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	10/28/2024

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 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** 45942 Based on staff interview and record review, the facility did not provide pharmaceutical services to ensure prescribed medication was available and administered correctly for 1 resident (R) (R1) of 8 sampled residents. R1 had an order for heparin sodium injection solution 5000 unit/milliliter (ml) inject 1 ml subcutaneously every 8 hours for blood thinner for 14 days. R1 was not administered heparin as ordered. Findings include: The facility's Administering Medications policy, revised April 2019, indicates: Medications are administered in a safe and timely manner, and as prescribed .6) Medications errors are documented, reported, and reviewed by the Quality Assurance Performance Improvement (QAPI) committee to inform process changes and or the need for additional staff training .13) Vials labeled as single use are not used on multiple residents, such vials are used only for one resident in a single procedure .21) If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space provided for that drug and dose. 22) The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next one. 23) As required or indicated for a medication, the individual administering the medication records in the resident's medical record .g) The signature and title of the person administering the drug. 26) Medication ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the Director of Nursing Services. On 10/28/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including fracture of right femur (thigh bone) and immunodeficiency due to drugs. R1's Minimum Data Set (MDS) assessment, dated 8/23/24, was not completed because R1 was discharged on [DATE]. R1's medical record indicated R1 did not have an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed R1's August 2024 MAR related to heparin administration and noted the following: ~ R1's 10:00 PM heparin dose on 8/23/24 was administered by Licensed Practical Nurse (LPN)-H. ~ R1's 8:00 AM heparin dose on 8/24/24 was administered by LPN-E. (continued on next page)

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	~ R1's 2:00 PM heparin dose on 8/24/24 was blank which indicated it was not administered. ~ R1's 10:00 PM heparin dose on 8/24/24 was initialed by LPN-D and contained a 6 (which indicated hospitalized). R1's medical record did not contain a progress note related to the 10:00 PM heparin dose. ~ R1's 8:00 AM heparin dose on 8/25/24 was initialed by LPN-I and contained a 5 (which indicated hold/see progress note). R1's medical record did not contain a progress note related to the 8:00 AM heparin dose. ~ R1's 2:00 PM heparin dose on 8/25/24 was blank which indicated it was not administered. ~ R1's 10:00 PM heparin dose on 8/25/24 was administered by Registered Nurse (RN)-F. ~ R1's 8:00 AM heparin dose on 8/26/24 was initialed by LPN-I and contained a 5 (which indicated hold/see progress note). R1's medical record did not contain a progress note related to the 8:00 AM heparin dose. ~ R1's 2:00 PM heparin dose was initialed by LPN-G and contained a 9 (which indicated other/see progress note). R1's medical record did not contain a progress note related to the 2:00 PM heparin dose. R1 discharged from the facility on 8/26/24 at approximately 10:30 AM. On 10/28/24 at 1:17 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated residents' medications should be available. DON-B confirmed nurses do not need DON-B's permission to order heparin from the pharmacy. DON-B indicated nurses should not use other resident's medication and stated the pharmacy can STAT orders for delivery. DON-B indicated R1 had heparin and it appeared to be in the facility. DON-B confirmed a 9 after a nurse's initials on the MAR indicated there was a progress note, however, DON-B could not find a progress note for R1. DON-B indicated DON-B expects staff to document progress notes so DON-B can follow up. On 10/28/24 at 2:35 PM, Surveyor interviewed Pharmacy Medication Order Technician (PMOT)-J. PMOT-J indicated the pharmacy dispensed heparin on 8/24/24 which was delivered to the facility and signed for by RN-C on 8/24/24 at 10:17 PM. PMOT-J confirmed the pharmacy had STAT capability and said the turnaround time was 4 hours. PMOT-J indicated the facility needed to inform the pharmacy if a STAT order was needed for a medication. PMOT-J indicated the facility had an Omnicell machine which contained contingent medication and kept track of which medications were used. PMOT-J verified the last documented Omnicell transaction was on 7/15/24 and said the facility's inventory contained four 1 ml vials of heparin. PMOT-J indicated at the time of R1's admission, heparin was available and staff could have pulled heparin from contingency. On 10/28/24 at 3:00 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated all nurses have an Omnicell login. NHA-A indicated if a resident is admitted and their medications are unavailable, nurses should pull the medication from contingency or call the pharmacy for a STAT order. NHA-A indicated if a medication was not signed out on a resident's MAR, NHA-A viewed the medication as not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 3:29 PM, Surveyor interviewed DON-B who indicated if the facility did not have a resident's medication, the