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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525668	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newcastle Place	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43361 Based on staff interview and record review, the facility did not implement their abuse policy for 3 of 8 employees reviewed for background checks. Registered Nurse (RN)-K did not have a background check completed within the last 4 years. The facility was unable to provide background check information for Dietary Manager (DM)-L and Certified Nursing Assistant (CNA)-M who were contracted employees. Findings include: The facility's Resident Abuse Neglect Exploitation and Reporting Requirements policy, with a review date of 9/8/22, indicates: Lifespace complies with and conducts pre-employment and other background and abuse registry checks as required by local, state, and federal regulation and law. On 5/29/24, Surveyor reviewed RN-K's Background Information Disclosure (BID) form, Department of Justice(DOJ) report, and Integrated Background Information System (IBIS) report. RN-K was hired on 5/6/04. RN-K's BID form was dated 3/6/19. RN-K's DOJ and IBIS reports were dated 3/7/19. Surveyor requested updated BID, DOJ, and IBIS information for RN-K that was completed within the last 4 years. The information was not provided. On 5/29/24, Surveyor requested BID, DOJ, and IBIS information for DM-L and CNA-M who were contracted staff. The information was not provided. On 5/29/24 at 3:43 PM, Surveyor interviewed Interim Nursing Home Administrator (INHA)-C who confirmed RN-K's BID, DOJ, and IBIS information was obtained in 2019 and was out of compliance with the requirement to be completed every 4 years. On 5/30/24, INHA-C indicated via email that the facility sent a reminder to RN-K on 12/6/23 to complete a new BID form, but RN-K did not complete the form. On 6/3/24 at 2:56 PM, Surveyor followed up with Nursing Home Administrator (NHA)-A via email regarding DM-L and CNA-M's missing BID, DOJ, and IBIS information. NHA-A indicated the facility did not have the background check information.

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure appropriate care and treatment was provided for 1 resident (R) (R2) of 7 sampled residents. R2 experienced a low irregular heart rate on 5/1/24 and low blood pressure on the morning of 5/3/24. Staff did not notify a physician of R2's change in condition in a timely manner. In addition, staff did not obtain R2's daily weights as ordered. Findings include: The facility's Change in a Resident's Condition or Status policy, with a revised date of February 2021, indicates: Our community promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition .1. The nurse will notify the resident's attending physician or physician on-call when there has been a(an): .d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly .3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider .4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: .b. there is a significant change in the resident's physical, mental, or psychosocial status. On 5/29/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dementia, wedge compression fracture of T11-T12 vertebra, atrial fibrillation, left bundle branch block (a condition that affects the electrical impulse of the heart), congestive heart failure (CHF), and sick sinus syndrome (a group of abnormal heart rhythms resulting from the malfunction of the heart's primary pacemaker, the sinus node). R2's medical record indicated R2's mentation varied with some confusion, but R2 was generally able to make R2's needs known and was responsible for R2's healthcare decisions. R2's medical record contained a physician order from admission, dated 4/29/24, for daily weights and to notify the physician of a change of 2 to 3 pounds in 2 days or 5 pounds in a week. A Registered Dietician assessment, dated 5/2/24, indicated the assessment was based on a weight obtained at the hospital on 4/29/24 of 136.7 pounds. The assessment indicated R2 refused meals on 5/2/24 and had poor intake during the days prior. No weights were documented since admission but daily weights were ordered due to CHF. R2 was high risk for weight loss and malnutrition. Ensure (a nutritional supplement) three times daily (TID) for poor appetite was recommended. The note indicated to provide diet and supplements as ordered, weigh per MD order, and monitor oral intake and weight changes. R2's medical record contained one documented weight of 137.0 pounds on 5/3/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's medical record indicated R2's pulse