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	06/10/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview, record review, and review of the facility's policy, the facility did not ensure the medical record was complete and accurate for 1 resident (R) (R9) of 9 sampled residents. R9 had medications brought from home that R9 administered independently. The medications were not identified in R9's medical record. This had the potential for staff not to be aware of what medications were being independently administered by R9 which could potentially create a medication error. Findings include: R9's undated Face Sheet located under the Profile tab in R9's electronic medical record (EMR) indicated R9 was admitted to the facility on [DATE]. R9's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/5/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R9 was cognitively intact. During an interview on 6/10/25 at 10:00 AM, R9 stated, The first night that I was here, the facility was not ready for me and didn't have my medications here that I needed to take. I got so upset that I called my husband at work and told him I needed him to bring me my medicines so that I would have something to take. I have to take my pain medicine and the nurse told me there wasn't any of it here for me to take. The nurse said she called the pharmacy and they wouldn't give her permission for me to have any until it was delivered and it was going to be around 3:00 AM. R9 confirmed R9 took pain medication and insulin that R9's husband brought to the facility on the first night. R9's nursing progress notes did not contain documentation that Licensed Practical Nurse (LPN)1 spoke to R9 about what medications were available at the facility for R9 other than a documented conversation that indicated R9's pain medication would be available once received from the pharmacy delivery at approximately 3:00 AM. The documentation also indicated the physician was not notified that R9 took R9's medications from home because R9's medications were not available until 3:00 AM during the next pharmacy delivery. (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

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	06/10/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/25 at 1:05 PM, Director of Nursing (DON)B revealed DONB spoke with the nurse who was assigned to R9 on the evening R9 was admitted . DONB indicated the nurse told R9 the facility had R9's insulin and offered the insulin. R9 refused and stated R9 would take R9's insulin when R9's spouse returned to the facility with it. The nurse indicated the facility did not have R9's narcotic medication and had to wait until the pharmacy delivered the medication at approximately 3:00 AM. When DONB was asked if this was documented in R9's medical record, DONB stated, I would have to look at the documentation for that specifically. There was no further documentation provided from DONB regarding medications brought into the facility by R9's family member. During an interview on 6/10/25 at 1:28 PM, LPN2 revealed R9 was a difficult admission. LPN2 said LPN2 asked R9 that evening what medications R9 took. LPN2 indicated R9 took R9's own insulin even though LPN2 told R9 the facility had insulin in the emergency refrigerator that LPN2 could administer. The facility's Charting and Documentation policy, dated July 2017, indicates: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychological condition, shall be documented in the resident's electronic medical record. The electronic medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .