STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

(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 From 02/06/2025 to 02/17/2025, Surveyor conducted four complaint investigations at New Perspectives Waukesha, a CBRF in Waukesha. Three deficiencies were identified. Four of 4 complaints were substantiated. Census: 31	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1's legal representative was immediately notified when there was an incident affecting Resident 1's physical or mental condition. Findings include: From 02/06/2025 to 02/17/2025, Surveyor conducted a complaint investigation alleging the provider did not immediately update a resident's legal representative when s/he was involved with an altercation and sustained a fall.	N 169		

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

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N 169	Continued From page 1 On 02/06/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/21/2024 with diagnoses of dementia. Resident 1's Health Care Power of Attorney (HCPOA) was activated on 10/23/2024. Resident 1's record included an incident report, dated 11/21/2024, that stated "Resident yelling at another resident, caregiver intervened and got between them, resident attempted to hit caregiver, caregiver grabbed [his/her] wrists let go [sic], resident tried to hit caregiver lost balance and fell backwards." The incident report indicated Resident 1's HCPOA was notified of the incident on 11/26/2025, 5 days after the incident. A corresponding progress note, dated 11/22/2024, indicated Resident 1's primary care physician would be updated, but not did not indicate Resident 1's family had or would be updated regarding the incident. On 02/06/2025 at approximately 12:00 p.m., Surveyor requested additional documentation of follow up regarding Resident 1's 11/21/2024 incident from Regional RN D. Regional RN D checked Resident 1's record and stated s/he had no additional information to provide On 02/07/2025 at approximately 9:30 a.m., Surveyor asked Administrator A, who was out of the office on 02/06/2025, if s/he was aware of any follow up that occurred after the 11/21/2024 incident. On 02/10/2025 at approximately 2:00 p.m., Administrator A replied that the incident occurred prior to his/her start date with the provider, and s/he had no additional documentation or follow up to provide.	N 169		

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N 169	Continued From page 2 On 02/17/2025 at approximately 12:00 p.m., Surveyor and Administrator A reviewed Resident 1's 11/21/2024 incident report together. Administrator A agreed that family should have been notified of the occurrence immediately and wasn't sure why the RN who completed the report and was no longer with the facility did not do so. Cross Reference: N0433 DHS 83.38(1)(i) Behavior Management	N 169		
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 record review and interview, the provider did not ensure 2 of 3 residents reviewed received their medications as prescribed. Resident 2 missed medications for several days post hospitalization. Resident 3 did not receive his/her medications within prescribed intervals. Findings include: From 02/06/2025 to 02/17/2025, Surveyor conducted 4 complaint investigations. Two of 4 complaints alleged residents did not receive medications as prescribed from the provider. On 02/17/2025 at approximately 9:30 a.m.,	N 352		

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N 352	Continued From page 3 Surveyor reviewed resident records and identified the following concerns: Example 1 - Resident 2: Resident 2 was admitted to the provider's facility on 08/27/2024 with diagnoses of dementia and diabetes. Resident 2's record indicated the provider's staff were responsible for medication administration. Resident 2's Medication Administration Record (MAR), dated 02/01/2025 to 02/17/2025, documented the following occurrences of medications not being administered: - Simvastatin 40 mg (Start Date: 08/28/2024) - Take 1 tablet daily at bedtime: Not administered from 02/07/2025 through 02/12/2025. Notations indicated the medication was unavailable. - Sertraline 100 mg (Start Date: 08/28/2024) - Take 1 tablet daily in the morning: Not administered 02/11/2025 through 02/14/2025. Notations indicated the medication was unavailable. - Risperidone .5 mg (Start Date: 08/30/2024) - Take 1 tablet 2 times daily in the morning and evening: Not administered 02/10 PM through 02/13/2025 AM. Notations indicated the medication was unavailable. - Risperidone .5 mg (Start Dae: 08/28/2024) - Take 2 tablets daily at bedtime: Not administered 02/07/2025 through 02/12/2025. Notations indicated the medication was unavailable - Oyster Shell 500 mg (Start Date: 08/29/2024) - Take 1 tablet daily at bedtime: Not administered 02/07/2025 through 02/12/2025. Notations indicated the medication was unavailable. - Metformin 100 mg (Start Date: 08/28/2024) - Take 1 tablet 2 times daily at bedtime in the morning and evening: Not administered	N 352		

