STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013514	A. BUILDING: _____ B. WING _____	R-C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE SUPERIOR	1915 N 34TH ST SUPERIOR, WI 54880

(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 On 12/13/2024, Surveyor conducted a complaint investigation and verification visit at New Perspective Superior. Data was collected through 12/17/2024. Two violations were identified. One of 2 violations was a repeat deficiency. See Statement of Deficiencies (SOD) MIBP13, dated 07/03/2024 and MIBP12, dated 08/03/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 29	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 immediately notify Resident 1's legal representative when Resident 1 fell on 10/28/2024 and 10/29/2024, or when s/he had a change of condition on 10/29/2024. Findings include:	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 11/20/2024, the Department received a complaint related to the provider's communication with legal representatives. On 12/13/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 04/12/2023, with diagnoses that included congestive heart failure and Lewy Body dementia. Resident 1 had an activated healthcare power of attorney (POA), POA B. Resident 1's record included the following incident reports: - 10/28/2024 at 11:00 PM, Resident 1 had an unwitnessed fall in his/her room. Resident 1 reported pain in his/her knees. The provider notified POA B on 10/29/2024 at noon. - 10/29/2024 at 5:15 AM, Resident 1 had an unwitnessed fall in his/her room. Resident 1 was found with a skin tear and rug burn on his/her abdomen and elbow. The provider notified POA B on 10/29/2024 at noon. A progress note dated 10/29/2024 at 8:54 AM, indicated staff contacted the provider's triage nurse on 10/29/2024 at 7:46 AM, to report a change in condition. The note read, "Resident with increased blood pressure 204/151, pulse 125 and demonstrates increased anxiety. Resident has had increasing anxiety. Administer anxiety medications per eMAR (electronic medication administration record). Hospice notified and will make visit today... Community nurse to make other notifications." Resident 1's record did not indicate POA B was notified of this change in condition. On 12/13/2024 at 1:50 PM, Surveyor interviewed Executive Director (ED) A. ED A stated the provider's nurses were responsible for notifying	N 169		

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N 169	Continued From page 2 legal representatives when there was an incident. ED A stated the provider had onsite nurses Monday through Friday during normal business hours and triage nurses available outside normal business hours. ED A stated triage nurses were expected to notify legal representatives when they received a call from staff. On 12/13/2024 at 2:15 PM, Surveyor interviewed Licensed Practical Nurse (LPN) C. Surveyor asked if there was a reason POA B was not notified immediately when Resident 1 experienced a fall on 10/28/2024, 10/29/2024, and a change on 10/29/2024. POA B reviewed Resident 1's record and stated triage should have notified POA B immediately when they took the calls from staff. On 12/17/2024 at 9:06 AM, Surveyor interviewed Health and Wellness Director (HWD) D. HWD D reviewed the provider's written policies on notifications and stated the policies did not specify how soon after an incident that the provider needed to notify legal representatives but s/he expected notices to occur within 24 hours. HWD D stated the provider was not responsible to notify POA B but they tried to contact POA B as a courtesy. HWD D stated when hospice was involved, as they were with Resident 1, the provider was only responsible to notify hospice and hospice would notify the legal representatives.	N 169		
{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	{N 239}		

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{N 239}	Continued From page 3 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Caregiver E completed fire safety and first aid and choking training within 90 days of hire. This is a repeat violation. See Statement of Deficiencies (SOD) MIBP13, dated 07/03/2024 and MIBP12, dated 08/03/2023. Findings include: On 12/13/2024, Surveyor reviewed Caregiver E's training file and the Wisconsin Community-Based Care and Treatment Training Registry record. Caregiver E was hired on 08/21/2024. Caregiver	{N 239}		

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{N 239}	Continued From page 4 E's training file and the Registry record indicated s/he had not completed the Department-approved fire safety course or first aid and choking course. On 12/13/2024 at 2:05 PM, Surveyor interviewed Executive Director (ED) A. ED A stated s/he was unsure why Caregiver E had not completed these courses. ED A stated Care Team Manager (CTM) F was responsible for ensuring staff were adequately trained. ED A provided Surveyor with a copy of the provider's written plan of correction from the previous survey (SOD MIBP13) that read, "Going forward, Community will document CBRF (community based residential facility) sign-up (name) and track sign-up. Nursing completes Care Skills which includes standard precautions and first [sic] and choking before working with residents." On 12/17/2024 at 11:58 AM, Surveyor interviewed CTM F. CTM F voiced frustration that s/he was placed in his/her role on 10/07/2024 and had yet to receive training on the provider's training systems. CTM F stated s/he was unsure what the Department-approved courses were or how to get staff to complete them. CTM F stated s/he was unaware Caregiver E had not completed training requirements. Surveyor asked if Caregiver E had any training exemptions and CTM F stated, "I don't believe so."	{N 239}		