STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

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N 000	Initial Comments On 11/25/2025, the bureau of assisted living southern regional office conducted a standard survey and 2 complaint investigations at New Perspectives a CBRF located in Sun Prairie, WI. As a result of this survey, 7 violations of DHS Chapter 83 were identified. Two complaints were substantiated. Census: 26	N 000		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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

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N 239	Continued From page 1	N 239		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 1 of 3 employees reviewed had completed training in First Aid and Choking.

Findings include:

First Aid and Choking

On 11/25/2025, Surveyor reviewed Caregiver H's employee file. Caregiver H was hired 05/23/2025. There was no evidence that Caregiver H had completed training in First Aid and Choking. There was no evidence found in the file indicating that Caregiver H was exempt from this training. On 11/25/2025, Surveyor verified Caregiver H was not on the Community-Based Care and Treatment training registry for First Aid and Choking.

On 11/25/2025 at approximately 10:00 AM, Surveyor asked Administrator A if Caregiver H had provided cares for residents since being hired. Administrator A stated yes, Caregiver H has worked and provided cares for residents since being hired. Surveyor asked Administrator A if Caregiver H would have to provide first aid to residents if necessary. Administrator A stated yes. Surveyor asked Administrator A if there was any documentation indicating that Caregiver H had completed training in First Aid and Choking. Administrator A stated that s/he thought that Caregiver H was still within the 90 days from hire. Surveyor and Administrator A looked at the staff roster provided and agreed that Caregiver H was outside of the 90 days from hire. Administrator A

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N 239	Continued From page 2 acknowledged that all employees must be trained in First Aid and Choking within 90 days of hire and that Caregiver H had not completed training in First Aid and Choking as required. Administrator A stated, "We will get Caregiver H signed up for that training as soon as possible."	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.	N 243		

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N 243	Continued From page 3	N 243		

Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure that 1 of 3 employees reviewed obtained all training as required within 90 days after starting employment. Caregiver I did not have training in resident rights or challenging behaviors within 90 days of employment.

Findings include:

On 11/25/2025 at 10:30 AM, Surveyor reviewed Caregiver I's employee file. Caregiver I was hired 01/29/2024.

Resident Rights

The record for Caregiver I, hired 01/29/2024, did not contain evidence of training or evidence of meeting an exemption for resident rights training.

Recognizing, Preventing, Managing and Responding to Challenging Behaviors.

The record for Caregiver I, hired 01/29/2024, did

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N 243	Continued From page 4 not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 11/25/2025 at 12:00 PM, Surveyor interviewed Administrator A. Administrator A acknowledged that all employees must be trained in resident rights and challenging behaviors within 90 days of starting employment. Administrator A acknowledged that Caregiver I had not completed training in resident rights or challenging behaviors. Administrator A stated that caregivers are given a list of trainings to complete when hired and that Caregiver I had not completed training in resident rights or challenging behaviors, but would complete those trainings as soon as possible.	N 243		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation	N 247		

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N 247	Continued From page 5 and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that 1 of 3 employees reviewed obtained all training as required before performing duties in personal cares. Caregiver I did not have training in personal cares. Findings include: On 11/25/2025 at 10:30 AM, Surveyor reviewed Caregiver I's employee file. Caregiver I was hired 01/29/2024. Personal Cares The record for Caregiver I, hired 01/29/2024, did not contain evidence of training or evidence of meeting an exemption for personal cares training. On 11/25/2025 at 12:00 PM, Surveyor interviewed	N 247		

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N 247	Continued From page 6 Administrator A. Administrator A acknowledged that all employees must be trained in personal cares prior to performing those duties. Administrator A acknowledged that Caregiver I works alone and does assist residents with personal cares. Administrator A acknowledged that Caregiver I had not completed training in personal cares. Administrator A stated that caregivers are given a list of trainings to complete when hired and that Caregiver I had not completed training in personal cares, but would complete those trainings as soon as possible.	N 247		
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 physical or mental condition.	N 389		