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N 352	Continued From page 4 02/09/2025 in the evening, 02/10/2025 in the evening, 02/11/2025 in the morning, 02/12/2025 in the morning and evening and 02/13/2025 in the morning. Notations indicated the medication was unavailable. - Memantine Hcl 5 mg (Start Date: 08/29/2024) - Take 1 tablet daily in the morning: Not administered 02/11/2025 through 02/13/205. Notations indicated the medication was unavailable. - Melatonin 10 mg (Start Date: 10/16/2024) - Take 1 tablet at bedtime. Not administered 02/10/2025 through 02/12/2025. Notations indicated the medication was unavailable. - Mag Oxide 400 mg (Start Date: 08/29/2024) - Take 1 tablet at bedtime. Not administered 02/11/2025 through 02/13/2025. Notations indicated the medication was unavailable. - Famotidine 20 mg (Start Date: 08/29/2024) - Take 1 tablet at bedtime. Not administered on 02/07/2025, 02/09/2025 through 02/12/2025). Notations indicated the medication was unavailable. - Probiotic (Start Date: 02/07/2025) - Take 1 tablet daily in the morning: Not administered 02/13/2025 and 02/14/2025. Notations indicated the medication was unavailable. Resident 2's progress notes included the following: - Late Entry for 01/28/2025: Resident was taken to hospital on 01/27/2025. - 02/04/2025: Returned from the hospital with diagnoses including pneumonia, urinary tract infection and COVID. All discharge paperwork faxed to pharmacy for review. No new orders or medication changes. - 02/13/2025: Spoke to individual at the pharmacy regarding missing medications/medications not	N 352		

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available. Medication will be shipped out. Verified fax was received on 02/03/2025 and again on 02/06/2025.

On 02/17/2025 at approximately 12:00 p.m., Surveyor reviewed concern regarding Resident 2's missed medications with Administrator A, Regional RN D, and RN F. Regional RN D explained that the provider's pharmacy dispensed 14-day supplies of medications at one time. Regional RN D stated the pharmacy had access to the provider's system and could see that Resident 2 was hospitalized on 01/31/2025 when the facility's next 14-day supply of medications, due to start on 02/08/2025, was sent out, so Resident 2's medications were not sent. RN F explained that upon Resident 2's return to the community, s/he sent discharge paperwork to pharmacy on 02/03/2025 and 02/06/2025; however, the pharmacy did not process the paperwork. RN F explained that the provider's medications were packaged by day and s/he had gone through the medication supply and dated packages for past days (unused packages that covered dates resident was hospitalized) and dated them for ~3 days beyond Resident 2's return from the hospital thinking that would cover Resident 2 until his/her new cycle arrived from pharmacy. RN F stated s/he did not follow up to ensure Resident 2's medications were delivered and was unaware s/he had gone without medications. Surveyor asked why Resident 2 did not have additional medications "left over" from the time period s/he was hospitalized that could have been used during the pharmacy delay. RN F stated the provider was having a "mock survey" completed at the time and any medications not dated with a future date were disposed of, so when Resident 2 ran out of medications entirely and pharmacy did not deliver, the provider did not

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have medications to administer. RN F stated s/he did not realize how many dates Resident 2 had gone without medications until auditing another resident. RN F stated, "It's no excuse" and went on to explain that caregivers should have informed RN F of the missed medications and RN F should have reviewed the "dashboard" to audit for missed medications.