generally ranged from 74 to 86 beats per minutes (bpm) and was regular (normal rate is 60-100 bpm with regular rhythm). On 5/1/24, R2's pulse was documented as 50 bpm and irregular- new onset when R2's 8:00 PM metoprolol (a medication used to treat high blood pressure) was administered. R2's medical record did not indicate what staff did in response to R2's low, irregular pulse rate. R2's medical record indicated R2's blood pressure (BP) generally ranged from 100-108/50-64 (less than 120/80 is considered normal; less than 90/60 is considered low). On 5/3/24, R2's BP was documented as 75/52 when R2's 8:00 AM metoprolol was administered. R2's medical record did not indicate what staff did in response to R2's low blood pressure reading. A progress note, dated 5/3/24, indicated R2's family requested R2 be seen in the emergency room (ER) related to decline and refusal to eat. R2 had hypotension (low blood pressure). R2's blood pressure was 85/47 at 6:14 PM. The physician was notified and R2 was sent to the ER via ambulance at 7:00 PM. Surveyor reviewed R2's hospital admission note, dated 5/3/24, that indicated R2 presented to the ER with a chief complaint of altered mental status and was admitted to the intensive care unit (ICU) for hypotension. On 5/29/24 at 3:34 PM, Surveyor interviewed Director of Nursing (DON)-B who verified staff should have notified a physician or nurse practitioner of R2's low irregular pulse on 5/1/24 and low blood pressure on 5/3/24. On 5/29/24 at 4:13 PM, Surveyor interviewed DON-B who indicated staff should have followed R2's physician order for daily weights.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50467 Based on observation, staff interview, and record review, the facility did not ensure staff used a gait belt during transfers for 4 residents (R) (R4, R5, R6, and R7) of 5 sampled residents. R6's baseline care plan indicated R6 required assistance with transfers. The facility's practice was to use a gait belt for transfers. On 5/29/24, Certified Nursing Assistant (CNA)-G transferred R6 from recliner to wheelchair without a gait belt. In addition, R4, R5, and R7 stated staff did not consistently use a gait belt during transfers. Findings include: On 5/29/24, Surveyor requested the facility's transfer policy and was provided a policy titled Back Safety from Life Space Incorporated, with a review date of 12/1/21, that indicated team members should use proper body mechanics when performing daily tasks. A policy for transferring residents was not provided. On 5/29/24, Surveyor reviewed R6's medical record. R6 was admitted to facility on 5/28/24 (the day prior to the survey) and did not have an activated power of attorney (POA). R6's baseline care plan indicated R6 required partial to moderate assistance for sit-to-standing and toilet transfers. R6's medical record also indicated R6 required supervision/touching assistance for chair-to-chair transfers. On 5/29/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including history of falls with right intertrochanteric hip fracture. R4's Minimum Data Set (MDS) assessment, dated 5/13/24, documented R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition. The MDS also indicted R4 required partial to moderate assistance with transfers. R4's medical record included special instructions to use a gait belt with walker for transfers. On 5/29/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack (TIA) (mini stroke), muscle weakness, difficulty walking, and unsteadiness on feet. R5's MDS assessment, dated 5/22/24, documented R5 had a BIMS score of 15 out of 15 which indicated R5 had intact cognition. The MDS also indicated R5 required partial to moderate assistance with transfers. On 5/29/24, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] with diagnoses including muscle weakness, difficulty walking, muscle spasms, restless legs, rheumatoid arthritis, and peripheral vascular disease (PVD). On 5/29/24 at 11:19 AM, Surveyor noted R6's call light was activated and observed R6 in a recliner in R6's room. Surveyor observed CNA-G enter R6's room and move R6's wheelchair in front of R6. R6 attempted to stand up but could not. R6 indicated to CNA-G that R6 needed help. Surveyor observed CNA-G hook CNA-G's arm under R6's left arm, assist R6 to a standing position, and pivot R6 into R6's wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 11:38 AM, Surveyor interviewed R4 who stated staff did not use a gait belt during transfers and just grabbed R4 under the arm. On 5/29/24 at 11:01 AM, Surveyor interviewed R5 who stated staff were supposed to use a gait belt with R5 but did not. On 5/29/24 at 11:20 AM, Surveyor