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N 389	Continued From page 7 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, SOD ZZI813 dated 08/28/2024 and SOD DS4J12 dated 04/30/2025. FINDINGS INCLUDE: On 11/25/2025, Surveyor arrived at facility for a standard survey. On 11/25/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 07/20/2023. Resident 1 has an activated power of attorney. Resident 1 was diagnosed with but not limited to, "Alzheimer's disease, type 2 diabetes mellitus, anxiety disorder, depression, atrial fibrillation, history of stroke, and unspecified convulsions. On 11/25/2025, Surveyor reviewed Resident 1's observation notes: 1.) On 10/17/2025 at 12:45 PM, Nurse B documented Resident 1 was currently being hospitalized for a stroke. Hospital reported Resident 1 was having difficulty with speech and word placement. 2.) On 10/24/2025 at 7:58 AM, Nurse E documented the following, "10/24/25, 0620 (6:20AM) ...TRIAGE CALL: Med passer called to report that resident was found outside of building. Another resident heard resident hollering for help and alerted caregivers. Resident was alert and LOC (level of consciousness) at baseline. Caregivers brought resident back into the building, resident noted to have dirt to pant legs and skin is cool to touch. No injuries noted. Med Passer was instructed to call 911 for EMS eval, resident transported to [Name Of Local Hospital] via ambulance ...".	N 389		

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3.) On 10/30/2025 at 1:22 PM, Nurse F documented order for Resident 1 to receive Warfarin 2.5 mg once daily for the next 15 days.
4.) On 11/06/2025 at 1:39 PM, Nurse B documented the following, " ...Staff reported that resident was experiencing increased confusion and wandering. Resident noted frequently attempted to elope ...Writer went down by resident. Resident in dining room, notably experiencing tremors and confusion. Pleasant with staff. Stuttering on words. Heart Rate and Oxygen Saturation continued to fluctuate. Accurate reading difficult to obtain d/t tremors. Resident sent via EMS to Emergency Room d/t symptoms ...".
5.) On 11/22/2025 at 4:47 PM, Nurse G documented the following, "TRIAGE CALL-resident found on the floor in [his/her] room visibly shaking with loose stool ...".
6.) On 11/23/2025 at 4:17 PM, Nurse F documented the following, "PCP notified of fall from 11/22/25. PCP recommended resident be evaluated at the ED d/t being on blood thinner and unsure if there were head impact ...".

On 11/25/2025, Surveyor reviewed Resident 1's November 2025 medication administration record (MAR). Resident 1 was prescribed the anti-coagulant Warfarin 5mg to be administered once daily.
According to the Pearson Nurse's Drug Guide 2015, "Warfarin Sodium ...Black Box Warning Warfarin has been associated with serious, sometimes fatal bleeding events." (Pearson Nurse's Drug Guide, 2015, p.1646-1649)
On 11/25/2025, Surveyor reviewed Resident 1's hospital discharge orders dated 10/20/2025. Resident 1 had been hospitalized for stroke. On page 2 of the following was documented, " ...Other Discharge Patient Care Instructions -

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N 389	Continued From page 9 Hypertension ...please follow up with your Primary Care Physician to monitor your blood pressure. Our overall goal in the future would be for your blood pressure to be less than 130/90 a few weeks after a stroke. If your blood pressure is greater than 180/100, repeat the measurement in 5 minutes. Call your Primary Care Physician if it remains high. If your blood pressure is higher than 180/120 and you are experiencing signs of stroke or heart attack, (chest pain, shortness of breath, back pain) do not wait to see if your pressure comes down on its own. Call 9-1-1." On 11/25/2025, Surveyor reviewed Resident 1's emergency department after visit summary dated 11/06/2025. Resident 1 was diagnosed with seizure. Resident 1 was prescribed the anti-convulsant medication Keppra (levetiracetam) 500 mg tablets twice daily for seizure prophylaxis. On 11/25/2025, Surveyor reviewed Resident 1's individualized service plan (ISP) signed on 10/29/2025. Resident 1's ISP didn't have documentation of Resident 1's seizure activity, stroke, warfarin therapy and/or elopement. On 11/25/2025 at 12:00 PM, Surveyor discussed the above concern with Administrator A and Nurse B. Nurse B asked for guidance on authoring a comprehensive ISP. Nurse B and Administrator A acknowledged Resident 1's ISP hadn't been updated upon changes in condition from 10/20/2025 to 11/06/2025. CROSS REFERENCE N0426 DHS Chapter 83.38(1)(b) Supervision	N 389		

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N 426	Continued From page 10	N 426		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not arrange adequate supervision appropriate to meet Resident 1's needs. On 10/24/2025, Resident 1 eloped from the memory care unit. Another resident heard by him/her yelling for help from the outside. Staff noted that upon discovery his/her skin was cool to the touch. Resident 1 was immediately transported to a local hospital via ambulance for evaluation. This is a repeat violation from previous statement of deficiency (SOD) DS4J11 dated 11/15/2024. FINDINGS INCLUDE: On 10/28/2025, Administrator A sent the Department a self-report for an elopement which occurred on 10/24/2025. Administrator A documented the following, " ... On 10/24/25 at approximately 5:45 AM Careteam (sic.) members	N 426		

