STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 000	INITIAL COMMENTS On 04/28/2026, with information obtained through 05/08/2026, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation and standard licensing survey at New Perspective Waukesha, a certified residential care apartment complex (RCAC) located in Waukesha, WI. As a result of the survey, 1 deficiency was identified. The complaint was substantiated. Census: 43	U 000		
U 267	89.34(16) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (16) MEDICATIONS. Except as provided for in the service agreement, to have the facility not interfere with the tenant's ability to manage his or her own medications or, when the facility is managing the medications, to receive all prescribed medications in the dosage and at the intervals prescribed by the tenant's physician and to refuse medication unless there is a court order.	U 267		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
U 267	Continued From page 1	U 267		

This Rule is not met as evidenced by:
Based on record review, observation, and interview, the provider did not ensure that 2 of 3 tenants reviewed received all prescribed medications in the dosage and at the intervals prescribed by their physicians.

Findings include:

On 04/28/2026, Surveyor conducted a complaint investigation into an allegation that tenant medications were not being administered as prescribed.

Example 1 - Tenant 1's polyethylene glycol

On 04/28/2026, at approximately 2:00 p.m., Surveyor observed the third-floor medication carts with Care Team Shift Lead C. Surveyor observed 1 container of polyethylene glycol powder prescribed to Tenant 1 located in the cart. The prescription label identified that the container was dispensed on 11/28/2025 and contained instructions to, "Mix 17 [grams] in 4-8 ounces of juice or water and take by mouth once daily," (Photo 1). The manufacturer's label on the container identified that the container contained 238 grams of powder, or "14 once-daily doses." A handwritten annotation on the container in marker indicated an open date of 03/04/2026 (Photo 2). Surveyor opened the container and observed that it appeared to be approximately one-third full. Surveyor did not observe any other polyethylene glycol containers in the medication cart prescribed to Tenant 1.

On 04/28/2026, Surveyor reviewed Tenant 1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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U 267	Continued From page 2	U 267		

record. Tenant 1 was admitted to the provider on 01/29/2024. Tenant 1 was documented as having an activated power of attorney (POA) for healthcare. Tenant 1's service agreement, dated 10/16/2025, indicated that staff administered his/her medication. Tenant 1's prescriptions included polyethylene glycol, active as of 10/22/2025, with the same prescription instructions as on the container observed by Surveyor. Surveyor reviewed Tenant 1's medication administration record (MAR) from 03/01/2026 - 04/28/2026. From 03/05/2026, the day after it was indicated that Tenant 1's polyethylene glycol container was opened/started, through 04/28/2026, staff documented 47 administrations of Tenant 1's polyethylene glycol.

Surveyor noted that 47 administrations of polyethylene glycol, as documented in Tenant 1's MAR was inconsistent with the container containing only 14 once-daily doses and having still been observed approximately one-third full as observed earlier.

At approximately 3:30 p.m., Surveyor interviewed Administrator A and Health and Wellness Director B. Both acknowledged Surveyor's concern that Tenant 1's documented polyethylene glycol administration was inconsistent with the observed on-hand amount.

On 05/07/2026, at approximately 1:56 p.m., Surveyor interviewed Pharmacist E from the pharmacy that dispensed Tenant 1's medications. Pharmacist E reported that prior to 04/28/2026 (when Surveyor was onsite), the most recent deliveries of Tenant 1's polyethylene glycol, all in 238-gram containers (the same size as observed by Surveyor onsite), were 11/01/2025, 11/15/2025, 11/29/2025, 12/13/2025, 12/27/2025,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 3	U 267		

and 01/10/2026. Pharmacist E also confirmed the container dispense dates, which were identified as the dates prior to each delivery.

In reviewing Tenant 1's MARs from 11/01/2025 through 04/28/2026, staff initialed off on having administered 143 doses of Tenant 1's polyethylene glycol. Surveyor noted that when administered as prescribed, 143 doses would have indicated that approximately 10.2 bottles of Tenant 1's polyethylene glycol would have been used. Surveyor noted that this was generally inconsistent with 6 containers having been dispensed since 11/01/2025, including the one dispensed on 11/28/2025 which was observed by Surveyor onsite to be approximately one-third full.

On 05/08/2026, at approximately 1:30 p.m., Surveyor interviewed Administrator A and Health and Wellness Director B again. Both acknowledged Surveyor's concern that Tenant 1's documented polyethylene glycol administration was inconsistent with the observed on-hand amount and had no further questions.

