting the right option in their electronic health record to ensure medications are available for residents to receive.	N 352		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of	N 454		

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N 454	Continued From page 3 sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released.	N 454		

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N 454	Continued From page 4	N 454		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 1) record reviewed was maintained.

Resident 1 sustained 3 falls within 24 hours falls which resulted in an intercranial bleed. Resident 1's record did not include documentation to accurately describe his/her condition from 03/14/2024 (12:00 PM)-03/15/2024 (4:56 AM). During this time, Resident 1's record indicated a nursing directive to complete vital checks every 2 hours following 2 falls within 8 hours. These vital checks were not documented in the record. Resident 10's blood pressure was 190/90 on the morning of 03/15/2024. This value was not documented in the record.

Findings include:

On 03/15/2024, the Department received a self-report documenting the following:
"Resident has a diagnosis of irreversible memory impairment and lives in a private room in our memory care unit. Resident ambulates independently with a 2-wheeled walker but does requires cueing with some hands on assistance and redirection for ADLs' meal reminder/escorts, and overall assistance with anticipating care needs. On March 14th, 2024, Resident alleged that [s/he] had a fall. This is very unlikely as the resident would not be able to get up from the floor without the assistance. Resident was not assisted off of the floor by a caregiver and no caregiver reported seeing the resident on the floor as resident alleged. On 03/15/2024, resident had two unwitnessed falls. There were no apparent injuries, concern, or acute pain noted after the

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N 454	Continued From page 5	N 454		

falls. Resident was assessed by RN and no injuries were noted .....On March 15, 2024 we received an update from emergency room. Resident was being admitted to the hospital with a diagnosis of a new subdural hematoma. On March 19, 2024, the community was notified that the resident will be moving to an inpatient hospice setting due to deterioration during hospitalization."

On 05/01/2024, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the facility on 07/13/2023 with a diagnosis of irreversible memory impairment. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident

Resident 1's individual service plan (ISP) dated 08/11/2023 documented:
"Cueing: 4-5x/24hrs. Caregivers to provide interventions as describe and report changes in need for cues to nursing.
Falls: Resident is at risk for falls. Encourage resident to wear properly fitting foot ware or non-slip socks; keep walkways within apartment free of clutter' participate in community exercise activities to support physical endurance and strength; keep call pendant, if in use, within reach; place pull cord, if available, within reach when in their bedroom; and drink fluids in-between meals and at bedtime. Promptly report to nursing any changes in cognitive status, such as confusion, increased confusion from baseline, or impulsiveness; symptoms of UTI."

Resident 1's incident report documented:
"03/14/2024 12:00 PM: Resident stated [s/he] went to the bathroom and realized there was no toilet paper and fell. Resident stated [s/he] did not

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N 454	Continued From page 6	N 454		

hit [his/her] head and someone helped [him/her] up. Resident was laying on [his/her] bed. Writer asked team members regarding assisting resident up off the floor. Team members denied assisting resident off the floor.
03/14/2024 8:20 PM: Resident was on the floor with pants and underwear halfway down. Resident was not certain if [s/he] was coming from or going to the bathroom.
03/15/2024 4:56 AM: Resident found on floor on [his/her] back. Appeared to have slid out of [his/her] chair. No apparent head strike, no apparent injury."

Resident 1's progress notes documented:

03/14/2024 11:37 PM, Triage Call 20:04: Resident was found lying next to [his/her] bed with [his/her] pants halfway down. Stated [s/he] was trying to reach the bathroom. Team reports that resident has appeared more confused today. Resident denies injury, but reports [his/her] elbow is sore. Resident able to move all extremities per [his/her] usual range of motion. Unknown if [s/he] hit [his/her] head. Vital signs 186/100; pulse 95; respirations 20; temperature 97.5; oxygen 95%. Team able to assist resident up without difficulty. To complete vital signs every 2 hours x 12 for surveillance.

03/15/2024 8:14 AM, Triage Call 04:56 am: Resident was found laying on the floor on [his/her] back having apparently slid out of [his/her] chair. Resident without apparent injury, able to move all extremities without difficulty, unknown head strike. Vitals signs 163/75, pulse 72 (other vitals not available). Team was able to assist resident back to bed without difficulty or indications of pain. Team to continue with vital signs every 2 hours x 12 for surveillance.

