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	04/22/2026

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 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** Based on interview and record review the facility did not ensure residents received treatment and care in accordance with professional standards of practice for 2 (R5 & R4) of 9 residents. *R5 spilled hot soup on R5's right abdomen, right lower breast and left pinky assessment on 1/23/26. There is no evidence the nurse spoke with the physician on 1/23/26, a treatment was not ordered until 1/24/26 and the area was not assessed until 1/26/26 by the physician. *The facility did not obtain R4's admission weight on 12/8/25 and daily weights on 12/9/25 & 12/10/25 according to R4's physician orders. Findings include: 1.) R5's diagnoses includes hypertension (high blood pressure), muscle weakness, Alzheimer's disease (progressive brain disorder that causes gradual cognitive decline), dementia (loss of cognitive function that interferes with a person's daily life and activities), and anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life). R5's quarterly MDS (minimum data set) with an assessment reference date of 12/30/25 has a BIMS (brief interview mental status) score of 3 which indicates severe cognitive impairment. R5 is assessed as requiring partial/moderate assistance for eating. R5's nurses note dated 1/23/26 at 17:45 (5:45 p.m.), written by Licensed Practical Nurse (LPN)-C documents [R5's first name] was not observed wasting hot to R (right) abdomen, R lower breast, and L (left) pinky finger. [R5's first name] called out for help after wasting soup, temp (temperature) of skin 98.8, fire engine red, no broken skin or blister noted at time of assessment. Forehead temp 97.5, P (pulse) 82, R (respirations) 18, BP (blood pressure) 159/79 and O2 (oxygen) 99RA (room air). Pain rated 6/10 schedule Tylenol given, cool compress applied. Report relief after 15 minutes. On call updated, POA (power of attorney) and [Physician-U] office notified. In w/c (wheelchair) with nurse at nursing station for reassurance everything will be okay. Dietician updated with request to change order to all hot liquids to be covered at mealtimes. Plan of care assess every shift x (times) three days. R5's nurses note dated 1/24/26 at 13:28 (1:28 p.m.), written by LPN-C documents Skin to R (right) abdomen area noted with scattered clear filled blisters. Largest blister noted 0.5cm (centimeter) x (times) 1cm and the rest smaller. Redness to abdomen 3.5cm x 7cm and breast redness 3cm x 4.5 decreased in size. [R5's first name] denies pain/discomfort. [Physician-U's name] after hours notified. [Physician-V's name] gave verbal order Vaseline daily followed by boarder foam dressing (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	until resolved. Assess for any changes and S/S (signs/symptoms) of infection update with concerns. POA [Name] updated with care plan. Dietary staff updated with order to cover all hot liquids with meals. R5's late entry nurses note dated 1/25/26 at 8:06 a.m., written by LPN-C documents All clear filled blisters open, cleanse with wound cleanser, pat dry, Vaseline applied covered with boarder foam dressing. Report discomfort with dressing change. In bed with call light within reach. R5's nurses note dated 1/26/26 at 07:30 (7:30 a.m.), written by LPN-C documents Dressing to R abdomen not intact. [R5's first name] noted holding area due to discomfort. Wound area beefy red with no S/S infection noted. Cleanse with wound cleanser, pat dry, Vaseline applied followed by boarder foam dressing. Reports itching during dressing change, encourage not to rub or scratch. R5's nurses note dated 1/26/26 at 11:05 a.m., written by LPN-C documents [Physician-U's name] did face to face visit