

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2024
NAME OF PROVIDER OR SUPPLIER  Newcastle Place		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 N Port Washington Rd #300 Mequon, WI 53092	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48794</b></p> <p>Based on staff interview and record review, the facility did not ensure 1 resident (R) (R7) of 11 sampled residents was free from abuse.</p> <p>The facility did not ensure interventions were implemented after staff members voiced concerns regarding Certified Nursing Assistant (CNA)-E's interactions with residents on 2/27/24. On 3/13/24, the facility submitted a facility- reported incident (FRI) regarding an allegation of abuse that identified CNA-E as the accused staff member.</p> <p>Findings include:</p> <p>The facility's Resident Abuse/Neglect/Exploitation and Reporting Requirements policy, with a review date of 9/8/22, indicates it is the policy of the facility to provide a safe environment free from all types of resident abuse, by all persons, including team members. The policy indicates team members will receive training on freedom of abuse at time of hire, annually, and on an as needed basis.</p> <p>On 4/23/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI), muscle weakness, and non-pressure chronic area of lower legs. R5's Minimum Data Set (MDS) assessment, dated 2/27/24, contained a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R5 had moderate cognitive impairment. R5 was discharged from the facility on 3/7/24.</p> <p>On 4/23/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (a syndrome that results from the death of muscle fibers and release of their contents into the bloodstream that can lead to complications including kidney failure), weakness, and a history of falls. R6's MDS assessment, dated 2/13/24, contained a BIMS score of 15 out of 15 which indicated R6 had intact cognition.</p> <p>On 4/23/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] with diagnoses including weakness, insomnia, major depression, unspecified, and anxiety disorder, unspecified. R7's MDS assessment, dated 3/12/24, contained a BIMS score of 11 out of 15 which indicated R7 had moderate cognitive impairment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/23/24, Surveyor reviewed two FRIs that indicated on 2/27/24, R5 and R6 reported allegations of abuse to staff. The investigations indicated other staff were interviewed on 2/27/24 and asked: Are you aware of any other staff member speaking rudely or unkind to you or any resident on this unit? The interviews indicated two Licensed Practical Nurses (LPNs) answered CNA-E. Surveyor noted CNA-E was not named in R5 and R6's allegations on 2/27/24.</p> <p>On 4/23/24, Surveyor reviewed the facility's nursing schedule between 2/26/24 and 3/7/24. Surveyor noted CNA-E was scheduled for the following PM shifts: 2/27/24, 2/28/24, 2/29/24, 3/1/24, 3/4/24, 3/5/24, and 3/6/24.</p> <p>On 4/23/24, Surveyor reviewed a FRI that indicated on 3/6/24 between 6:30 AM and 6:45 AM, staff reported R7 had new bruising on the right lateral thigh and left thigh. The investigation indicated R7 reported on 3/5/24 at 9:30 PM that staff assisted R7 with cares and threw R7 around in bed. As a result of R7's description of the CNA, the nursing schedule, and staff and resident interviews, the facility identified the individual as CNA-E.</p> <p>On 4/23/24 at 1:20 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the facility received concerns from staff that CNA-E was rude and short with residents. DON-B stated the Assistant Director of Nursing (ADON) spoke with CNA-E and provided verbal education. The facility could not provide documentation that verbal education was provided to CNA-E prior to the incident with R7 on 3/5/24.</p> <p>On 4/23/24 at 1:42 PM, Surveyor interviewed DON-B and requested investigation documentation after the facility was made aware of staffs' concerns about CNA-E on 2/27/24. The facility could not provide documentation of a thorough investigation of the concerns. CNA-E was terminated from the facility on 3/14/24 due to the incident on 3/7/24.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43361</p> <p>Based on staff interview and record review, the facility did not ensure allegations of abuse were reported timely to the State Agency (SA) or local law enforcement for 5 residents (R) (R5, R6, R7, R3, and R4) of 8 sampled residents.