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N 454	Continued From page 7 03/15/2024 8:53 AM: Late entry for 03/14/2024 12:00 PM. Alleged unwitnessed fall. Resident stated [s/he] went to the toilet noticed there was no-toilet paper and fell. Resident stated someone helped [him/her] off the floor. Writer questioned team members and team members denies assisting resident off the floor. Q2 vitals to be done per protocol. 03/15/2024 11:18 AM: Resident had multiple falls with in the last 24 hours with altered mental status as well as elevated BP. 03/18/2024 10:26 AM: Late entry for 3-14-2024. Writer was informed by another team member about condition of residents room. Team member entered residents room to assist with cares and found shredded papers and toilet paper strewn around [his/her] room. Resident briefs were tucked in carious locations such as under [hi/her] mattress, pillow, blankets, and chair. 03/25/2024 10:26 AM: Late entry for 03/15/2024 11:11 AM: Resident sent to Froedtert West Bend Hospital for AMS, frequent falls, and elevated BP .... Resident was admitted with intercranial bleed then discharged to inpatient hospice, Discharge summary completed." On 05/01/2024 at 2:25 PM, Surveyor interviewed Nurse C. Nurse C stated s/he observed Resident 1 at approximately 9:00 AM on 03/15/2024. Nurse C stated Resident 1 was in bed restless, incoherent, and was staring at the ceiling. Nurse C stated this was a change of condition (COC) for Resident 1 since the day before s/he was telling Nurse C how s/he fell while going to the bathroom and was ambulating the unit. Nurse C stated Resident 1's legal representative only liked to	N 454		

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N 454	Continued From page 8	N 454		

send him/her to the emergency room (ER) if only a medical emergency, so Nurse C had Resident 1's occupation therapist (OT) assess and call legal representative after assessment. Nurse C stated s/he tried to call Resident 1's legal representative several times before finally reaching a back-up family member who initially did not want Resident 1 sent to the ER. Nurse C stated Resident 1 was sent out shortly after his/her OT assessed and observed change of condition. Surveyor asked why Resident 1's condition on the morning of 03/15/2024 was not documented in the record. Nurse C stated s/he entered a late entry after the incident to include information about staff finding paper shredded and strewn across Resident 1's bedroom on 03/14/2024. Nurse C stated s/he would reach out Resident 1's OT to see if a note exists for morning of 03/15/2024.

On 05/09/2024 at 3:00 PM, Surveyor interviewed Administrator A and Nurse B regarding missing documentation in Resident 1's record. Surveyor noted Resident 1's record indicated a nursing directive for staff to complete vitals checks every 2 hours x 12 hours following Resident 1's 2 falls on 03/14/2024. Nurse B stated staff record vital checks on a shift report sheet but these documents are not saved. Nurse B stated s/he did not have evidence staff completed vital checks following Resident 1's 2 falls on 03/14/2024. Surveyor expressed concern Resident 1's record did not accurately describe his/her condition observed by Nurse C or the OT on the morning of 03/15/2024. Nurse B acknowledged an understanding of the concern and noted s/he will work with staff to maintain resident records.

Surveyor reviewed Resident 1's OT coordination

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N 454	Continued From page 9 noted dated 03/15/2024 at 10:35 AM: "Upon OT arrival OT is notified by caregivers (CGS) that patient has had at least 2 falls in the last 24 hours and is demonstrating atypical behaviors. There is concern for UTI. Behaviors reported include shredding all toilet paper, cards from family, notes, etc, and scattering them around room. Taking all depends out of package and hiding throughout [his/her] room. OT assessment this morning identified patient lying in [his/her] bed, restless, confused, and disoriented. [S/he] is unable to keep attention on answering simple questions, vital: B/P 162/86, HR 64, RESP 16, Temp 97.5, VS taken by facility this morning yielded BP at 190/90 per [Nurse C]. Patients POA has been unable to be contacted. Local [daughter/son] initially did not want patient sent to the hospital. [S/he] wanted PCP to perform assessment and needed testing today. PCP was notified patient falls and confusion and sent orders for UA should confusion continue. Given patient's presentation vs, several falls in 24 hours and demonstration of atypical behaviors, OT and [Nurse C] have concerns patient will not have access to needed care/supervision and treatment over the weekend in ALF. OT spoke with patient's [daughter/son] who was updated on all of the above and is agreeable for patient to be sent to ER for assessment."	N 454		