STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016219	A. BUILDING: _____ B. WING _____	R-C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE NORTH SHORE	8875 N 60TH ST BROWN DEER, WI 53223

(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 03/13/2024, Surveyor conducted 2 complaint investigations and verification visits at New Perspective North Shore for Statement of Deficiency (SOD) LEFP11, and HDNL11. Two deficiencies were identified and 2 complaints substantiated. One of 2 deficiencies were repeat citations. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 39	{N 000}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) was implemented for 1 of 1 resident. Resident 3's ISP identified behaviors were to be documented every shift, on every day, and the behaviors were not documented. This is a repeat deficiency. See Statement of Deficiency HDNL11, dated 07/20/2023. Findings include: On 11/16/2023 and 01/08/2024, the Department received complaints alleging a resident had eloped from the facility and staff was unaware s/he was missing for over 4 hours. On 03/13/2024, at 11:30 AM, Surveyor reviewed Resident 3's record and identified the following:	N 388		

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

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N 388	Continued From page 1	N 388		

-Resident 3 was admitted on 08/29/2023, with diagnoses including Alzheimer's disease.
-Resident 3's ISP, dated 08/29/2023, indicated Resident 3's behaviors were to be documented on every shift daily.
-An incident report, dated 09/05/2023, identified Resident 3 eloped from the facility.
-Resident 3's ISP, dated 09/05/2023, indicated Resident 3's behaviors were to be documented on every shift daily.
-Surveyor reviewed Resident 3's behavior logs. Resident 3's behavior logs for September 2023 and October 2023 were not in the record. Behavior logs in the record were for November 2023, December 2023, January 2024, and February 2024.
The behavior log titled "Behavioral Expressions Monitoring Log," contained columns for the day of the month and rows for each shift to document behaviors, interventions, and outcome of intervention. A "Behavioral Expressions Monitoring Key," which accompanied the logs, contained assigned numbers to the type of behavior, the intervention, and the outcome of intervention.

Resident 3's behavior logs:
-September 2023- the log was not in the record.

Resident 3's Progress notes:
On 09/05/2023, at 11:28 AM, Resident 3 eloped from the facility at approximately 7:00 AM. On 09/05/2023, at 5:22 PM, Resident 3 continued to have behaviors through the evening.
On 09/06/2023, at 6:38 PM, Resident 3 continued with agitation.
On 09/12/2023, at 9:33 PM, Resident 3 "is very agitated, was exit seeking and yelling."

Resident 3's behavior log:

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N 388	Continued From page 2 -October 2023- the log was not in the record. Resident 3's behavior log: -November 2023 The following days and shifts contained documentation: 11/05/2023, on the evening shift. 11/09/2023, 11/10/2023, 11/11/2023, 11/12/2023, 11/15/2023 on the night shift. All other shifts were not documented. The form with the date range of 11/17/2023 to 11/30/2023, was missing. Resident 3's Incident Report: On 11/14/2023, Resident 3 eloped from the facility. Resident 3's Progress Notes: On 11/15/2023, at 4:37 PM, "Late Entry for 11/14/2023 5:45 PM" Resident 3 eloped and was missing from approximately 10:00 AM until 2:45 AM. The provider was unaware Resident 3 was missing until s/he was returned by Power of Attorney (POA) E. Resident 3's behavior log: -December 2023 The following days and shifts contained documentation: 12/04/2023 on the night shift. 12/05/2023 and 12/06/2023 on the evening shift and night shift. 1207/2023, the day shift, evening shift and night shift. 12/08/2023, the night shift. 12/09/2023, the day shift and night shift. 12/10/2023, 12/13/2023, 12/14/2023, 12/19/2023, 12/20/2023 and 12/27/2023 on the night shift. All other shifts did not have documentation.	N 388		

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Resident 3's behavior log:
-January 2024
The following days and shifts contained documentation:
01/12/2024 on day shift.
01/15/2024 and 01/16/2024 on night shift.
01/18/2024, 01/19/2024, 01/20/2024, 01/23/2024, 01/24/2024, 01/27/2024 and 01/31/2024 on the night shift.
01/28/2024 and 01/29/2024 on the evening and night shift.
01/30/2024 on the evening shift.
All other shifts did not have documentation.

Resident 3's Progress notes:
On 01/02/2024, at 5;25 PM, Resident "becoming more restless and agitated; putting [her/his] coat on and pacing near the exit doors."
On 01/03/2024, at 7:24 AM, Resident 3 attempted to exit the unit. Resident 3 had "increased exit seeking behaviors."
On 01/03/2024, at 6:32 PM, Resident 3 continued with exit seeking and aggressive behaviors. Resident 3 became "physically violent with care staff members." Resident 3 was sent to the hospital for workup.
On 01/05/2024, at 6:04 PM, Resident 3 returned to the facility. On 01/05/2024, at 10:58 PM, "resident again aggressively trying to elope building ... Resident screaming ...conversation surrounding guns as resident has never expressed thoughts like that before."