</p> <p>On 2/27/24, R5 and R6 reported allegations of abuse. The facility did not report the allegations of abuse to the SA in a timely manner.</p> <p>On 3/6/24 between 6:30 AM and 6:45 AM, R7 reported an allegation of abuse with injury. The initial report was not submitted to the SA until 3/7/24 at 1:48 PM.</p> <p>On 3/28/24, the facility discovered R3 had a dislocation of the right humerus head. The facility did not report the injury of unknown origin to the SA in a timely manner.</p> <p>On 2/25/24, R4 reported an allegation of abuse. The facility did not report the allegation of abuse to the SA in a timely manner and did not notify local law enforcement.</p> <p>Findings include:</p> <p>The facility's Resident Abuse/Neglect/Exploitation and Reporting Requirements policy, with a review date of 9/8/22, indicates: Team members are required to report suspicion that a crime has been committed against a resident to the local law enforcement agency, state survey agency .Identification and Investigation: Community Abuse and/or Neglect Designee: Report allegations as defined by the federal/state regulatory agency. Telephone numbers and email addresses are located in the community. Reporting Requirements for Abuse, Neglect, Exploitation, Misappropriation, or Reasonable Suspicion of a Crime: If a covered individual reasonably suspects that a crime has occurred against a resident or person receiving care in the facility, the individual must report the suspicion to the Abuse and/or Neglect Coordinator and follow the federal/state regulations. If the suspected crime involves serious bodily injury, the incident must be reported within 2 hours, and in all instances, a report will be made to the appropriate state agency within 24 hours or as defined by state regulations. If the incident does not involve serious bodily injury, it must be reported within 24 hours. The results of abuse investigations must be reported .to the state survey agency within 5 working days of the alleged incident.</p> <p>1. On 4/23/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI), muscle weakness, and non-pressure chronic area of lower legs. R5's Minimum Data Set (MDS) assessment, dated 2/27/24, contained a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R5 had moderate cognitive impairment. R5 was discharged from the facility on 3/7/24.</p> <p>On 2/27/24, R5 reported to staff that Certified Nursing Assistant (CNA)-C was rude and unkind during cares on the 2/26/24 PM shift. R5 indicated CNA-C stated if R5 had a problem with CNA-C, R5 should go to CNA-C. R5 stated CNA-C did not care for R5 and did not display a caring attitude. R5 also stated CNA-C took too long to toilet R5.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor reviewed a facility-reported incident (FRI) submitted to the SA regarding R5's allegation of abuse. Surveyor noted the initial report (due within 24 hours) was not submitted until 3/4/24 and the five-day investigation (due within 5 business days) was not submitted until 3/7/24.</p> <p>On 4/23/24 at 1:20 PM, Surveyor interviewed Director of Nursing (DON)-B who stated neither DON-B or Nursing Home Administrator (NHA)-A had access to the portal to submit FRIs to the SA until 3/7/24. DON-B indicated DON-B was not aware of the ability to fax or email concerns. In a subsequent interview on 4/23/24 at 1:42 PM, DON-B stated DON-B started as the interim Director of Nursing on 2/16/24.</p> <p>On 4/23/24 at 3:00 PM, Surveyor interviewed NHA-A who did not start at the facility until 3/4/24. NHA-A indicated NHA-A was aware the FRI regarding R5 was not submitted timely to the SA.</p> <p>2. On 4/23/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (a syndrome that results from the death of muscle fibers and release of their contents into the bloodstream that can lead to complications such as kidney failure), weakness, and history of falls. R6's MDS assessment, dated 2/13/24, contained a BIMS score of 15 out of 15 which indicated R6 had intact cognition.</p> <p>On 2/27/24, R6 reported to AM staff that CNA staff who worked the 2/26/24 PM shift were rude and slammed down items which made R6 feel uncomfortable. R6 did not indicate staff physically hurt R6, but stated R6 felt as though staff were going to kill R6. After further interview, R6 indicated CNA staff who worked the 2/26/24 PM shift got mad at R6 and became frustrated when R6 asked for care and dropped R6's call light on the floor.