Example 2 - Resident 3:

Resident 3 was admitted to the provider's facility on 02/03/2025 with diagnoses including Parkinson's disease, glaucoma and dementia. Resident 3's record indicated the provider's staff assisted with medication administration. Resident 3's MAR, dated 02/03/2025 to 02/17/2025, identified the following concerns with administration intervals:

* The provider's procedure regarding medication administration times indicated the following scheduled times for medications: morning 7:00 a.m. to 9:59 a.m., midday 10:00 a.m. to 1:59 p.m., afternoon 2:00 p.m. to 4:59 p.m., evening 4:59 p.m. to 7:00 p.m. and bedtime 7:00 p.m. to 10:59 p.m.

- Acetaminophen 500 mg (Start Date: 11/05/2024) - Take 2 tablets 3 times daily at morning, mid-day and evening: On 02/04/2025, the mid-day dose was not administered with no notation as to why. On 02/06/2025, the morning dose and mid-day dose were both administered at 11:13 a.m. On 02/09/2025, the evening dose was administered at 8:03 p.m. (greater than 1 hour after the designated administration interval). On 02/12/2025, the mid-day dose was administered at 12:31 p.m. and the morning dose was administered at 12:34 p.m. (just 3 minutes

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apart). On 02/13/2024, the morning dose was administered at 11:13 a.m. and the mid-day dose was administered at 12:04 p.m. (less than 1 hour apart). On 02/16/2025, the evening dose was administered at 9:32 p.m. (greater than 1 hour after the designated administration interval). *"If you missed a dose of this medicine, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not double doses." (Source: The Mayo Clinic Website, Acetaminophen, February 1, 2025, https://www.mayoclinic.org/drugs-supplements/acetaminophen-oral-route-rectal-route/description/drg-20068480, (retrieval date - February 17, 2025).).

- Brimonidine Solution. 2% (Start Date: 02/27/2024) - Instill 1 drop into both eyes twice daily at morning and bedtime: On 02/06/2025, the morning dose was administered at 11:13 a.m., on 02/12/2025, the morning dose was administered at 12:34 p.m. and on 02/13/2025, the morning dose was administered at 11:13 a.m. (all greater than 1 hour after the designated administration interval).
- Brinzolamide Sus 1% (Start Date: 02/27/2024) - Instill 1 drop in both eyes twice daily at morning and bedtime: On 02/06/2025, the morning dose was administered at 11:13 a.m., on 02/12/2025, the morning dose was administered at 12:34 p.m. and on 02/13/2025, the morning dose was administered at 11:13 a.m. (all greater than 1 hour after the designated administration interval).
- Carbidopa-Levodopa Er 25-100 mg (Start Date: 05/15/2024) - Take 1 tablet in the morning: On 02/06/2025, the medication was administered at 11:13 a.m., on 02/12/2025, the medication was administered at 12:34 p.m. and on 02/13/2025, the medication was administered at 11:13 a.m. (all administrations greater than 1 hour after the

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designated administration interval). *"Delaying medications by more than one hour, for example, can cause patients with Parkinson's disease to experience worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating," (Source: Grissinger, M. (2018). Delayed administration and contraindicated drugs place hospitalized Parkinson's disease patients at risk. Pharmacy & Therapeutics 43(1): 10-11, 39).
- Digoxin 125 mcg (Start Date: 10/18/2024) - Take 1 tablet every other day in the morning: On 02/13/2025, the medication was administered at 11:13 a.m. (greater than 1 hour after the designated administration interval).
- Eliquis 2.5 mg (Start Date: 02/27/2024) - Take 1 tablet twice daily in the morning and at bedtime: On 02/06/2025, the medication was administered at 11:13 a.m., on 02/12/2025, the medication was administered at 12:34 p.m. and on 02/13/2025, the medication was administered at 11:13 a.m. (all administrations greater than 1 hour after the designated interval time). *"You should try to take Apixaban (Eliquis) at the same time each day, and approximately 12 hours apart. The tablet should be swallowed whole with water." (Source: Plymouth Hospitals website, Apixaban, February 2025, https://www.plymouthhospitals.nhs.uk/display-pil/apixaban-6092 (retrieval date - February 17, 2025).
- Flecainide 50 mg (Start Date: 02/27/2024) - Take 1 tablet twice daily in the morning and evening: On 02/06/2025, the medication was administered at 11:13 a.m., on 02/12/2025, the medication was administered at 12:34 p.m., on 02/13/2025, the medication was administered at 11:13 a.m. and on 02/16/2025, the evening dose was administered at 9:34 p.m. (all administrations greater than 1 hour after the designated administration interval). "Flecainide prevents and