nurse should contact the pharmacy to get the medication as soon as possible and document the communication. DON-B verified nurses do not need permission to pull medication from contingency and indicated all nurses have their own access. DON-B indicated if medication was not signed out in a resident's MAR, the medication was not administered. DON-B confirmed R1's 2:00 PM heparin doses on 8/24/24 and 8/25/24 were not administered since they were both blank and indicated staff were not allowed to borrow medication from other residents. On 10/28/24 at 4:00 PM and 4:30 PM, Surveyor interviewed LPN-I who confirmed LPN-I's initials were followed by a 5 on R1's MAR for the 8:00 AM heparin doses on 8/25/24 and 8/26/24. LPN-I indicated LPN-I would borrow medication from another resident depending on the urgency of the medication. LPN-I indicated LPN-I did not remember R1 and did not remember borrowing heparin from another resident. LPN-I indicated LPN-I should have written a progress note in R1's medical record and should have documented a 9 instead of a 5 if heparin wasn't administered. LPN-I indicated if heparin wasn't administered, the facility probably didn't have the medication. LPN-I confirmed R1's 2:00 PM heparin doses on 8/24/24 and 8/25/24 appeared to not have been administered. On 10/28/24 at 4:47 PM, Surveyor attempted to call LPN-D and left a message. Surveyor did not receive a return call as of this writing. On 10/28/24 at 4:49 PM, Surveyor attempted to call LPN-E and left a message. Surveyor did not receive a return call as of this writing. On 10/28/24 at 4:50 PM, Surveyor interviewed RN-F via phone. RN-F indicated RN-F did not remember administering heparin to R1. RN-F indicated RN-F was unable to access contingency medication. RN-F confirmed RN-F's initials and indicated if RN-F's initials were on R1's MAR, RN-F must have signed out the medication. RN-F indicated if a resident did not have a prescribed medication, RN-F would get access to contingency medication from another nurse. RN-F indicated if a medication was not available in contingency, RN-F would notify the pharmacy and call for a STAT delivery. On 10/28/24 at 5:08 PM, Surveyor attempted to contact LPN-G and left a message. Surveyor did not received a return call as of this writing. On 10/28/24 at 6:06 PM and 6:12 PM, Surveyor interviewed DON-B who indicated heparin was not available at the facility, however, R1's MAR indicated heparin was administered. When Surveyor asked DON-B why heparin was signed out as administered if it wasn't available outside of contingency, DON-B indicated nurses signed heparin out in error because the Omnicell did not indicate heparin was removed. DON-B indicated when a medication error is identified, the nurse who identified the error should notify the provider, complete an incident report, and notify the responsible party and nursing management. DON-B indicated the resident should be monitored and follow-up education provided for all nursing staff involved. DON-B indicated DON-B was not aware R1's heparin wasn't administered prior to that day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45943 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infection for 1 resident (R) (R8) of 1 resident observed during the provision of incontinence care. During an observation of perineal care for R8 on 10/28/24, Certified Nursing Assistant (CNA)-K did not appropriately remove gloves and cleanse hands. Findings include: The facility's Hand Hygiene Policy, revised 6/5/22, indicates: Hand Hygiene is the most effective measure for preventing the spread of infections .Hand hygiene will be practiced by all team members working in a licensed health care entity or health center. Indications for hand hygiene: after any contact with blood or other body fluids-even if gloves are worn; any time a team member removes protective gloves or personal protective equipment (PPE); between performing different procedures on the same resident. Note: Wearing gloves does not replace the need for hand hygiene. On 10/28/24 at 1:08 PM, Surveyor observed CNA-K provide perineal care for R8. CNA-K wiped R8's peri-rectal area with wipes. Without removing gloves and cleansing hands, CNA-K pulled up R8's clean incontinence brief and pants and assisted R8 with ambulation while touching R8's gait belt and walker. CNA-K then adjusted R8's recliner with a remote control and touched R8's blanket, call light, tray table, and television remote. CNA-K also closed R8's bathroom door by touching the doorknob and placed R8's clean night gown in a dresser drawer. CNA-K then removed gloves, carried a garbage bag outside R8's room, and left R8's room without completing hand hygiene. Immediately following the observation, Surveyor interviewed CNA-K who indicated CNA-K had two pair of gloves on and was moving so fast that Surveyor did not see CNA-K remove the first pair of gloves after pericare was completed. CNA-K indicated CNA-K completed hand hygiene routinely after leaving a resident's room, however, Surveyor did not observe CNA-K do so. On 10/28/24 at 6:05 PM, Surveyor interviewed Director of Nursing (DON)-B who verified staff should not double glove when providing care. DON-B indicated staff should remove soiled gloves after pericare, complete hand hygiene, and don clean gloves. DON-B stated DON-B expects staff to use the closest hand sanitizer station if hands are not visibly soiled.