interviewed R7 who stated most of the time staff did not use a gait belt for transfers. On 5/29/24 at 1:14 PM, Surveyor interviewed Physical Therapist Assistant (PTA)-H who stated PTA-H used a gait belt for safety if a resident needed assistance. PTA-H confirmed from a therapy standpoint, staff should use gait belts when assisting residents. PTA-H stated residents have said to PTA-H that staff did not use gait belts when they assisted residents with transfers. On 5/29/24 at 3:50 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who stated the facility's policy for residents who are a 1 assist is to use a gait belt. If the resident is too weak, staff should have the resident sit down, use two staff for assistance, and report it to the nurse. On 5/29/24 at 3:58 PM, Surveyor interviewed Director of Nursing (DON)-B who stated on the day of admission, a therapy evaluation for transfers is completed. DON-B stated DON-B expects staff to use a gait belt for all assisted transfers.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure the accurate administration of medication for 3 residents (R) (R1, R3, and R5) of 5 sampled residents. R1 had an order for oxycodone (an opioid pain medication) as needed (PRN). R1's narcotic count sheet and medication administration record (MAR) did not match. As a result, R1 did not have follow-up documentation for the effectiveness of the medication. In addition, the facility ran out of R1's oxycodone and staff accepted oxycodone brought from R1's home. R3 did not receive 4 doses of prescribed medication because the medications were not available upon admission. R5 did not receive 2 doses of prescribed medication because the medications were not available upon admission. Findings include: The facility's Medication Administration policy, with a review date of 12/1/21, indicates: All medications will be monitored by nursing personnel to determine: .response to drug therapy. Under Controlled Substances: Each medication is to be accounted for according to the agency's procedure as it is removed from the container and before it is administered to the client. The facility's Pain Management policy, with a review date of 12/1/21, indicates: All field staff shall be educated initially and through ongoing education in pain assessment and treatment, in documentation of pain-related data, and in care planning procedures. The facility did not have a policy related to medication brought from home. 1. On 5/29/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility from the hospital on 4/30/24 following a fall at home and had diagnoses including fracture of the lower end of the radius, type 2 diabetes mellitus with diabetic polyneuropathy, insomnia, and low back pain. R1's Minimum Data Set (MDS) assessment, dated 5/7/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. A hospital discharge summary, dated 4/30/24, indicated in addition to a left radius fracture, R1 experienced right shoulder pain. R1's medical record contained the following information: ~ R1 had an order for oxycodone 5 mg (milligrams) 1 capsule every 6 hours as needed for moderate to severe pain. ~ R1 had an order for APAP (acetaminophen) (an analgesic used to treat minor aches and pains) 650 mg 1 tablet every 6 hours as needed for generalized pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ A progress note, dated 5/6/24 at 1:11 AM by Licensed Practical Nurse (LPN-D), indicated R1 had increased pain and reported pain at a level 10 out of 10. LPN-D administered APAP 650 mg at 11:16 PM and Benadryl (an antihistamine medication). R1 did not have PRN oxycodone in the medication cart. R1's last dose of oxycodone was administered at 6:47 AM on 5/5/24. R1 asked R1's family to come to the facility and take R1 to the hospital. R1's family asked R1 if they should bring oxycodone from home which was the same dose R1 took at the facility. R1's family arrived with oxycodone 5 mg and an ice machine. R1 was administered oxycodone and assisted back to bed. LPN-D called the pharmacy and was told R1 needed a new prescription for oxycodone. LPN-D called the on-call physician who agreed to send a script to the pharmacy for a 1 day supply. The noted indicated LPN-D would update R1 and R1's family. ~ A progress note, dated 5/6/24 at 1:46 AM by LPN-D, indicated LPN-D spoke with pharmacy staff who stated they would work on getting R1's pain medication to the facility. LPN-D updated R1 and R1's family who were pleased with the outcome. R1's daughter left two 5 mg oxycodone tablets in case the pharmacy was unable to get the medication to the facility before R1's next dose was allowed. With R1's daughter as a