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N 352	Continued From page 9 treats a fast or irregular heartbeat ... Take your doses at regular intervals." (Source: The Cleveland Clinic Website, Flecainide Tablets, https://my.clevelandclinic.org/health/drugs/20452-flecainide-tablets (retrieval date - February 17, 2025). - Memantine Hcl 5 mg (Start Date: 01/03/2025) - Take 1 tablet daily in the morning: On 02/06/2025, the medication was administered at 11:13 a.m., on 02/12/2025, the medication was administered at 12:34 p.m. and on 02/13/2025, the medication was administered at 11:13 a.m. (all administrations greater than 1 hour after the designated administration interval). - Senoxon Plus 8.6-50 mg (Start Date: 01/01/2025) - Take 1 tablet daily in the morning: On 02/06/2025, the medication was administered at 11:13 a.m., on 02/12/2025, the medication was administered at 12:34 p.m. and on 02/13/2025, the medication was administered at 11:13 a.m. (all administrations greater than 1 hour after the designated administration interval). - Sertraline 25 mg (Start Date: 11/05/2024) - Take 1 tablet daily in the morning: On 02/06/2025, the medication was administered at 11:13 a.m., on 02/12/2025, the medication was administered at 12:34 p.m. and on 02/13/2025, the medication was administered at 11:13 a.m. (all administrations greater than 1 hour after the designated administration interval). - Sertraline 50 mg (Start Date: 10/31/024) - Take 1 tablet daily in the morning: On 02/06/2025, the medication was administered at 11:13 a.m., on 02/12/2025, the medication was administered at 12:34 p.m. and on 02/13/2025, the medication was administered at 11:13 a.m. (all administrations greater than 1 hour after the designated administration interval). On 02/17/2025 at approximately 12:00 p.m.,	N 352		

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N 352	Continued From page 10 Surveyor reviewed concern regarding Resident 3's medications being given outside designated intervals with Administrator A, Regional RN D, and RN F. Administrator A reviewed the provider's schedule and stated staffing issues may have affected the medication administration on 02/06/2025, 02/12/2025 and 02/13/2025. Regional RN D stated nursing should be informed when staffing affected medication administration so nursing could help out. RN F stated nursing should also be notified if a dose was missed to determine next steps rather than administering 2 doses at once. Administrator A stated the provider was in the process of hiring 9 or 10 caregivers with the goal of all caregivers being delegated to pass medications in hopes of rectifying all medication administration concerns the provider was experiencing.	N 352		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents reviewed had his/her harmful behaviors managed. Resident 1 exhibited aggressive behaviors while s/he resided at the provider's facility from	N 433		

