

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 01/21/2026
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility did not assess a resident's ability to self-administer medication before leaving medication at the bedside for 1 resident (R) (R1) of 5 sampled residents reviewed for self-administration of medication. Findings include: Review of the facility's policy titled Administering Medications policy, last revised 4/2019, revealed residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy and hypertension. Review of R1's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/13/25, revealed a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R1 was severely cognitively impaired. Review of an Incident Note, dated 12/29/25, revealed whole medications were left at the bedside over the weekend. R1's daughter notified the nurse that two pills had been found in R1's room. Review of R1's care plan revealed R1 did not have a care plan for self-administration of medication. Review of R1's assessments revealed R1 had not been assessed for self-administration of medication. Review of R1's physician orders revealed R1 did not have an order to leave medications at the bedside for R1 to self-administer. During an interview on 1/22/26 at 11:47 AM, Family Member (FM) 2 reported when she visited R1 on 12/29/25 there were two pills sitting on the bedside table which the nurse said may have been blood pressure medication. During an interview on 1/21/26 at 5:28 PM, the Administrator was asked if R1 was assessed for self-administration of medication and responded, .She wouldn't be able to. She was living in our memory care unit before she was admitted to our skilled nursing unit when she came in from the hospital.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 525668	Facility ID: 525668 If continuation sheet Page 1 of 3

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility did not ensure 1 resident (R) (R1) of 5 residents reviewed for medication administration was free from a significant medication error. On 12/29/25, R1 received duplicate doses of prescribed blood pressure medication. This error resulted in R1 experiencing hypotension (low blood pressure) and requiring evaluation in the Emergency Department (ED). Findings include: Review of the facility's policy titled Administering Medications, last revised 4/2019, revealed medications are administered in accordance with prescriber orders, including any required timeframes. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Review of R1's Face Sheet revealed R1 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy and hypertension (high blood pressure). Review of R1's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/13/25, revealed R1 was assessed with a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R1 was severely cognitively impaired. Review of R1's Medication Administration Record (MAR), dated December 2025, revealed R1 had an order, dated 12/10/25, for carvedilol (blood pressure medication) oral tablet 25 milligrams (mg). Give 1 tablet by mouth two times a day for hypertension (HTN). Take with meals. The medication was scheduled for AM and PM. There was no order to self-administer the medication. Licensed Practical Nurse (LPN) 2 documented that LPN 2 administered R1's two evening medications on 12/28/25, including carvedilol. Review of R1's care plan revealed R1 did not have a care plan for self-administration of medication. Review of an Incident Note, written on 12/29/25 by LPN 1, indicated whole medications were left at R1's bedside over the weekend. At approximately 10:30 AM while administering AM medications, R1's daughter notified LPN 1 that two pills were found in R1's room. R1's daughter stated she assumed the pills were R1's AM medications and had already given them to R1 prior to LPN 1's arrival. LPN 1 clarified that no medications had been administered yet that morning. R1's daughter described the pills as white and long form. LPN 1 showed R1's daughter several of the pills prescribed to R1. R1's daughter identified the pills as likely to be R1's blood pressure medication. R1's vital signs were stable; R1's blood pressure at 10:00 AM was 132/67. Approximately thirty minutes later, R1's daughter reported that R1 seemed very tired and fell asleep in the middle of a card game. LPN 1 assessed R1 and noted R1 wasn't responsive to verbal or tactile stimuli. R1's vitals were retaken and revealed a significant drop in blood pressure (78/54). R1 was symptomatic and experienced altered consciousness. R1 was transferred to the ED for monitoring. Review of R1's ED provider notes, date of service 12/29/25, revealed R1 had a blood pressure of approximately 88 systolic with slight bradycardia (low heart rate) of 58 after taking 2 doses of carvedilol earlier that day. R1 was slightly hypotensive at 104 systolic with bradycardia of 58. Poison control was contacted and an electrocardiogram (EKG) (a quick, painless, noninvasive test lasting about 5-10 minutes that measures the heart's electrical activity to detect arrhythmias, heart damage, and structural issues) was completed. No other treatment was administered in the ED. The provider notes indicated R1 could be sent home. Review of the facility's Investigative Summary, dated 12/29/25, revealed the Director of Nursing (DON) investigated the medication error and determined the pills in R1's room were left by staff from a previous shift. R1's daughter identified the pills as likely to be R1's carvedilol and atorvastatin (cholesterol medication); both medications were ordered to be administered in the evening. The facility's investigation revealed the medications were left at the bedside by LPN 2. During an interview on 1/21/26 at 12:51 PM, LPN 2, who documented administering R1's evening</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>medications on 12/28/25, stated, The Director of Nursing asked me if I left medications at (R1's) bedside and I told him that I didn't. During an interview on 1/21/26 at 3:22 PM, LPN 1 stated, I worked that morning shift on 12/29/25 and normally when I get in, I start to take the residents' vital signs and then I start passing my medications. When I took (R1's) vital signs, her family was not in her room yet, and I didn't notice any medications on (R1's) bedside table. Before going into (R1's) room, I crushed her blood pressure medication (carvedilol) and mixed it with apple sauce. While I was scooping the blood pressure medication in apple sauce out of the medicine cup and giving (R1) the medication, the daughter notified me that her mom took two pills that were in a medicine cup a few minutes ago. When I asked the daughter to describe the pills to me, they were colored white and shaped like an oblong. When I checked (R1's) MAR for 12/28/25 for evening shift, they were likely to be blood pressure medication .fifteen minutes later, I was called to (R1's) room. I checked (R1) and she was unresponsive to verbal and tactile stimulation. The family said that she fell asleep during a board game or a card game. When I checked (R1's) blood pressure, it was in the 70s systolic. She was sent out via 911 by the doctor. During an interview on 1/22/26 at 11:47 AM, Family Member (FM) 2 stated, When my husband, my son, and I arrived at (R1's) room around 10:15 AM, there were a couple of pills sitting on the bedside table. My mom ended up taking the medication in the cup. About ten minutes later, one of the nurses came in with apple sauce in a medicine cup. While she was scooping the apple sauce out of the medicine cup and giving it to my mom, I was telling her that my mom just took the two pills in a medicine cup that was sitting on the bedside table. The nurse told me to always check first before giving anything to my mom. The nurse continued to give the apple sauce while I was asking her if there was any 'danger of things' interacting or a chance of there being a problem that my mom took those pills and the nurse immediately answered, 'I will go and check the records.' When the nurse came back, she showed me pills and asked if the pills I found on the bedside table looked like 'this.' I said they were white and oblong in shape. She said that the pills may have been blood pressure medication and that she had to report this to the nurse manager. Soon after, the nurse gave the apple sauce to my mom. Probably about 30 to 45 minutes later, my mom started looking drowsy and then just kind of fell asleep while we were playing gin with her. During an interview on 1/21/26 at 5:28 PM, the Administrator stated R1 could not self-administer medication left at the bedside due to her cognition.</p>		