Example 2 - Tenant 2's mirtazapine administration

On 04/28/2026, at approximately 12:20 p.m., Surveyor interviewed Tenant 2. Upon entering Tenant 2's apartment, Surveyor observed a sign at the entrance of his/her apartment indicating that video recording was taking place within his/her apartment. Tenant 2 reported that there had been a previous issue with the administration of /hisher nighttime medication.

At approximately 1:37 p.m., Surveyor interviewed Health and Wellness Director B. Health and Wellness Director B reported that there had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 4	U 267		

care concerns discussed between him/herself and Tenant 2's family about Tenant 2's care. Health and Wellness Director B reported s/he had e-mails in which some of these discussions took place. Health and Wellness Director B reported there was a nighttime medication prescribed to Tenant 2, mirtazapine, that was supposed to be administered at bedtime. Health and Wellness Director B reported that Tenant 2's prescriber later clarified that Tenant 2's mirtazapine was to be administered at 8:00 p.m., which was also the understanding of Tenant 2's family. Health and Wellness Director B reported that s/he explained to Tenant 2's family that the medication administration could occur in a 1-hour window surrounding 8:00 p.m. such that it could be administered anytime between 7:00 p.m. and 9:00 p.m.

On 04/28/2026, Surveyor reviewed Tenant 2's record. Tenant 2 was admitted to the provider on 06/13/2025. Tenant 2 was documented as having an activated power of attorney for healthcare. Tenant 2's service agreement dated 06/15/2025 indicated that staff managed and administered Tenant 2's medications. Surveyor reviewed Tenant 2's prescribed medications and medication administration records (MARs) from 03/01/2026 - 04/28/2026 and observed that Tenant 2 was prescribed 1 nighttime medication - mirtazapine 7.5 mg tablets with a start date of 03/28/2026. The instructions in Tenant 2's MAR documented, "Take 1 tablet by mouth at bedtime for sleep/mood" and the scheduled time in the MAR was set for 8:00 p.m. However, the prescription itself from Tenant 2's medical provider contained directions to, "Take 1 tablet (7.5 mg total) by mouth nightly. For sleep and mood. Please bring to [Tenant 2] at 8pm." Surveyor observed the following from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 5	U 267		

documented administrations of Tenant 2's mirtazapine from his/her MAR:

- 04/03/2026: Signed as given at 7:02 p.m.
- 04/04/2026: Signed as given at 7:15 p.m.
- 04/12/2026: Signed as given at 7:12 p.m.
- 04/14/2026: Signed as given at 7:17 p.m.

Surveyor then reviewed e-mail exchanges between Health and Wellness Director B, Registered Nurse (RN) F, Care Team Manager G, Family Member H, and Power of Attorney for Healthcare (POA) I, who was activated. The e-mails showed the following:

- E-mail from POA I to RN F, with Health and Wellness Director B and Family Member H carbon copied, sent 04/05/2026 (10:25 p.m.): " ...The doctor ordered [Tenant 2]'s night med to be given at 8pm. The doctor prescribed it as a sleep aid for [Tenant 2]. It has not been given at the appropriate time. Please explain ..."

- E-mail reply from Health and Wellness Director B to the group, sent 04/06/2026 (11:42 a.m.): " ...With our medication pass, the med passer can give the medication within a [sic] hour time frame which means 7pm -9pm. Since [Tenant 2] likes to go to bed early it was always advised to give before 7:30pm."

- E-mail reply from Family Member H just to Health and Wellness Director B, sent 04/06/2026 (12:30 p.m.): " ...The doctor talked to [Tenant 2] about staying up later. I understand what you are saying, but if the medication is given too early, [s/he] will not sleep the whole night. [Tenant 2] has been doing a whole lot better with staying up later. The whole purpose of the medication is to help [him/her] sleep during the night. They began

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 6	U 267		

giving [him/her] the medication on 3/31 at 7:27 pm, 4/1 at 7:49. Those times worked well because [s/he] was able to sleep the whole night for the first time in a long time. On 4/2 is when the meds started being given to [him/her] not within those time frames. On 4/2 it was 5:56 pm, 4/3 it was 6:49 pm, 4/4 it was 5:40 pm, 4/5 it was 6:20 pm. Now [s/he] has started getting up at 9:00 and 10:00 pm again. These times are not within the timeframe you stated. This is the same problem we had when [s/he] was taking pm meds before. We were truly hoping that this time around would be better. We told the doctor about this problem with [New Perspective (NP)] giving night medications, but [s/he] felt if [s/he] wrote a specific time NP would understand its [sic] more for sleeping and give it to [him/her] on the later end of giving meds. How can we all get on the same page about the timeframe of giving this medication?..."