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N 433	Continued From page 11 10/21/2024 to 12/06/2024. Resident 1 was hospitalized due to behaviors on 12/06/2024 and did not return to the facility. Findings include: The provider's facility is licensed to provide care for 60 residents with diagnoses including physically disabled, advanced age, irreversible dementia/Alzheimer's and terminally ill. From 02/06/2025 to 02/17/2025, Surveyor conducted a complaint allegation alleging the provider did not manage resident behaviors. On 02/06/2025 at approximately 8:00 a.m., Surveyor reviewed hospital records, obtained by Surveyor, that documented Resident 1 was admitted to the emergency room on 12/06/2024 due to aggressive behaviors at the provider's facility. The report documented Administrator A stated Resident 1 was aggressive toward staff and other residents and was an elopement risk, having figured out how to get out of the facility's secured unit. The report stated Resident 1 was running through halls stating, "They are trying to kill me," and had been 1:1 over the past few days. The report indicated Resident 1 required Midazolam x 2 to control aggression for transport to the hospital. The report documented that Administrator A stated, "[Resident 1] was accepted by a 3rd party to their facility and [Administrator A] states they likely would not have accepted [Resident 1]." On 02/06/2025 at approximately 10:25 a.m., Surveyor interviewed Caregiver B and asked about caring for residents with behaviors. Caregiver B identified Resident 1, who had discharged, as a difficult resident to care for.	N 433		

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Caregiver B described Resident 1 as "cussing, fussing, always looking to fight" and stated, "[S/he] knew to push on the door to leave the unit." Caregiver B stated Resident 1's behaviors made other residents at the facility fearful. Caregiver B stated the only intervention s/he knew of to manage behaviors was to take Resident 1 for a walk off the secured unit.

On 02/06/2025 at approximately 10:45 a.m., Surveyor interviewed Caregiver C and asked about caring for residents with behaviors. Caregiver C described Resident 1 as a pretty challenging resident, and stated Resident 1 didn't seem appropriate for the facility. Caregiver C stated Resident 1 would beat on doors, yell at staff and become aggressive with caregivers during cares. Caregiver C stated s/he heard Resident 1 pinned a caregiver against the wall, but had no additional details for Surveyor. Caregiver C stated the only interventions s/he was aware of was taking Resident 1 on a walk to the facility's bistro or giving medications with soda.

On 02/06/2025 at approximately 11:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 10/21/2024 with diagnoses including early onset Alzheimer's disease. Resident 1's physician assessment, dated 09/26/2024, indicated s/he had a history of agitation, confusion, was argumentative and agitated toward family, had been neglecting him/herself and had a history of paranoia. Resident 1's individual service plan (ISP), dated 10/21/2024, did not address behavioral concerns. Resident 1's progress notes, dated 10/21/2024 to 12/06/204, documented the following behavioral concerns:

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	0018236	A. BUILDING: _____ B. WING _____	C 02/17/2025

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 433	Continued From page 13 - Progress Note, 10/22/2024: Resident is agitated and unable to be redirected. Resident is sounding door alarms. Resident is yelling at caregivers that s/he is being held prisoner. Resident struck caregiver several times. Family arrived to facility and assisted with deescalating behaviors. - Progress Note, 10/23/2024: Resident is agitated, exit seeking, verbally aggressive and threw water. - Incident report, dated 11/21/2024: "Resident yelling at another resident, caregiver intervened and got between them, resident attempted to hit caregiver, caregiver grabbed [his/her] wrists let go [sic], resident tried to hit caregiver lost balance and fell backwards." - Late Entry Progress Note, 11/21/2024: Resident approached another resident aggressively, caregiver tried to intervene. Resident attempted to hit caregiver; caregiver tried to stop him/her by grabbing Resident 1's wrists. Resident 1 tried to swing again, lost balance and fell. - Progress Note, 11/27/2025: Resident continues to frequently refuse scheduled and PRN medications unless crushed or hidden in food or drink. Resident becoming increasingly belligerent with other residents, staff and resident family members. Name calling, yelling, striking out at staff/residents. Throwing items, including beverages. Frequently exit seeking, banging on doors and setting off alarms. - Progress Note, 12/06/2025: Resident with behavior expressions throughout shift. Wandering, banging on doors, pushing on doors long enough for emergency opening, refusing to return to secured area. Required 1:1 staff all shift for safety. Administrator A made decision to send resident out for Resident 1's safety and the safety of staff/residents. 911 called. Resident 1's Medication Administration Record	N 433		