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were doing rounds and determined that [Resident 1] was not in [his/her] room. Resident was last seen in Memory Care commons area at approximately 5:15 AM. A search began for resident and at 6:04 AM [S/he] was found outside of the community (sic.) in a fenced in/secured part of the Memory Care. Resident was immediately brought inside and tended to with warm blankets and a change of clothes. Resident stated [s/he] was trying to get to [his/her] room and got lost. EMS called and transported to Emergency Department for further evaluation. It was determined that a team member inadvertently left the door unalarmed allowing the resident to get out of the indoor secured area without an audible alarm ...Incident Outcome Resident admitted to hospital for additional monitoring from a previous CVA unrelated to the elopement. Action Taken to Ensure Resident's Health, Safety, and Well-Being ...".

On 11/13/2025, the Department received a complaint about resident supervision.

On 11/25/2025, Surveyor reviewed Resident 1's facility record. Resident 1 was admitted to the facility on 07/20/2023. Resident 1 has an activated power of attorney. Resident 1 was diagnosed with but not limited to, "Alzheimer's disease, type 2 diabetes mellitus, anxiety disorder, depression, atrial fibrillation, history of stroke, and unspecified convulsions.

On 11/25/2025, Surveyor reviewed Resident 1's observation notes. On 10/24/2025 at 7:58 AM, Nurse E documented the following, "10/24/25, 0620 (6:20AM) ...TRIAGE CALL: Med passer called to report that resident was found outside of building. Another resident heard resident hollering for help and alerted caregivers. Resident was

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N 426	Continued From page 12 alert and LOC (level of consciousness) at baseline. Caregivers brought resident back into the building, resident noted to have dirt to pant legs and skin is cool to touch. No injuries noted. Med Passer was instructed to call 911 for EMS eval, resident transported to [Name Of Local Hospital] via ambulance ...". On 11/25/2025 at 12:00 PM, Surveyor discussed the above concern with Administrator A and Nurse B. Administrator A acknowledged Resident 1 had eloped from the unit without staff knowledge. Administrator A acknowledged Resident 1 had not been provided adequate supervision the morning of 10/24/2025. CROSS REFERENCE N0389 DHS Chapter 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 426		
N 431	83.38(1)(g) Health monitoring. 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: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a	N 431		

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N 431	Continued From page 13 CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure that Resident 2 was monitored for health and safety. Resident 2 sustained a fall on 10/28/2025 and was not monitored. Findings include: On 10/29/2025, the Department received a complaint alleging that a resident fell and was not monitored for health for several hours afterwards. On 11/05/2025, Surveyor reviewed an email that was sent from family to Administrator A. The email stated that the facility had a fall monitoring system called "Safely You" that was supposed to alert staff of resident falls. This system was installed in Resident 2's room. The Safely You system did alert staff around 1:40 AM, and staff responded at approximately 1:55 AM. Family went to the facility, saw the injury to Resident 2's head and took Resident 2 to the hospital for evaluation. On 11/05/2025, Surveyor reviewed a picture of Resident 2's head taken 10/28/2028 at 10:00 AM according to date and time stamp on photo (see	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015199	A. BUILDING: _____ B. WING _____	C 12/02/2025

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N 431	Continued From page 14	N 431		

photo head injury). Picture shows Resident 2 with an obvious head wound with dried blood on scalp approximately 1.5-2 inches long.

On 11/25/2025 at 9:30 AM, Surveyor reviewed Resident 2's medical record. Resident 2 was admitted 12/31/2019 with diagnoses that include but are not limited to: primary insomnia, pain in joints, amnesia, osteoporosis, dementia, chronic pain, depression, intervertebral disc degeneration, generalized muscle weakness, unsteadiness on feet, lack of coordination.

On 11/25/2025 at 10:00 AM, Surveyor reviewed progress notes from Resident 2's medical record.

Progress notes dated 10/28/2025 at 8:25 AM indicated that Resident 2 had been found on the floor lying on left side after an unwitnessed fall. Progress notes indicated that Resident 2 stated s/he hit his/her head on the left side above the eye during the fall, vital signs were taken, and Resident 2 was assisted back to bed. There was a camera in Resident 2's room that captured Resident 1's fall on 10/28/2025 at 1:10 AM according to the date and time stamp of video. Video of fall was provided by family upon request by Surveyor. (See video)

Progress notes dated 10/28/2025 at 10:00 AM indicated that Resident 2 had a notable scratch to the left side of head which was scabbed over. Notes indicate that Resident 2 stated his/her head was sore. Resident 2's Power of Attorney (POA) was notified at 9:48 AM.