Resident 3's behavior log:
-February 2024
The following days and shifts contained documentation:
02/05/2024, 02/07/2024, 02/08/2024, 02/12/2024, and 02/13/2024 on the evening shift.
All other shifts did not have documentation.

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N 388	Continued From page 4 On 03/13/2024, at 12:30 PM, Surveyor interviewed Executive Director (ED) A and Registered Nurse (RN) C. ED A confirmed Resident 3's ISPs, dated 08/29/2023 and 11/22/2023, identified her/his behaviors were to be documented on behavior logs. RN C reported staff were to document daily regarding Resident 3's behaviors. RN C confirmed staff did not document as indicated in the ISP. RN C reported s/he was responsible for auditing the behavior logs daily; however, s/he was not able to review them daily. RN C reported s/he was reviewing the logs weekly when s/he was able. RN C reported s/he was unable to locate September 2023 and October 2023 logs.	N 388		
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 record review and interview, the provider did not ensure residents received supervision appropriate to the needs for 1 of 1 resident. Resident 3 eloped from the secured memory care unit. On 11/14/2023, staff were not	N 426		

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aware Resident 3 eloped from the secured memory care unit until s/he was returned to the facility by Health Care Power of Attorney (POA) E, approximately 5 hours after s/he eloped.

Findings include:

The facility is licensed to serve irreversible dementia/Alzheimer's, advanced aged, terminally ill, and physically disabled residents.

On 11/16/2023 and 01/08/2024, the Department received complaints alleging a resident had eloped from the facility and the staff were unaware s/he was missing.

On 03/13/2024, at 7:30 AM, Surveyor reviewed Brown Deer Police Report # 23-013972.
On 11/14/2023, at 12:44 PM, reported a patrol unit was dispatched to the area of W. County Line and N. Green Bay Road. WE Energies employees reported a confused elderly person near their construction site. Police Officer (PO) F reported s/he contacted POA E and updated her/him regarding Resident 3. POA E was going to pick up Resident 3 and return her/him to the facility. PO F reported s/he spoke with Executive Director (ED) A after 3:30 PM. ED A reported the secured memory care unit had delayed egress door which were locked and had alarms. The door was supposed to release after 15 seconds; however, the alarm was not supposed to stop until acknowledged by staff. ED A reported the doors were to be tested bi-weekly but was not sure exactly when it was tested last. ED A reported it appeared Resident 3 eloped at approximately 10:00 AM.

On 03/13/2024, at 10:30 AM, Surveyor reviewed Resident 3's record and identified the following:

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N 426	Continued From page 6 -Resident 3 was admitted on 08/29/2023, with diagnoses including Alzheimer's disease. -Incident report, dated 09/05/2023, indicated at approximately 7:00 AM, Resident 3 eloped from the secured memory care unit. Resident 3's POA E was notified at approximately 8:20 AM. Resident 3's family found her/him at a local gas station, approximately 2.6 miles away. -Incident report dated 11/14/2023, indicated Resident 3 eloped from the secured memory care unit. Resident 3 was returned to the facility at approximately 2:45 PM. ED A notified by POA E Resident 3 had eloped. Resident 3's service plan (SP), dated 08/29/2023, indicated Resident 3 was to receive cueing 4-6 times per day. -Resident 3's SP, dated 09/05/2023, indicated Resident 3 was at risk for elopement. Resident 3 was to receive cueing 4-6 times per day. On 03/13/2024, at 10:35 AM, Surveyor interviewed Health Wellness Director (HWD) C regarding Resident 3's service plan and "cueing." HWD C reported cueing indicated how often staff were to check on residents. Staff were to check on Resident 3 every 4-6 hours per day. Surveyor asked why Resident 3's cueing was not increased after her/his first elopement. HWD C reported s/he did not know. HWD C stated, "[Resident 3] should have been checked on between breakfast and lunch." On 03/13/2024, at approximately 12:00 PM, Surveyor interviewed ED A. ED A confirmed Resident 3 eloped, and staff were not aware s/he	N 426		

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N 426	Continued From page 7 was missing until POA E returned her/him to the facility, approximately 5 hours later. Surveyor asked how Resident 3 was missing and staff was not aware. ED A reported s/he did not know. ED A reported the door Resident 3 eloped from was not working correctly. The door would alarm; however, it turned off after it closed instead of continuing to alarm until staff turned it off. ED A reported the delayed egress door mechanism was checked the day after the elopement. Surveyor asked how staff did not notice Resident 3 was not at lunch. ED A reported staff thought s/he was with the activity person.	N 426		