- E-mail reply from Health and Wellness Director B to Family Member H, with POA I added back in the message and Care Team Manager G blind carbon copied, sent 04/06/2026 (3:15 p.m.): "I want to start off I am going to respond to [POA I]'s email ...I have the staff documenting that they are giving it at 7pm- 8pm. I have to go off what the staff has documented. Thank you for letting me know and I will talk to the staff about closer to 8pm."

At approximately 3:30 p.m., Surveyor interviewed Administrator A and Health and Wellness Director B. When asked how medications were signed out, Health and Wellness Director B reported that staff click in the provider's electronic record system that they administered the medication after the medication was administered to the tenant. When reviewing the applicable regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 7	U 267		

related to medication administration, Wis. Admin Code § DHS 89.34(16) with them, Health and Wellness Director B reported that s/he believed it was standard for staff to have a 1-hour window to administer medications. When reviewing the e-mail exchanges above with Health and Wellness Director B, s/he replied that there was no other reply or electronic correspondence regarding Tenant 2's nighttime medication concern with his/her family.

On 05/01/2026, at approximately 8:37 a.m., Surveyor interviewed Family Member H. Family Member H confirmed there was a camera in Tenant 2's room. Family Member H reported s/he had video footage of 4 dates - 04/02/2026, 04/03/2026, 04/04/2026, and 04/05/2026 - in which s/he observed staff administering Tenant 2's nighttime medication outside of its 8:00 p.m. prescription time and even outside the 1-hour window that Health and Wellness Director B reported to him/her that staff were administering it.

On 05/07/2026, Surveyor reviewed video footage, provided by Family Member H. The videos were provided in screen recording format, which showed the videos being played from the third-party surveillance company's smart phone application connected to the camera in Tenant 2's apartment and showed the date and timestamps of the recordings from the company's application. The videos were also provided as standalone media files, which allowed Surveyor to view the continuity of each recording, and 2 of the videos were provided as links from the third-party company's online video storage library. Surveyor observed that the screen recordings and standalone video clips corroborated with each other and showed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 8 - Video dated 04/02/2026 (5:56 p.m.): A caregiver later identified to be Caregiver D walked towards Tenant 2 holding a small cup, consistent in appearance with a medication cup, and a clear cup with a clear liquid, consistent in appearance with water. Caregiver D greeted Tenant 2, who was sitting in his/her recliner. Caregiver D handed Tenant 2 the small cup. Tenant 2 appeared to empty the small cup's content into his/her left hand and use his/her right hand to grab the content from his/her left hand and put it in his/her mouth. Caregiver D observed this process before walking away. - Video dated 04/03/2026 (6:49 p.m.): Care Team Shift Lead C, identified by Surveyor from an earlier onsite interview, entered Tenant 2's apartment. Care Team Shift Lead C greeted Tenant 2, who was sitting in his/her recliner, and walked over to him/her holding a clear cup with a clear liquid, consistent in appearance with water. Care Team Shift Lead C then handed Tenant 2 a smaller item. Tenant 2 was observed to move his/her right arm in a manner consistent in appearance with putting something from his/her hand into/towards his/her mouth. Tenant 2 then took the liquid cup from Care Team Shift Lead C. Care Team Shift Lead C observed this process before walking away. - Video dated 04/04/2026 (5:40 p.m.): A caregiver later identified to be Caregiver D entered Tenant 2's apartment and greeted him/her. Caregiver D then walked towards Tenant 2 holding a small cup, consistent in appearance with a medication cup, and a clear cup with a clear liquid, consistent in appearance with water. Tenant 2 was sitting in his/her recliner. Caregiver D then handed Tenant 2 the small cup. Tenant 2 appeared to empty the	U 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 9	U 267		

small cup's content into his/her left hand and then use his/her right hand to move the content into/towards his/her mouth. Afterwards, Caregiver D handed Tenant 2 the liquid cup. Caregiver D observed this process before walking away.

- Video dated 04/05/2026 (6:20 p.m.): A caregiver later identified to be Caregiver D entered Tenant 2's apartment and greeted him/her. Caregiver D then walked towards Tenant 2 holding a small cup, consistent in appearance with a medication cup, and a clear cup with a clear liquid, consistent in appearance with water. Tenant 2 was sitting in his/her recliner. Caregiver D then handed Tenant 2 the small cup. After a couple of moments of watching Tenant 2, whose back was largely to the camera, Caregiver D then handed Tenant 2 the liquid cup. Caregiver D then walked away and conducted other tasks.