</p> <p>Surveyor reviewed a FRI submitted to the SA regarding R6's allegation of abuse. Surveyor noted the initial report was not submitted until 3/4/24 and the five day investigation was not submitted until 3/7/24.</p> <p>On 4/23/24 at 1:20 PM, Surveyor interviewed DON-B who stated neither DON-B or NHA-A had access to the portal to submit FRIs to the SA until 3/7/24. DON-B indicated DON-B was not aware of the ability to fax or email concerns.</p> <p>On 4/23/24 at 3:00 PM, Surveyor interviewed NHA-A who indicated NHA-A was aware the FRI regarding R6 was not submitted timely to the SA.</p> <p>48794</p> <p>3. On 4/23/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] with diagnoses including weakness, insomnia, major depression, unspecified, and anxiety disorder, unspecified. R7's MDS assessment, dated 3/12/24, contained a BIMS score of 11 out of 15 which indicated R7 had moderate cognitive impairment.</p> <p>On 3/6/24 between 6:30 AM and 6:45 AM, CNA staff reported R7 had new bruising on the right lateral thigh and left thigh. Staff stated R7 stated a CNA threw R7 around in bed the night prior. DON-B interviewed R7 on 3/6/24 at 8:20 AM. During the interview, R7 stated on the evening of 3/5/24, a CNA threw R7 around and the CNA was strong. R7 also stated a few days prior, R7 wanted to go to bed and was told by same CNA that it was too early to go to bed. R7 stated the same thing happened and R7 was thrown around in bed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Surveyor reviewed a FRI submitted to the SA and noted the initial report for R7's allegation of abuse was not submitted until 3/7/24 at 1:48 PM.</p> <p>On 4/23/24 at 1:20 PM, Surveyor interviewed DON-B who stated neither DON-B or NHA-A had access to the portal to submit FRIs to the SA until 3/7/24. DON-B indicated DON-B was not aware of the ability to fax or email concerns.</p> <p>32768</p> <p>4. On 4/23/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, neurocognitive disorder with Lewy bodies, aphasia (a language disorder that affects a person's ability to communicate), and hemiplegia (weakness on one side of the body).</p> <p>On 3/28/24, the facility discovered R3 had an injury to the right arm. R3 was sent to the Emergency Department (ED) and diagnosed with a right humerus head dislocation. The facility did not submit an initial report for the injury of unknown origin to the SA in a timely manner and did not submit the five day investigation until 4/4/24.</p> <p>On 4/23/24 at 1:20 PM, Surveyor interviewed DON-B who stated neither DON-B or NHA-A had access to the portal to submit FRIs to the SA until 3/7/24. DON-B indicated DON-B was not aware of the ability to fax or email concerns.</p> <p>On 4/23/24 at 3:00 PM, Surveyor interviewed NHA-A who indicated NHA-A was aware the FRI regarding R3 was not submitted timely to the SA.</p> <p>5. On 4/23/24, Surveyor reviewed R4's medical record. R4 was admitted to facility on 2/5/24 with diagnoses including compression fracture, difficulty walking, muscle weakness, and dysphagia (difficulty swallowing).</p> <p>On 2/25/24, R4 reported CNA-G was rough and rude with R4 on 2/24/24. The facility did not report the allegation of abuse to the SA within 24 hours, did not notify local law enforcement, and did not submit the five day investigation to the SA until 3/7/24.</p> <p>On 4/23/24 at 1:20 PM, Surveyor interviewed DON-B who stated neither DON-B or NHA-A had access to the portal to submit FRIs to the SA until 3/7/24. DON-B indicated DON-B was not aware of the ability to fax or email concerns. DON-B also verified the allegation of abuse was not reported to local law enforcement.</p> <p>On 4/23/24 at 3:00 PM, Surveyor interviewed NHA-A who indicated NHA-A was aware the FRI regarding R4 was not submitted timely to the SA.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43361</p> <p>Based on staff interview and record review, the facility did not ensure allegations of abuse were thoroughly investigated for 6 residents (R) (R5, R6, R8, R3, R4, and R2) of 8 sampled residents.</p> <p>R5 and R6 reported allegations of abuse on 2/27/24. The investigation did not include interviews with other residents. In addition, concerns with care provided by staff members identified through staff interviews were not thoroughly investigated.