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	01/09/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50479 Based on staff interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 resident (R) (R1) of 3 sampled residents. On 11/4/24, staff witnessed Licensed Practical Nurse (LPN)-C verbally abuse R1. The facility did not report the verbal abuse to local law enforcement. Findings include: The facility's Abuse Neglect and Exploitation Policy, revised 9/20/24, indicates: Abuse means the willful infliction of . intimidation .pain or mental anguish, which can include staff and resident abuse .it includes verbal abuse .and mental abuse .Verbal abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability .A. The community will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services, and all other required agencies (e.g., law enforcement when applicable) within specified time frames: a. Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse . On 1/9/25, Surveyor reviewed R1's medical record. R1 received Hospice services and had diagnoses including dementia, anxiety, and depression. R1's Minimum Data Set (MDS) assessment, dated 12/23/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney for Healthcare (POAHC) who was responsible for R1's health care decisions. On 1/9/25, Surveyor reviewed a facility-reported incident (FRI) regarding an allegation of verbal abuse that involved R1 and LPN-C. The FRI indicated on 11/4/24 at approximately 7:45 AM, R1 was in a common area crying out for help. Staff observed LPN-C yell at R1. Staff reported LPN-C stated Stop and Shut up and Stop being a fool. You should be ashamed of yourself. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 11:25 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-E who confirmed CNA-E witnessed the verbal abuse on 11/4/24. CNA-E indicated LPN-C was more than 20 minutes late for work and LPN-C's behavior was abnormal. CNA-E was providing care in a resident's room when CNA-E heard LPN-C yelling loudly in the central area. CNA-E went to the central area in response to LPN-C's raised voice and observed R1 seated and crying out for help. CNA-E observed LPN-C repeatedly yell Be quiet at R1. On 1/9/25 at 11:35 AM, Surveyor interviewed Housekeeper (HK)-D who confirmed HK-D witnessed the verbal abuse on 11/4/24. HK-D indicated HK-D observed LPN-C yell Shut up with a raised voice in response to R1 calling out for assistance. HK-D expressed concern that LPN-C was under the influence of alcohol at the time because LPN-C had an unsteady gait, a raised voice, and unusual behavior. On 1/9/25 at 1:34 PM, Surveyor interviewed LPN-F who indicated LPN-F witnessed the verbal abuse on 11/4/24. LPN-F indicated LPN-C reported to work approximately 30 minutes late. LPN-F attempted to give (nursing) report to LPN-C, however LPN-C was disruptive, yelled, cussed, slurred LPN-C's words, and swayed when standing. LPN-F observed LPN-C yell and say inappropriate things to R1. On 1/9/25 at 2:20 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed the incident between LPN-C and R1 on 11/4/24 constituted verbal abuse. NHA-A verified law enforcement was not notified of the incident. NHA-A indicated the local police department have been notified of the allegation of abuse.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45943 Based on staff interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 1 resident (R) (R1) of 3 sampled residents. On 11/4/24, staff witnessed Licensed Practical Nurse (LPN)-C verbally abuse R1. The facility did not thoroughly investigate the allegation of abuse. Findings include: The facility's Abuse Neglect and Exploitation Policy, revised 9/20/24, indicates: Abuse .includes verbal abuse .III. Prevention of Abuse, Neglect, and Exploitation .D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect .IV. Identification of abuse .Possible indicators of abuse include: .5. Verbal abuse of a resident overheard .V. Investigation of Alleged Abuse .B. Written procedures for investigations include .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses . 6. Providing complete and thorough documentation of the investigation .VI. Protection of Resident: The Community will make efforts to ensure all residents are protected from physical and psychosocial harm .G. Revision of the resident's care plan if the resident's medical, nursing, mental, or psychosocial needs or preferences change as a result of an incident of abuse. On 1/9/25, Surveyor reviewed R1's medical record. R1 received Hospice services and had diagnoses including dementia, anxiety, and depression. R1's Minimum Data Set (MDS) assessment, dated 12/23/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated Power of Attorney for Healthcare (POAHC) who was responsible for R1's healthcare decisions. On 1/9/25, Surveyor reviewed a facility-reported incident (FRI) that alleged on 11/4/24 at approximately 7:45 AM, R1 was in a common area crying out for help. Staff observed LPN-C yell at R1 and heard LPN-C say Stop and Stop being a fool. You should be ashamed of yourself. R1 was assisted away from LPN-C who left the facility and did not return. Staff responded appropriately to the incident and an investigation was initiated. Surveyor noted the investigation did not include notification of local law enforcement, interviews with R1 and other residents, and interviews with all staff on duty when the allegation occurred, including LPN-F who witnessed the incident. The investigation did not indicate R1's care plan was reviewed or revised after the incident. In addition, the investigation did not include documentation of staff education. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 1:05 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the facility did not contact local law enforcement because R1's POAHC said there was no need to since R1 had dementia. NHA-A indicated abuse education (as indicated in the Report Attachment) was not provided since staff responded appropriately and it was an isolated incident, however, NHA-A indicated abuse education was started on 1/9/25. NHA-A indicated 3 staff interviews were completed, however, summaries of only 2 staff interviews (Housekeeper (HK)-D and Certified Nursing Assistant (CNA)-E) were included. (There were no signed statements by HK-D and CNA-E.) In addition, LPN-F (who witnessed the incident) was not interviewed as indicated in the Report Attachment although NHA-A attempted to contact LPN-F and NHA-A verified R1 and other residents were not interviewed. NHA-A also verified there was no documentation that R1's POAHC and physician were notified and no indication that R1's care plan was reviewed or revised after the incident to monitor R1 for the psychosocial impact of the abuse.