witness, LPN-D locked the 2 tablets of oxycodone in the medication cart. Surveyor reviewed R1's narcotic count sheet, dated 5/1/24, that indicated R1 started with 13 oxycodone 5 mg tablets. Surveyor compared R1's narcotic sheet with R1's MAR and noted 4 doses of oxycodone that were administered and documented on the narcotic sheet were not documented on R1's MAR. R1 received oxycodone on the following dates: ~ 5/1/24 at 6:45 PM - Surveyor noted no documentation on R1's MAR ~ 5/2/24 at 12:50 AM - Surveyor noted no documentation on R1's MAR ~ 5/2/24 at 6:41 AM - Surveyor noted no documentation on R1's MAR ~ 5/2/24 at 1:15 PM ~ 5/2/24 at 7:50 PM ~ 5/3/24 at 2:00 AM - Surveyor noted no documentation on R1's MAR ~ 5/3/24 at 8:22 AM ~ 5/3/24 at 5:45 PM ~ 5/4/24 at 12:24 AM ~ 5/4/24 at 8:22 AM ~ 5/4/24 at 2:25 PM ~ 5/4/24 at 7:00 PM ~ 5/5/24 at 6:00 AM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R1's medical record to see if progress notes were written for the administration and/or effectiveness of the 4 doses that were not documented on R1's MAR. R1's medical record did not contain progress notes for the 4 doses. On 5/30/24 at 8:35 AM, Surveyor interviewed LPN-D who stated LPN-D was an agency nurse and picked up shifts occasionally at the facility. LPN-D recalled the evening of 5/6/24 which was the first time LPN-D worked with R1. LPN-D confirmed R1's family brought oxycodone because R1 was in severe pain. LPN-D stated R1 contacted R1's family and wanted to go to the hospital. R1's family asked if R1 wanted pain medication from home. LPN-D stated LPN-D could not give the medication because LPN-D did not have an order; however, R1's family gave R1 the medication. LPN-D stated LPN-D attempted multiple strategies to calm R1 who was anxious also. LPN-D confirmed R1 received a dose of oxycodone from home and R1's family left 2 oxycodone tablets which LPN-D (with R1's daughter as a witness) locked with R1's medication. LPN-D stated LPN-D wrote a new narcotic sheet and added the 2 oxycodone tablets. When asked how often the facility ran out of medication or didn't receive medication timely for new admissions, LPN-D stated more than half the time. LPN-D stated LPN-D usually worked the night shift and at times there were 2 agency nurses on duty who did not have access to the facility's contingency medication. On 5/29/24 at 1:40 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-E who confirmed staff should not accept medication from home. ADON-E stated R1's nurse practitioner was recently asked not to come back to the facility due to issues with ensuring medication refills were completed timely and sent to the correct location. ADON-E stated when ADON-E and Director of Nursing (DON)-B first started at the facility, only a few nurses had access to contingency medication. ADON-E verified the facility used agency staff who did not have access to contingency medication. ADON-E stated the facility has been giving contingency medication access to agency staff who work regularly at the facility which has helped. ADON-E stated the pharmacy requires that medication be submitted by 5:00 PM for same day delivery; however, it can still take a number of hours for medication to arrive even though the pharmacy is 20 minutes away. ADON-E stated if staff request the medication as STAT (now), the pharmacy has a 4 hour turn around time and residents still could miss doses of medication. ADON-E stated intravenous (IV) medications were delivered from a pharmacy in Chicago. On 5/29/24 at 2:40 PM, Surveyor interviewed DON-B who confirmed staff are expected to document in the MAR when a medication is administered. DON-B indicated staff should also document the effectiveness when a PRN opioid is administered. Surveyor and DON-B discussed the 5/6/24 progress notes at 1:11 AM and 1:46 AM that stated R1's family brought oxycodone from home. DON-B confirmed staff should not accept residents' medication from home. DON-B stated R1's nurse practitioner sent several reorders of medication to the wrong pharmacy which resulted in residents not having their medication. DON-B stated because R1's refill was an opioid medication, the refill could not be transferred from pharmacy to pharmacy which resulted in R1 not having the medication. 