Progress notes dated 10/28/2025 at 12:20 PM indicated that Resident 2's POA would be taking Resident 2 to see the doctor due to complaints of pain.

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N 431	Continued From page 15 There were no further progress notes to indicate follow up after 10/29/2025. On 11/25/2025 at 10:30 AM, Resident 2 was sent to the hospital due to being lethargic and unresponsive to conversation with staff, which is not normal for Resident 2. Resident 2 is normally talkative and alert. Nurse B stated that it is possible that there would be lasting effects from the fall if Resident 2 hit his/her head. On 11/25/2025 at 11:00 AM, Surveyor interviewed Administrator A. Administrator A stated that to his/her knowledge there were no injuries to Resident 2. Surveyor showed Administrator A the video provided by Family Member J. Administrator A reacted to seeing the video, "WOW! I did not have access this, that is very different from the information that was portrayed to me. Resident 2 should have been sent out. "When in doubt, send them out."" Administrator A acknowledged that Resident 2 likely hit his/her head on the floor during the fall. And since it was an unwitnessed fall, Resident 2 should have been sent to the hospital for evaluation.	N 431		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure employee followed hand washing procedures according to centers for disease control and prevention standards.	N 441		

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N 441	Continued From page 16 FINDINGS INCLUDE: On 11/25/2025, Surveyor arrived at facility for a standard survey. On 11/25/2025 at 11:04 AM, Surveyor initiated a medication cart audit with Caregiver C. Caregiver C unlocked the medication cart and opened the top drawer. Surveyor couldn't locate any hand sanitizer on top of or attached to the medication cart. Surveyor asked Caregiver C if there was a bottle of hand sanitizer inside the medication cart. Caregiver C reported hand sanitizer dispensers were attached to the walls around the floor. Caregiver C pointed to the closest hand sanitizer dispenser to the medication cart. Surveyor observed the hand sanitizer dispenser was approximately 10 feet from the medication cart. Surveyor walked down to the hand sanitizer dispenser and completed hand hygiene then returned to the medication cart. Caregiver C stated while staff pass medications they will move the medication cart closer to the hand sanitizer dispenser for easier access. Surveyor then began to review the contents of the medication cart. Caregiver D approached the medication cart and indicated they had been passing residents medication since approximately 9:30 AM. Caregiver D stated s/he required access to the medication cart. Surveyor observed Caregiver D to have a resident medication in his/her hand, Caregiver D then opened the medication cart with a key, Caregiver D opened the medication cart bottom drawer and pulled out a bottle of polyethylene glycol placing it on top of the medication cart. Caregiver D then returned the original resident medication in his/her hand to the middle drawer of the medication cart and closed the drawer. Caregiver D then placed his/her hand on the purple top of the polyethylene glycol.	N 441		

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N 441	Continued From page 17 Surveyor asked Caregiver D to stop and wash his/her hands before continuing with medication pass. Caregiver D complied and immediately walked to the hand sanitizer dispenser mounted on the wall approximately 10 feet down the hall and returned to the medication cart. Caregiver D acknowledged s/he had opened the medication cart without performing hand hygiene, returned a medication into the cart without performing hand hygiene, and had pulled out a bottle of polyethylene glycol without performing hand hygiene. Caregiver D and Caregiver C stated facility leadership had instructed them not to have bottles of hand sanitizer stored inside or on top of the medication carts. Caregiver D and Caregiver C stated facility leadership felt having bottles of hand sanitizer on top of the medication cart could pose a health risk if a resident were to ingest it. Caregiver D and Caregiver C could not explain to Surveyor how the hand sanitizer mounted on the wall was safer than staff keeping a bottle of the hand sanitizer on or inside of the medication cart. On 11/12/2025 at 12:00 PM, Surveyor discussed the above concern with Administrator A and Nurse B. Administrator A and Nurse B explained staff were expected to perform adequate hand hygiene by utilizing the hand sanitizer dispensers mounted to the walls. Administrator A and Nurse B acknowledged Caregiver D had not performed hand hygiene to break the cycle of infection from coming to the medication cart or the polyethylene glycol stored inside the medication cart. Nurse B stated s/he would create a new system to make hand hygiene more accessible to staff.	N 441		