STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018236	A. BUILDING: _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

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N 000	Initial Comments On 06/29/2023, Surveyor conducted a complaint investigation at New Perspective Waukesha. One deficiency was identified. The complaint was substantiated. Census: 22	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is 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 prompt and adequate treatment. Resident 1, a hospice patient, did not receive adequate pain management and care when the provider did not ensure physician ordered medications were available and a trained caregiver was available to pass medications. Findings include: The provider is licensed to care up to 60 residents in the client groups of physically disabled, irreversible dementia/Alzheimer's, advanced age, and terminally ill. On 05/15/2023, the Department received a complaint alleging concerns the provider did not	N 353		

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N 353	Continued From page 1	N 353		

have a medication passer on the 3rd shift.

On 06/27/2023, Surveyor conducted a complaint investigation and reviewed resident records. The following was found:

Resident 1 admitted on 03/12/2023 with diagnoses including congestive heart failure, dementia, and anxiety disorder. Resident 1 had an activated healthcare power of attorney that made decisions on his/her behalf. Resident 1 was on hospice services, started to enter his/her end of life stage on 05/02/2023, and eventually passed away on 05/08/2023.

Resident 1's progress notes for May 2023 documented:
05/02/2023:"Hospice provider RN here for visit noted, noted resident to be short of breath with rate of 28 per min. Oxygen level was in the 80s. Resident unable to transfer with assist of 1, needing A2 to stand pivot transfer. EX lift/sit to stand ordered as well as oxygen concentrator for resident to use. Family aware per hospice staff."
05/03/2023: "Resident requiring EZ stand to transfer. Unable to stand pivot any longer. Hospice RN here resident using accessory muscles to breathe and appears SOB resps 28-30 per min. Oxygen on at 2LPM with spo2 88-91%. PRN Lorazepam administered and effective. Resident not calling "help" today as [s/he] often does. When staff asks if [s/he] need anything [s/he] replied "to be left alone." Refused toileting during night, did not want to get up. Incontinent of urine and bowel as a result .....PRN Lorazepam has been given x 2 today due to sob. Abd breathing and using accessory muscles. Hospice staff here at many different times, and called back for change of condition visit. Resident unable to stand today, slumping in sit to stand,

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N 353	Continued From page 2	N 353		

hoyer ordered. Hospice educating family on condition changes and expectations. Staff will continue to observe and update nursing on any changes ....Hospice here with family and resident new orders for Morphine and Lorazepam every hour if needed. Family to stay overnight. Hospital bed ordered. Hoyer lift ordered."
05/08/2023: "Med passer called to report that resident passed away around 0245, family present at bedside and notified hospice who is on their way to community. Community nurse updated as well."

Resident 1's physician orders included:
-Lorazepam 0.5 mg-Take 1 tablet by mouth every four as needed for anxiety/restlessness with a start date of 05/03/2023 and end date of 05/04/2023.
-Lorazepam 0.5 mg-Take 1 tablet by mouth every hour as needed for anxiety/restlessness with a start date of 05/04/2023 and end date of 05/06/2023.
-Lorazepam 1 mg-Take 1 tablet by mouth every hour as needed for anxiety/restlessness with a start date of 05/06/2023.
-Morphine 0.25ML (5MG)-Every four hours as needed for severe pain with a start date of 05/03/2023 and end date of 05/04/2023.
-Morphine 0.25ML (5MG)-Every hour as needed for severe pain with a start date of 05/04/2023 and end date of 05/06/2023.

According to hospice medication orders, a new script for Morphine 0.5ML-every hour as needed was ordered on 05/05/2023 at 3:33 PM and sent to the provider's Pharmacy E. An email sent from Hospice RN F to Licensed Practical Nurse (LPN) D confirms s/he received the new orders.

On 05/17/2023, Family Member C provided text

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N 353	Continued From page 3	N 353		

messages sent from LPN D, which documented the following:
LPN D on 05/05/2023 at 8:44 PM: "Its [LPN D]. We have no med person in tonight. Can they give you the meds for [Resident 1]?
Family Member C: "Yes. Did we get the upped dose?
LPN D: I [LPN D] don't know if it's in yet. I [LPN D] have to ask them to check the med safe.
Family Member C: Staff said something about only having 2 left of the 5s.
LPN D: I did ask them to rush it. Meds are being sent will arrive overnight.
Family Member C: So what does that mean, we only have 2 doses till morning?
LPN D: I am working to get them in your hands.
Family Member C: Should I call hospice?
LPN D: U can.
Family Member C: This is totally unacceptable.
LPN D: I have the [staff] checking delivery box all nite (sic). They know how to check it. Hospice mite (sic) be able to do something else, not sure.
Family Member C: What pharmacy? [Pharmacy E]? This is not what the [son/daughter] of a dying [man/woman] should be dealing with, Overnight no less .....Hospice nurse wants someone to get some from Walgreens, [s/he] is calling the triage nurse to get someone from the facility to get it, but then it will be in a bottle and I'm [Family Member C] not allowed to draw it up so a hospice nurse has to come out to draw it up.
Family Member C on 05/06/2023 at 8:31 AM: The meds are still not here!!"

Resident 1's hospice notes documented:
05/06/2023 at 12:00 AM: "RN in house to assist with medications. [Family Member C] retrieved Morphine concentrate and Ativan from 24 hour Walgreens because facility did not have any more for [Resident 1] and

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N 353	Continued From page 4	N 353		

pharmacy did not deliver this evening. RN drew up X10 syringes of 0.5ml morphine with 1mg lorazepam mixed in for [Family Member C] to administer. Reviewed frequency of dosing and encouraged [him/her] to keep a log of when [s/he] administers. [Family Member C] asked what to do with the remaining syringes/medication. RN suggested [s/he] give it to staff RN in am. [Family Member C] noted [s/he] may hold on to it. [S/he] placed remainder of medications in a medicine cabinet in the room. Patient appeared comfortable while RN present. Given [Family Member C] emotional support and hugs. [S/he] denied needs. Unable to locate a caregiver to report off to them.

05/06/2023 at 1:00 PM: [Social Worker G] visited with patient on 5/6/23 for PRN visit due to patient actively transitioning and family needing support. Upon arrival, patient was lying in bed unresponsive with family members at bedside. Patient appeared comfortable and not in any distress. [Family Member C] asked to speak to [Social Worker G] privately in another room. [Family Member C] is overwhelmed and emotionally exhausted due to frustrations with patients plan of care related to facility. [Social Worker G] allowed [Family Member C] time to vent and express [his/her] emotions in a healthy way. [Social Worker G] also spoke with facility staff on these frustrations to help bridge the gap and communication."

On 06/27/2023 at 10:05 AM, Surveyor interviewed Regional Director B. Surveyor asked if LPN D sent the above text messages noting the facility did not have a medication passer for the night of 05/05 into 05/06. Regional Director B confirmed LPN D admitted to sending the above messages to Family Member C. Regional

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N 353	Continued From page 5 Director B confirmed the facility was having staffing issues for many months, so agency staff were being utilized. Regional Director B stated agency staff cannot administered medications without being delegated from the facility nurse and on the registry. Regional Director B stated on the morning of 05/05/2023, s/he received a call from Administrator A, so s/he came to the facility to investigate. Regional Director B stated Family Member C called hospice and got an order sent to Walgreens. Regional Director B stated Family Member C picked up the medication, hospice RN drew up the doses, and family administered until the next day. Regional Director B stated him/her and Administrator A did not know about the above concerns until 05/06/2023 and once arriving that morning s/he saw the pharmacy delivering Resident 1's medications.	N 353		