50479 2. On 5/29/24, Surveyor reviewed R3's medical record. R3 was admitted to facility in the early afternoon on 3/15/24 with a past medical history of lung cancer, chronic obstructive pulmonary disease (COPD), and hypertension. R3's medical record contained the following orders: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ atorvastatin calcium (a statin medication used to treat high cholesterol and triglyceride levels) tablet 80 mg give tablet by mouth at bedtime ~ mirtazapine (an antidepressant medication) tablet 15 mg give 1 tablet by mouth at bedtime ~ Singulair (an anti-inflammatory medication) oral tablet 10 mg give 1 tablet by mouth at bedtime ~ guaifenesin (a cough and cold medication) oral tablet give 2 tablets by mouth every 12 hours R3's March 2024 MAR indicated R3 was not administered R3's evening doses of atorvastatin, mirtazapine, Singulair, and guaifenesin on 3/15/24. On 5/29/24 at 3:36 PM, Surveyor interviewed LPN-J who verified LPN-J was an agency nurse and cared for R3 on the 3/15/24 night (NOC) shift. LPN-J confirmed R3 did not receive R3's evening doses of atorvastatin, mirtazapine, Singulair, and guaifenesin on 3/15/24 and stated the pharmacy did not deliver the medication on 3/15/24. LPN-J stated it was common for new admissions to not have medication available on the day of admission. LPN-J stated on the 3/15/24 NOC shift, the nurses on duty (including LPN-J) did not have access to contingency medication stored in the Omnicell. On 5/29/2024 at 4:10 PM, Surveyor interviewed DON-B about the workflow for obtaining medication from the pharmacy. DON-B stated there were two pharmacy deliveries per day on weekdays and one delivery per day on weekends. Medication orders must be faxed to the pharmacy by 8:00 AM to be delivered by 4:00 PM. Medication orders must be faxed to the pharmacy by 5:00 PM to be delivered on the evening delivery which was typically six to eight hours after medication orders were faxed to the pharmacy. DON-B stated nurses should use contingency medication in the Omnicell if a resident's medication has not been delivered by the pharmacy. DON-B stated facility nurses had access to the Omnicell; however, agency nurses were given access on a case-by-case basis. DON-B confirmed LPN-J did not have Omnicell access on 3/15/24. 50467 3. On 5/29/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and arrived via ambulance at approximately 4:08 PM. R5 had diagnoses including transient cerebral ischemic attack, hypertension, hyperlipidemia, cardiac murmur, and had a cardiac pacemaker. R5's admitting orders indicated R5 should receive pravastatin sodium (a statin medication used to treat high cholesterol and triglyceride levels) 80 mg in the evening and Toprol XL extended release (ER) (a beta-blocker used to treat chest pain, heart failure, and high blood pressure) 25 mg twice daily (AM and PM). R5's MAR indicated R5 should have received scheduled medications on 5/17/24 in the evening and at bedtime (HS). Per R5's MAR, the medications were scheduled to start on 5/18/24 and omitted the doses R5 should have received on the evening of 5/17/24. The MAR confirmed R5 did not receive pravastatin 80 mg and Toprol XL 25 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 11:01 AM, Surveyor interviewed R5 who stated R5's medications were discombobulated at first and R5 had problems receiving medication the first couple of days after admission. R5 stated now that there are regular staff, R5 receives R5's medication in a timely manner. On 5/29/24 at 1:26 PM, Surveyor interviewed LPN-F about the medication process for new admissions. LPN-F stated nurses call the physician to verify all medication on the discharge summary from the sending facility. Narcotic prescriptions are faxed or e-signed to pharmacy. After confirmation of orders, the nurse faxes the admitting orders to the pharmacy. LPN-F confirmed the medication usually arrives the next day. LPN-F stated if medication is needed, staff can pull the medication from contingency with a physician's order. LPN-F stated ADON-E enters the admitting orders and nurses are responsible for verification with the physician. On 5/29/24 at 3:58 PM, Surveyor interviewed DON-B who confirmed the physician e-scribes prescriptions to the pharmacy and staff follow up the next day for missing medication that did not arrive. ADON-E or DON-B enter all admitting orders into the resident's medical record prior to the resident's arrival. The admitting orders are given to a nurse to verify with the physician. Once approval is confirmed, the nurse faxes the orders to pharmacy. DON-B indicated the medication is sent on the next run which can be 6-8 hours later. If medication is needed prior to delivery, certain medications can be pulled from the Omnicell. DON-B confirmed select staff have access to the Omnicell, including some agency staff. DON-B confirmed if medication is ordered by 8:00 AM it will arrive by 4:00 PM Monday through Friday. A second delivery is at approximately 6:00 PM and there is one delivery on weekends.