today. NOR (new order received) Cleanse wound to R breast and abdomen with wound cleanser, pat dry, apply Vaseline, followed by dry dressing BID (twice daily) and PRN (as needed). Monitor closely for S/S of infection. Update MD (medical doctor) with any concerns or signs of infection. [R5's first name] in bed with call light in reach. R5's skin assessment dated [DATE] at 15:10 (3:10 p.m.) written by Unit Manager/Registered Nurse (UM/RN)-F documents Skin Issue: #001: Skin issue has been evaluated. Location: Abdomen – generalized. Issue type: Burn. Progress: New: new wound. Full thickness burn. Wound acquired in-house. Wound is new. Signs and symptoms of infection: None. Painful: Yes. Wound pain (Frequency): Intermittent. Pain description: Aching. Pain description: Sharp. Wound pain interventions: Change in position. Wound pain interventions: Relaxation techniques. Wound pain interventions: Distraction techniques. Relief from interventions: Yes. Staged by: N/A (not applicable). Length (cm): 0.75 Width (CM): 0.34 Depth (cm): 0 Area (cm2) 0.12 Undermining: No. Tunneling: No. Epithelial: 50%. Eschar: 50% Exudate amount: None. Exudate type: None. Odor after cleansing: None. Other wound bed: pink or red. Other wound bed: scab. Peri wound: Attached. Surrounding tissue: Erythema. Induration: None present. Edema: No swelling or edema. Peri wound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Minimal < (less than) 25%. Modalities: None. Surveyor noted R5's burn was not assessed until three days after R5 spilled hot soup on themself. R5's burns were assessed by Physician-U. There was not an RN assessment until six days later on 1/29/26. On 4/21/26, at 12:02 p.m., Surveyor asked LPN-C on 1/23/26 after R5 spilled hot soup on herself did she speak with the doctor or left a message. LPN-C informed Surveyor she would have to look at her progress note. Surveyor informed LPN-C her nurse's note documents [name of Physician-U's] office notified. LPN-C stated we call and fax. Surveyor asked LPN-C if the doctor got back to her that night. LPN-C replied not that night but the following morning he did. On 4/21/26, at 3:04 p.m., Surveyor asked Director of Nursing (DON)-B when does a Registered Nurse (RN) complete an assessment on a new skin impairment. DON-B informed Surveyor it has been the practice the nurse on the floor does the assessment regardless of if they are a RN or LPN. On the next weekly wound round the RN will do an assessment. Surveyor informed DON-B a LPN can gather information, but a RN must complete an assessment. Surveyor informed DON-B R5 spilled hot soup on herself on 1/23/26, there was not an assessment until three days later by Physician-U and a RN assessment was completed six days after R5 spilled her hot soup on herself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) R4 was admitted to the facility on [DATE]. R4's admission physician orders document: -Admit weight one time only for 1 day-order date of 12/8/25 and end date of 12/9/25. -Daily weight X (times) 2 days, every day shift for 2 days-order date of 12/8/25 and end date of 12/11/25. Surveyor reviewed R4's Medication Administration Record (MAR) for December 2025. Surveyor notes: -Admit weight one time daily for 1 day is blank for 12/8/25. -Daily weight X2 days is blank for 12/9/25 and 12/10/25. Surveyor notes the facility did not obtain weights as ordered by R4's physician. On 4/21/26, at 3:03 PM, Surveyor informed Director of Nursing (DON)-B R4's weights were not obtained on admission as R4's physician ordered. DON-B confirmed R4's weights should have been obtained, and physician orders should be followed. On 4/21/26, at 3:46 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Regional Nurse (RN)-I, and DON-B that R4's physician orders for weighs to be obtained were not followed.

