Wisconsin Department of Health Services

| 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 _____ | C 10/23/2025 |

| 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 |
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| N 000 | Initial Comments<br><br>On 10/23/2025, Surveyor completed two complaint investigations at New Perspective North Shore.<br><br>One deficiency was identified.<br><br>Two complaints unsubstantiated.<br><br>Census: 42 | N 000 | | |
| N 454 | 83.42(1) Resident record maintained.<br><br>The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following:<br>(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 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 | N 454 | | |

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

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| N 454 | Continued From page 1<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure 1 of 1 resident record | N 454 | | |

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| N 454 | Continued From page 2 | N 454 | | |

reviewed (Resident 1) was complete and maintained. Resident 1 had a fall, and the triage nurse prescribed caregivers to monitor vital signs at 2-hour intervals for 24-hours.

Resident 1's medical record contained a primary provider notification indicating Resident 1 had a fall. On 03/23/2025 at 4:53 p.m. Triage Nurse C directed staff to take Resident 1's vital signs every two hours, for 24-hours. On 03/24/2025 at 7:40 a.m., Resident 1 was found deceased.

Provider did not have record of vital signs being checked every 2-hours from 03/23/2025 at 4:53 p.m. to time of death.

Findings include:

On 09/29/2025, the Department received a complaint indicating a resident did not receive his/her two-hour checks after a fall, prescribed by the triage nurse.

On 10/23/2025, at 1:40 p.m., Surveyor reviewed Resident 1's records. The following was identified:

Resident 1 was admitted to the facility on 02/20/2025 with diagnoses including weakness, syncope and collapse, atrial fibrillation, congestive heart failure, difficulty in walking and history of thrombosis and embolism. Resident 1 was his/her own person.

Resident 1's record contained an Individual Service Plan (ISP) dated 2/20/2025. Resident 1's ISP did not identify Resident 1's services and interventions concerning safety fall prevention. Under section titled, Focus, it read, "Safety fall prevention." Expected outcome, "Falls: To remain

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free from falls."

On 10/23/2025, Surveyor reviewed Resident 1's progress notes for the time-period of 02/21/2025 to 03/26/2025 and identified the following:

- "On 03/23/2025 at 4:53 p.m., Triage call: [Resident 1] had an unwitnessed fall in his/her room. Caregivers were bringing resident his/her dinner when they found him/her on the floor next to his/her bed ... Red mark noted under left eye to his/her cheek ... caregivers were instructed to assist resident off the floor per care plan, continue vital signs every two hours for 24 hours and notify nursing with any changes or concerns."

- On 03/24/2025 at 7:40 a.m., Triage call: Medication passer called to report that [Resident 1] was found laying [sic] face down on the floor near his/her bed. [Resident 1] is not responsive, appears to have passed away."

On 03/23/2025 at 5:00 p.m., Caregiver D completed Resident 1's incident report. The incident report provided boxes to check-off. It read, Type of incident; checked off was, "Found on floor." Were there any witnesses? Checked off was, "No." What did you do? Describe all assistance given. Handwritten it read, "Vitals, called triage, asst [sic] coworkers." Nurse on duty notified- name read, "Triage." Signed by Caregiver D on 3/23/2025.

On 10/23/2025 at 3:45 p.m., Surveyor reviewed provider's fall mitigation policy. Under post-fall vital signs and observations, it reads, " ...Document the fall and the frequency of vital signs and observations in the 24-Hour Shift Log so team members coming on shift are informed of the required vital signs and observations."

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| N 454 | Continued From page 4<br><br>Interviews<br><br>On 10/23/2025, at 11:15 a.m., Surveyor interviewed Health and Wellness Director (HWD) B, who stated if a resident fell and had any indication of hitting their heads, the care team would evaluate and monitor for the next 24-hours.<br><br>On 10/23/2025, at 1:00 p.m., Surveyor interviewed HWD B, who stated, Triage Nurse (TRN) C received a telephone call on 03/23/2025 that Resident 1 had a fall. The triage nurse provided instruction to the care team, over the phone to take vital signs every two hours, for the next 24-hours. Resident 1 had passed away the next morning, before the office staff had arrived. HWD B confirmed TRN C was a trained employee and was aware of the company fall policies.<br><br>On 10/23/2025, at 1:20 p.m., Surveyor interviewed Administrator A, who confirmed TRN C provided instruction to the care team, over the phone to take Resident 1's vital signs every 2 hours for 24-hours. Administrator A confirmed the staff would monitor Resident 1's vital signs for the next 24-hours on a paper form.<br><br>On 10/23/2025, at 2:07 p.m., Surveyor interviewed Administrator A, who confirmed the vitals were not in Resident 1's chart. Administrator A stated s/he believed the vitals were somewhere with Care Team Manager (CTM) F and s/he was not available. "They should be here." | N 454 | | |