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 05/29/2024
NAME OF PROVIDER OR SUPPLIER Newcastle Place		STREET ADDRESS, CITY, STATE, ZIP CODE 12600 N Port Washington Rd #300 Mequon, WI 53092	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 43361 Based on staff interview and record review, the facility did not ensure a medication was administered for its intended use for 1 resident (R) (R1) of 5 sampled residents. R1 was prescribed Benadryl (an analgesic medication) as needed (PRN) for itching. R1 requested and was administered Benadryl for reasons other than itching. Findings include: The facility's Medication Administration policy, with a review date of 12/1/21, indicates: Medications, dose, route, and frequency should be considered generally reasonable and acceptable therapy for the condition for which they are prescribed. On 5/29/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility from the hospital on 4/30/24 following a fall at home. R1 had diagnoses including fracture of the lower end of the radius, type 2 diabetes mellitus with diabetic polyneuropathy, insomnia, and low back pain. R1's Minimum Data Set (MDS) assessment, dated 5/7/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. A hospital discharge summary, dated 4/30/24, indicated in addition to a left radius fracture, R1 experienced right shoulder pain. R1's medical record indicated the following: ~ R1 had an order for Benadryl 25 allergy oral capsule 25 mg (milligrams) (Diphenhydramine HCL) give 1 capsule by mouth every 6 hours as needed for itching. ~ R1 had an order for oxycodone (an opioid medication) 5 mg give 1 capsule every 6 hours as needed for moderate to severe pain. ~ R1 had an order for APAP (acetaminophen) 650 mg give 1 tablet every 6 hours as needed for generalized pain. ~ A progress note, dated 5/6/24 at 1:11 AM by Licensed Practical Nurse (LPN-D), indicated R1 had increased pain and reported pain at a level 10 out of 10. LPN-D administered PRN APAP 650 mg at 11:16 PM and Benadryl. On 5/30/24 at 8:35 AM, Surveyor interviewed LPN-D who verified LPN-D was an agency nurse who occasionally picked up shifts at the facility. LPN-D stated the night of 5/6/24 was the first time LPN-D worked with R1. LPN-D stated R1 was in pain and LPN-D tried multiple strategies to help R1 calm down. LPN-D stated R1 was out of oxycodone but had APAP which LPN-D administered. When asked if R1 requested Benadryl, LPN-D stated R1 requested Benadryl because it helped R1 sleep better. LPN-D stated when R1 requested Benadryl, LPN-D asked if R1 was having an allergic reaction. R1 stated it was R1's normal routine at home to take Benadryl to help R1 sleep. LPN-D stated R1 was not itching and LPN-D was trying to keep R1 as calm as possible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525668	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newcastle Place	12600 N Port Washington Rd #300 Mequon, WI 53092

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 1:40 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-E who confirmed R1's Benadryl should only be administered for the prescribed reason. On 5/29/24 at 2:40 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed medication should only be administered for the prescribed reason.