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F 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents for 4 of 6 residents (R) reviewed for accidents (R3, R5, R8, and R7.) R3's and R5's examples rise to the severity/scope level of G. *R3 was admitted to the facility on [DATE]. On 12/24/25, facility staff assessed R3 to be at high risk for falls. Facility staff did not initiate resident specific fall interventions for R3. According to facility staff, R3 was confused and wandering during the overnight shift. On 12/25/25 at 6:45 AM, R3 was found lying on the floor in R3's room. R3 was sent to emergency room and diagnosed with bilateral (both sides) subarachnoid hemorrhage (bleeding into the space surrounding the brain) and a displaced fracture of left clavicle (broken collarbone that is out of alignment.) R3's fall was not thoroughly investigated by the facility to determine an accurate root cause. *R5 sustained a burn from hot soup served by facility staff. Facility staff did not complete a hot liquid assessment prior to R5 sustaining the burn. Surveyor observed R5 without R5's hot liquid and fall care plan interventions in place. *R8, who was assessed to be at high risk for falls, fell on [DATE]. R8's fall was not thoroughly investigated by the facility to determine a root cause. Surveyor observed R8 without R8's fall prevention care plan interventions in place. *R7 fell on 4/6/26 and the fall was not thoroughly investigated by the facility to determine a root cause. Surveyor observed R7 without R7's fall care plan intervention in place. Findings include: The facility policy titled Fall Mitigation Program with a last revision date of 1/23/26 documents in part: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls . For program identification purposes, the community utilizes high risk and at risk, using scoring method designated on the risk evaluation. Upon admission, the nurse will complete a fall-risk evaluation along with the admission assessment to determine the resident's level of fall risk. The nurse will initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk . High risk residents suggested interventions include but not limited to: . Indicate fall risk on care plan. May implement interventions from At Risk suggested interventions as appropriate . Provide additional interventions as directed by the resident's evaluation, including but limited to: Assistive devices, Increased frequency of rounds, Sitter-if indicated, Medication regimen review, Low bed, Alternate call system access, Scheduled ambulation or toileting assistance . Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The plan of care will be revised as needed. When any resident experiences a fall, the community will: Assess the resident. Complete a post-fall evaluation and continue monitoring for 72 hours. Complete an incident report. Notify physician and family. Review the resident's care plan and update as indicated. Document all assessments and actions. Obtain witness statements (if any) in the case of injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1.) R3 was admitted to the facility on [DATE] with diagnoses including Sleep behavior disorder, Stage 3 chronic kidney disease (moderate kidney damage,) and Parkinson's disease. R3's Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] documents: R3 is Independent to make decisions regarding tasks of daily life. R3 uses a walker. R3 requires substantial/maximum assistance for toileting. R3 is frequently incontinent urine. R3 had a fall in the last month. R3 had a fall in the last 2 to 6 months. R3 did not sustain an injury with these previous falls. R3 had a fall since being admitted at the facility. R3 has had a fall with injury since being admitted at the facility. Surveyor noted staff did not attempt a transfer, so transfer assistance required was not assessed or documented on R3's MDS assessment. R3's Hospital Discharge summary dated [DATE] documents in part: Final Discharge diagnoses: Syncope orthostatic hypotension (A sudden drop in blood pressure upon standing, causing dizziness, lightheadedness, or fainting,) thrombocytopenia and acute on chronic heart failure. Hospital Course: [R3] presented with episodes of loss of consciousness associated with rigidity and jerking, always preceded by prodromal dizziness and occurring upon standing. Initial workup included CT head, which showed no acute intracranial pathology . The principal problem during this admission was symptomatic orthostatic hypotension, likely multifactorial in the setting of cardiac amyloidosis (rare and serious condition where abnormal proteins deposit in the heart muscle making the heart stiff and thick) with autonomic dysfunction. [R3's] hospital course was complicated by acute, severe thrombocytopenia following recent heparin exposure during [cardiac] catheterization . Anticoagulation