</p> <p>R8 reported an allegation of abuse on 3/13/24 that involved Certified Nursing Assistant (CNA)-H. The investigation did not include interviews with staff and other residents or a statement from CNA-H. In addition, CNA-H was not removed from resident care pending the outcome of the investigation.</p> <p>R3 had an unwitnessed injury to the right arm that resulted in a right humerus head dislocation that was discovered on 3/28/24. The investigation did not include a summary or cause of the injury.</p> <p>R4 reported an allegation of abuse on 2/25/24. The investigation did not include resident interviews or additional staff interviews. The investigation also did not include a summary or proof of staff education.</p> <p>R2 reported an allegation of abuse on 3/5/24. The investigation did not include interviews or assessments of other residents.</p> <p>Findings include:</p> <p>The facility's Resident Abuse/Neglect/Exploitation and Reporting Requirements policy, with a review date of 9/8/22, indicates: Any reports or suspicion of resident abuse and/or neglect will be fully investigated . Identification and Investigation: If the alleged perpetrator is on the premises of the community, obtain and witness, and place the team member on an unpaid suspension pending further investigation. Review any statements provided, interview any other staff and witnesses who have information, and document statements. Interview the alleged victim and document statements. Determine the action to be taken with team members ensuring safety and resident rights are maintained at all times.</p> <p>1. On 4/23/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI), muscle weakness, and non-pressure chronic area of lower legs. R5's Minimum Data Set (MDS) assessment, dated 2/27/24, contained a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R5 had moderate cognitive impairment. R5 was discharged from the facility on 3/7/24.</p> <p>On 2/27/24, R5 reported to staff that CNA-C was rude and unkind during cares on the 2/26/24 PM shift. R5 indicated CNA-C stated if R5 had a problem with CNA-C, R5 should go to CNA-C. R5 stated CNA-C did not care for R5 and did not display a caring attitude. R5 also stated CNA-C took too long to toilet R5.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 4/23/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (a syndrome that results from the death of muscle fibers and release of their contents into the bloodstream that can lead to serious complications such as kidney failure), weakness, and a history of falls. R6's MDS assessment, dated 2/13/24, contained a BIMS score of 15 out of 15 which indicated R6 had intact cognition.</p> <p>On 2/27/24, R6 reported to AM staff that CNA staff on the 2/26/24 PM shift were rude and slammed down items which made R6 feel uncomfortable. R6 did not indicate staff physically hurt R6, but stated R6 felt as though staff were going to kill R6. R6 also stated CNA staff who worked the 2/26/24 PM shift got mad at R6 and became frustrated when R6 asked for care and dropped R6's call light on the floor. The facility identified the staff as CNA-C and CNA-D.</p> <p>On 4/23/24, Surveyor reviewed facility-reported incidents (FRIs) submitted to the State Agency (SA) for R5 and R6's concerns in addition to paper files provided to Surveyor. Surveyor noted neither of the FRIs contained interviews with other residents to determine if other residents had the same concerns or experienced similar treatment. The facility's paper files contained staff interviews that were completed on 2/27/24. The staff interviewed were asked: Are you aware of any other staff member speaking rudely or unkind to you or any resident on this unit? Three Licensed Practical Nurses (LPNs) identified CNA-E, CNA-F, and CNA-G. The investigation did not indicate anything further was done with the concerns.</p> <p>On 4/23/24, Surveyor reviewed nursing schedules between 2/26/24 and 3/7/24 and noted the following:</p> <p>~CNA-E worked the PM shift on 2/27/24, 2/28/24, 2/29/24, 3/1/24, 3/4/24, 3/5/24, and 3/6/24. CNA-E was terminated on 3/14/24 following an investigation into another resident's concern.</p> <p>On 4/23/24 at 1:42 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B might have resident interviews in a notebook, however, the interviews were not provided to Surveyor. Surveyor also requested investigation information regarding the concerns with CNA-E, CNA-F, and CNA-G that were identified through staff interviews. Information regarding the concerns was not provided. DON-B indicated CNA-C and CNA-D were terminated on 3/8/24, CNA-G was terminated on 3/12/24, and CNA-E was terminated on 3/14/24.