Surveyor observed that each of these interactions from the video recordings, consistent in activity with the administration of Tenant 2's mirtazapine, which was his/her only evening or bedtime medication, was consistent with the mirtazapine administration times reported by Family Member H in his/her e-mail to Health and Wellness Director B, detailed above. In synthesizing the information from the e-mail exchange, MAR, and video footage, Surveyor noted the following regarding Tenant 2's mirtazapine:

- 04/02/2026: Video footage showed administration at 5:56 p.m., Caregiver D documented administering it at 7:49 p.m.

- 04/03/2026: Video footage showed administration at 6:49 p.m., Care Team Shift Lead C documented administering it at 7:02 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
U 267	Continued From page 10	U 267		

- 04/04/2026: Video footage showed administration at 5:40 p.m., Caregiver D documented administering it at 7:15 p.m.

- 04/05/2026: Video footage showed administration at 6:20 p.m., Caregiver D documented administering it at 7:26 p.m.

On 05/08/2026, at approximately 10:00 a.m., Surveyor interviewed Family Member H. Family Member H reported that Tenant 2's camera recording was triggered by motion, activity, or sound. During the interview, Family Member H showed Surveyor the third-party surveillance company's application on his/her smart phone, which was where s/he reported s/he could observe the video recordings from the camera in Tenant 2's apartment. Surveyor verified that the time zone within Family Member H's account in the application was set to the central time zone consistent with where Tenant 2's apartment within the provider's facility was located. Surveyor then observed as Family Member H pulled up each of the video clips from the above dates/times through the third-party application on his/her smart phone. Surveyor verified that the dates/times and video contents corroborated the video clips sent and reviewed earlier.

As part of the interview, Family Member H reported s/he had provided these specific medication administration dates/times to Health and Wellness Director B and was frustrated by the e-mail response back in which Health and Wellness Director B seemed to him/her to be relying on staff's report over the administration times Family Member H reported. Family Member H reported s/he was tired of arguing with the provider's staff about what staff reported/documented in terms of services/cares

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 11	U 267		

Tenant 2 received versus what s/he was able to see from Tenant 2's camera.

As part of the same interview, Family Member H reported that Tenant 2's mirtazapine was prescribed to help Tenant 2 sleep. Family Member H reported Tenant 2's sleep concerns initially came up a couple of months ago when Tenant 2's family discussed them with his/her medical provider. Family Member H reported the concern was that Tenant 2 would go to bed early sometimes, like 5:00 p.m. or 6:00 p.m. in the evening, awake at 11:00 p.m. or 12:00 a.m., and then stay up most or all of the remaining night. Family Member H reported that there was also a concern that overall Tenant 2 was sleeping less and less. Family Member H reported that it was thought that these sleep disruptions could be contributing to newly-emerged cognitive/memory concerns for Tenant 2, including him/her not being oriented to day/time and not being able to follow conversations appropriately. Family Member H reported that Tenant 2's medical provider said that a sleeping pill would help Tenant 2. Family Member H reported that Tenant 2's family was initially reluctant to start the medication due to the fear of staff not administering the medication when it was supposed to be administered. Family Member H reported that when discussing this concern with Tenant 2's medical provider, the medical provider offered to write the order for the medication to be given specifically at 8:00 p.m., as this seemed to be a reasonable goal time for Tenant 2 to aim to stay up until.

As part of the same interview, Family Member H reported s/he recalled having an in-person conversation with Health and Wellness Director B where s/he discussed his/her concern that Tenant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018219	A. BUILDING: _____ B. WING _____	C 05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE WAUKESHA	1701 EAST 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
U 267	Continued From page 12 2's mirtazapine was not being administered at 8:00 p.m. Family Member H reported that Health and Wellness Director B had told him/her that staff had a 1-hour window on either side of 8:00 p.m. to administer Tenant 2's medications. Family Member H reported that the administration of Tenant 2's mirtazapine at 8:00 p.m. was an ongoing issue. At approximately 1:30 p.m., Surveyor interviewed Administrator A and Health and Wellness Director B. When asked if any additional conversation took place regarding the times Family Member H reported of Tenant 2's mirtazapine administrations, Health and Wellness Director B reported s/he believed s/he had further follow-up conversation with POA I but did not receive any other follow up information from him/her. Administrator A reported it was believed they could not prove the timestamp accuracy of the videos from Tenant 2's family but that an investigation would now be started into the medication administration process, given the discrepancy between the video timestamps and the documented administration times from staff.	U 267		