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 08/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

(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 08/25/2026, Surveyor conducted a complaint investigation at New Perspective Sun Prairie, a CBRF located in Sun Prairie, WI. As a result of the investigation, 1 violation of Chapter DHS 83 was issued. The complaint was substantiated.	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not provide prompt and adequate treatment for Resident 1. Resident 1 was left outside in 84-88 degree Fahrenheit (F) heat with heat index of 100 degrees for at least 1 hour and did not get treatment for over 5 hours. Findings include: On 08/10/2026, the Department received a complaint that on 07/26/2026, Resident 1 was taken to the outside courtyard around lunch time. Resident 1 was found slumped over in his/her chair around 3:30 PM. Staff called Health and Wellness Director A (HWD-A) at approximately 4:46 PM and reported Resident 1 was lethargic. HWD-A instructed staff to get Resident 1 to a cool room and monitor. Staff reported back to HWD-A at approximately 5:04 PM that Resident 1 was	N 353		

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

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now shivering and more lethargic. Hospice was notified and staff were told to monitor. Staff reported to HWD-A at 6:17 PM that Resident 1 was unresponsive and had been lowered to the floor to prevent a fall. Hospice called at 6:26 PM. Emergency services were called at 7:26 PM and Resident 1 was transported to the hospital and admitted with diagnoses of: dehydration, pneumonia and heat exhaustion.

According to weather.com, the high temperature on 07/26/2026 in Sun Prairie, WI was 91 degrees Fahrenheit with a heat index of 100 degrees Fahrenheit.

On 08/26/2026 at 9:00 AM, Surveyor observed the courtyard where Resident 1 was found. The courtyard is an outside space with no exits leading away from the facility. There is no area that offers shade in the courtyard.

On 08/26/2026 at 9:00 AM, Surveyor reviewed Resident 1's medical record. Resident 1 is an advanced age resident with diagnoses that include but are not limited to: anxiety, chronic kidney disease stage 3, dementia, insomnia, mild cognitive impairment.

According to facility documentation, PM staff (not identified), who had arrived on duty at 2:00 PM, notified HWD-A at 4:46 PM that staff had found Resident 1 in the courtyard slumped in his/her chair and brought him/her inside around 3:30 PM.

DOCUMENTATION

On 08/26/2026 at 9:15 AM, Surveyor reviewed facility documentation regarding Resident 1 being left in the courtyard. HWD-A indicated that Resident 1 was taken outside to the facility

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courtyard by staff at an undetermined time. HWD-A documented on 07/26/2026 that s/he had been notified by staff on 07/26/2026 at 4:46 PM that resident had been outside in the courtyard for an undetermined amount of time and became lethargic. HWD-A stated s/he instructed staff to bring Resident 1 to a cool room and place a cool compress on his/her forehead and underarms. HWD-A wrote that staff called again at 5:04 that Resident 1 was not responding to caregiver interaction and was shivering. Hospice called and staff instructed to continue to monitor. Hospice did not make a visit or an assessment at that time. HWD-A wrote that at 06:17 PM, Staff called to report that Resident 1 had become unresponsive and worsened. Resident was sliding out of his/her chair so caregivers lowered Resident 1 to the floor. Hospice informed. Hospice Nurse B arrived at 7:10 PM, made an assessment and Resident 1 was transported to the hospital.

On 08/27/2026 at 8:48 AM, HWD-A sent Surveyor an email with Hospice Nurse B's documentation regarding Resident 1 being in the courtyard.

According to Hospice Nurse B documentation, on 07/26/2026 at 11:31 PM, Hospice Nurse B documented that s/he arrived at the facility on 07/26/2026 at 7:10 PM and assessed Resident 1. Resident 1 was described as sweating and warm to the touch, wearing black sweat pants and a black long sleeve shirt. Hospice Nurse B documented that s/he was told by staff that staff had arrived for duty at 2:00 PM and Resident 1 was seated in the courtyard at that time. Staff could not determine how long Resident 1 had been outside. Hospice Nurse B documented that a nearby resident (not identified) stated that Resident 1 had been outside prior to lunch (12:00

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PM). Hospice Nurse B documented that staff stated they brought Resident 1 inside around 3:30 PM due to Resident 1 being unresponsive and slouched in his/her chair. Hospice Nurse B documented that s/he called Emergency Medical Services)EMS) at 7:26 PM. Resident 1 was admitted 11:11 PM with diagnoses of: dehydration, pneumonia and heat exhaustion.

INTERVIEW

On 08/26/2026 at 10:00 AM, Surveyor interviewed HWD-A. HWD- A stated that staff had reported that Resident 1 was outside for less than 1 hour, but exact time was not determined. Surveyor stated that complaint indicated that Resident 1 was taken to courtyard around lunchtime (12:00 PM) and was found slumped over in his/her chair around 3:30 PM. HWD-A stated that Resident 1 would not miss lunch but could not say that Resident 1 was NOT in courtyard for that amount of time. HWD-A stated that s/he was called on 07/26/2026 at 4:46 PM and staff reported Resident 1's condition. Surveyor asked HWD-A if anyone conducted an assessment of Resident 1 at this time. HWD-A stated, "No, it was a weekend and nursing services are not on duty, staff are to call me with concerns." HWD-A stated s/he directed staff to bring Resident 1 to a cool room and put cool compresses on her. HWD-A reported that staff called back around 5:04 PM to report that Resident 1's condition had worsened and that s/he was not responding to staff interaction and was shivering. HWD-A stated s/he called Hospice and was told to continue to monitor. HWD-A stated that staff called around 6:17 PM that Resident 1 was now unresponsive. HWD-A called Hospice to request a Hospice RN visit. HWD-A stated that Hospice called emergency

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services around 7:26 PM and Resident 1 was transported to the hospital emergency room and admitted at 11:10 PM with diagnoses of dehydration, pneumonia and heat exhaustion. Surveyor asked if anyone at facility conducted an assessment of Resident 1? HWD-A stated, "It was a weekend, there are no nursing services on duty on weekends. They are to call me and I inform Hospice if necessary." Surveyor asked HWD-A why s/he did not make the decision to send Resident 1 to the hospital sooner? HWD-A stated, "It is my understanding that we are not allowed to do that without Hospice permission." Surveyor explained that in emergent scenarios, facility can and should make the decision to send residents to the hospital.

08/27/2026- ADDITIONAL INFORMATION PROVIDED BY HWD-A

On 08/27/2026 at 8:48 AM, HWD-A sent Surveyor an email. HWD-A stated, "I would like to clarify that the information provided to me by the caregivers during their call differed from the information later communicated to the Hospice Nurse. HWD-A stated that the time that Resident 1 was in the courtyard was now undetermined, not 1 hour as previously stated.

SUMMARY:

On 07/26/2026, Resident 1 was taken to the outside courtyard AM staff and was brought back inside the facility by PM staff at 3:30 PM when s/he was found slumped over in his/her chair. HWD-A was informed at 4:46 PM and called Hospice at 5:04 PM and was told to monitor. Resident 1 was unresponsive as of 6:17 PM. HWD-A called Hospice again and Hospice Nurse

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N 353	Continued From page 5 arrived at 7:10 PM. EMS was called at 7:26 PM. Resident 1 was admitted to the hospital on 07/26/2026 at 11;10 PM with diagnoses of dehydration, pneumonia and heat exhaustion.	N 353		