</p> <p>On 4/23/24 at 3:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who verified additional resident interviews should be completed as part of an investigation and follow up should be completed when concerns with other staff are identified through an investigation.</p> <p>48794</p> <p>3. On 4/23/24, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, depression, unspecified, unsteadiness on feet, and weakness. R8's MDS assessment, dated 3/25/24, contained a BIMS score of 15 out of 15 which indicated R8 had intact cognition. R8 discharged from the facility on 3/25/24.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/13/24, R8 reported to staff that on 3/10/24 at approximately 5:25 PM, CNA-H was unkind and made rude comments to R8. R8 stated to CNA-H that R8 wanted to be CNA-H's friend, not enemy, and asked CNA-H if R8 did something to upset CNA-H. CNA-H was moved to another unit pending the outcome of the investigation. CNA-H was provided education on 3/15/24 regarding the facility's abuse policy and customer service. The facility's investigation did not include interviews with staff, other residents, or a statement from CNA-H.</p> <p>On 4/23/24 at 1:20 PM, Surveyor interviewed DON-B who stated R8 reported that R8 dropped R8's remote on the floor and asked CNA-H to pick it up. R8 stated CNA-H refused to pick up the remote and stated it was not CNA-H's job. Upon learning of the allegation, CNA-H was moved to another unit. DON-B confirmed CNA-H continued to provide resident care because the staffing coordinator did not get the message to suspend CNA-H pending the outcome of the investigation. DON-B stated on 3/14/24, DON-B contacted CNA-H and placed CNA-H on suspension. DON-B confirmed the facility did not have documentation that resident and staff interviews were completed and indicated a statement by CNA-H was not obtained.</p> <p>On 4/23/24 at 3:00 PM, Surveyor interviewed NHA-A who verified resident interviews should be completed as part of an investigation. NHA-A also verified an investigation should include a statement by the accused staff.</p> <p>32768</p> <p>4. On 4/23/24, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, dementia, neurocognitive disorder with Lewy bodies, and aphasia (a language disorder that affects a person's ability to communicate).</p> <p>On 3/28/24, the facility discovered R3 had a right humerus head dislocation which was an injury of unknown origin. The facility interviewed staff and residents, assessed R3, and sent R3 to the Emergency Department (ED). The facility also notified local law enforcement, R3's family, and R3's physician. The facility did not summarize the investigation or identify the cause of injury for R3.</p> <p>On 4/23/24 at 1:31 PM, Surveyor interviewed DON-B who indicated DON-B was not sure of the cause of injury and thought the injury was due to movement when getting dressed. DON-B indicated the facility did not have a summary or conclusion to the investigation.</p> <p>5. On 4/23/24, Surveyor reviewed R4's medical record. R4 was admitted to facility on 2/5/24 with diagnoses including compression fracture, difficulty walking, muscle weakness, and dysphagia (difficulty swallowing).</p> <p>On 2/25/24, R4 reported CNA-G was rough and rude with R4 on 2/24/24. The facility assessed R4, interviewed two staff, and suspended CNA-G pending the results of the investigation. The facility did not interview other residents or additional staff. The facility also did not summarize the investigation or complete staff education.</p> <p>On 4/23/24 at 1:11 PM, Surveyor interviewed DON-B who indicated the facility did not have a summary of the investigation and did not complete other interviews.</p> <p>38793</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. On 4/23/24, Surveyor reviewed R2's medical record. R2 was admitted to facility on 12/7/22 with diagnoses including Parkinson's disease, dementia, anxiety, and depression.</p> <p>On 3/5/24, R2 reported several people entered R2's home and sexually assaulted R2. The facility initiated an investigation, including staff interviews. The facility did not interview or assess other residents or summarize the investigation.</p> <p>On 4/23/24 at 1:15 PM, Surveyor interviewed DON-B who verified other residents were not assessed or interviewed during the investigation.</p>		