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N 433	Continued From page 14 (MAR), dated 10/18/2024 to 12/06/2025, documented the following physician orders: - Lexapro 10 mg 1 time daily for anxiety depression started on 10/25/2024. - Melatonin 5 mg 1 time daily for insomnia started on 10/24/2024. - Trazadone Hcl 50 mg 2 times daily as needed for anxiety or behavior expressions started on 10/31/2024 and was discontinued on 11/21/2024. Neither the MAR, nor the ISP documented a detailed description of behaviors that would have warranted the use of this PRN. - Trazadone Hcl 50 mg 2 times daily for anxiety disorder started on 11/20/2024. According to Drugs.com, Lexapro may take several weeks to start working and Trazadone may take up to 6 full weeks for the full benefit of medication to set in (Source: Drugs.com, How long does it take for Lexapro to work?, November 25, 2024, https://www.drugs.com/medical-answers/long-lexapro-work-3571757/ (retrieval date 02/12/2025).) and (Source: Drugs.com, How long does it take for trazadone to work, August 22, 2024, https://www.dr/ugs.com/medical-answers/long-trazodone-work-3561224/ (retrieval date 02/12/2025).). On 02/06/2025 at approximately 12:30 p.m., Surveyor interviewed Regional RN D. Surveyor reviewed Resident 1's documented behavioral concerns and Resident 1's 11/21/2024 incident report indicating a caregiver held Resident 1 by his/her wrists. Surveyor requested additional documentation related to Resident 1's behavior management, such as assessments or interventions, and asked if holding a resident or restraining a resident would be the proper	N 433		

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NEW PERSPECTIVE WAUKESHA	1701 E BROADWAY WAUKESHA, WI 53186

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intervention for aggressive behaviors. Regional RN D replied, "No." Regional RN D stated corrective action should have taken place with the caregiver involved with the 11/21/2024 incident; however, s/he was unable to locate any follow up. Regional RN D also stated s/he was unable to locate any documentation of behavior assessments or interventions trialed.

On 02/06/2025 at approximately 1:00 p.m., Surveyor interviewed Regional RN D and Director of Operations E regarding Resident 1's behavior management. Director of Operations E stated s/he worked onsite at the facility while Resident 1 resided at the facility and would have Resident 1 sit in his/her office with him/her as a behavior intervention. Neither Regional RN D, nor Director of Operations E were able to locate documentation of an assessment and/or alternate interventions trialed to manage Resident 1's behaviors and requested that Administrator A follow up with Surveyor upon his/her return to the facility on 02/10/2025.

On 02/10/2025 at approximately 2:00 p.m., Administrator A followed up with Surveyor and stated s/he had no additional information regarding Resident 1's behavior management or the 11/21/2024 incident when Resident 1's wrists were held by a caregiver to intervene on an altercation. Administrator A stated, "Staff providing 1:1 was the only successful intervention. [Resident 1] was not redirectable using tea (drink of choice), activities, or dining. [S/he] did not enjoy being around most caregivers or other residents."

On 02/17/2025 at approximately 12:00 p.m., Surveyor followed up with Administrator A to review concerns that the provider did not manage

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N 433	Continued From page 16 Resident 1's behaviors. Administrator A replied, "No doubt," in agreement with Surveyor. Administrator A explained that Resident 1's admission assessment was completed through a third party since Resident 1 had been residing out of state and that Resident 1 should not have been accepted for admission. Administrator A acknowledged the provider lacked documentation of assessments and interventions and stated that was an area s/he had identified that needed to be improved upon since recently joining the provider's facility. The provider, who accepted Resident 1 with a history of aggressive behaviors, did not manage his/her behaviors from 10/21/2024 to 12/06/2024. Resident 1 was hospitalized on 12/06/2024 due to his/her behaviors and discharged from the hospital to a different CBRF.	N 433		