and aspirin were held due to thrombocytopenia . Therapy assessments revealed significant decline in functional status compared to baseline, with ongoing needs for maximal assistance with bed mobility, transfers and ambulation due to orthostatic symptoms, generalized weakness, and Parkinsonism. Surveyor noted R3 was admitted to the facility and has multiple risk factors, history of falls and syncope, orthostatic hypotension, and a significant decline in functional status which contribute to R3's high risk for falls. Surveyor noted R3's therapy assessment completed at the hospital documents R3 requires maximal assistance with transfers and ambulation. Surveyor reviewed R3's Electronic Medical Record (EMR) and noted the facility did not document R3's transfer status on admission. R3's admission blood pressure taken at 3:26 PM, documented 88/49. Surveyor noted a normal blood pressure for adults is defined as less than 120/80. (National Heart, Lung, and Blood Institute: Blood Pressure Reading, July 12, 2018.) Surveyor noted R3's hypotension continued from the hospital, which contribute to R3's high risk for falls. R3's clinical admission assessment dated [DATE] at 3:23 PM, documents in part: . Resident follows commands . Alert and oriented x 3. Oriented to person. Oriented to place. Level of cognitive impairment: Alert (some forgetfulness.) Resident is coherent. Speech is clear . Mental status note: does have episodes of confusion per [family member] when having hypotensive episodes. Mood is (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pleasant, no unwanted behaviors witnessed. Resident sleeps intermittently. Resident does not wander at night. Safety: The resident had a fall prior to admission/entry or reentry. The resident had a fall in the last 2-6 months prior to admission/entry or reentry . Call light is within reach . Gait is unsteady. Surveyor noted facility staff documented R3 has some forgetfulness, has episodes of confusion with hypotension, has had previous falls, and has an unsteady gait. Surveyor noted all of these put R3 at risk for falls. Surveyor noted facility staff documented R3's call light was within reach in the admission assessment. R3's Fall risk evaluation dated 12/24/25 at 3:19 PM, documents in part: Level of consciousness/mental status-intermittent confusion. Resident is chairbound/incontinent . Predisposing disease: 3 or more present. Resident had a change in condition in the last 14 days. Recent hospitalization history in last 30 days: Yes. Notes: admitted to [hospital on] 12-18 with falls and hypotensive episodes. Gait/balance: N/A (not applicable) - not able to perform function. Medication: Takes 3-4 these medications (or medication classes) currently and/or within last 7 days. Fall Risk Score: 21. Surveyor noted R3's Fall risk score is 21. Surveyor noted on the Fall risk evaluation form is documented: . If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. Surveyor reviewed R3's EMR and noted R3 did not have a high risk for falls care plan initiated after scoring high on the fall risk evaluation. On 4/20/26 at 3:05 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. Surveyor asked what the expectation is for care planning when a resident is admitted to the facility. NHA-A indicated the baseline care plan needs to be completed within 72 hours of admission. DON-B stated the facility also completes the admission assessment and that document has care plan triggers that can be initiated and will show up in the care plan. Surveyor reviewed R3's clinical admission assessment for care plan interventions documented. Surveyor noted facility staff did not initiate any care plan interventions from the admission assessment. R3's progress note dated 12/24/2025 at 11:16 PM documents in part: At 2200 (10:00 PM), [R3] noted with Seizure like activity and unresponsiveness . lasted 10-12 seconds, unresponsiveness > (greater than) 8 minutes waiting for 911 to arrive. [R3] breathing normally able to obtain vitals . [temperature] 98.0, [heart rate] 96, [respiratory rate] 21, [blood pressure] 116/55, [oxygen level] 97% [room air]. [R3] slowly began to move and speak however slow to speak and alert and oriented X (times) 2 with confusion. [R3] refusing to let 911 assess. [R3] is own person and continues to refuse. Writer updated on call MD . no new orders. Surveyor noted R3 had an episode of seizure-like activity which R3 had been experiencing at the hospital prior to being admitted to the facility. Surveyor noted facility staff documented R3 had confusion after this episode. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/21/26 at 12:48 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-P, who worked the night of 12/24 into 12/25/25. CNA-P stated at the beginning of the shift, EMS (Emergency Medical Services) was at the facility trying to evaluate R3 who was refusing to be evaluated. R3 refused transport to the hospital multiple times. CNA-P stated EMS left the facility and R3 remained. CNA-P stated R3 was confused after the incident. CNA-P stated R3 was wandering the unit hall and had to be redirected into R3's room. CNA-P stated eventually R3 fell asleep. CNA-P stated at the change of shift, CNA-P told the oncoming CNA to keep an eye on R3 because R3 was wandering and confused. Surveyor noted staff recalled after R3 experienced the seizure-like activity, R3 was found wandering and confused. Surveyor noted this would contribute to R3's high fall risk. R3's progress note signed by Licensed Practical Nurse (LPN)-M and dated 12/25/25 at 10:37 AM, documents in part: Writer found [R3] at [approximately 6:45 AM] on floor in room, large amount of blood noted around face and head with large hematoma forming above left eye. [R3] was awake and responding appropriately, stated [R3] was dizzy. Head stabilized, neuro checks and vitals done with initial [blood pressure] at 78/40. [Range of motion evaluated] and [within normal limits (wnl)]. [R3] was able to easily sit onto buttock and then stand with one assist and take two steps onto bed. [R3] placed on back and legs elevated. [Blood pressure] rechecked and now at 114/69. neuro checks again wnl and [R3] continues to respond appropriately however began to have twitching. Writer called ambulance transport to send to ER for [evaluation due to] recent [history] of low platelets (blood thinners currently on hold) and obvious head trauma. Hematoma cleansed while in bed and laceration noted above left eye, which was only oozing, blood-clotting, cold cloth applied for swelling. Also noted 3 skin tears to back of left hand . Ambulance here at approx. [7:30 AM] and transferred to [hospital]. R3's Hospital Emergency Department note dated 12/25/25, documents in part: . Unfortunately, during the night, [R3] had an unwitnessed fall where [R3] suffered injuries to [R3's] left orbit, left shoulder, and left hand. It is unknown whether [R3] had any loss of consciousness. [R3] was found this morning by staff and sent to the emergency department for evaluation . Radiology results: Xray Shoulder Left Impression - . Displaced fracture of left clavicle acromial end . CT (Computed Tomography) head impression - . Multifocal subarachnoid hemorrhage over right greater than left bilateral frontal and temporal lobes . [R3's] CT scan has been discussed with radiology. [R3] has bilateral subdural hematomas . Case has been discussed with [outside hospital]. [MD] from neuro ICU has evaluated [R3's] pictures . [R3] will be transferred . R3's progress note dated 12/25/25 at 12:26 PM, documents in part: writer called . [Emergency Department] for update. Per RN (Registered Nurse), [R3] is currently in ED awaiting transport to [outside hospital] for brain bleed . Surveyor noted R3 was transferred to an outside hospital for continued care of R3's injuries. R3's risk management (investigation) for fall dated 12/25/25 at 6:50 AM, documents in part: Found [R3] on right side in fetal position on floor between foot of bed and bathroom door. Large hematoma forming above left eye and blood covering face and floor. [R3] was awake and responding . Noted that urinal with urine was spilled on floor between bed and doorway and bedside table had been pushed into bathroom doorway. [R3] was in bare feet (slippers noted on floor next to him). Call light was not engaged . Resident description, I don't really remember what I was doing, I am dizzy. Mental status: Oriented to person, situation and time . Other info: Spilled urine noted on floor from urinal however puddle was not near resident and did not appear [R3] had stepped or slipped on puddle . No statements found. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted R3 fell less than 24 hours after admission to the facility. Surveyor noted the investigation into R3's fall did not include when R3 was last seen and what R3 was doing the last time R3 was seen by facility staff. Surveyor noted the facility investigation did not include the last time R3 was assisted to the toilet or changed by staff. Surveyor noted facility staff did not collect statements from the previous shift to answer some of these questions. R3's Interdisciplinary Team (IDT) note dated 12/26/25 at 10:29 AM, documents: IDT team met to review 12/25/25 fall. Investigation reveals resident was self-transferring and/or slipped out of bed while utilizing urinal. Care plan was followed at time of fall. In so far as resident was transferred to acute care facility, care plan will be updated if resident returns - for [every 2 hours bowel and bladder] rounding and grippy socks. Surveyor noted the IDT team was uncertain of the root cause for R3's fall and documented R3 was either self-transferring and/or slipped out of bed. Surveyor noted the IDT team documented R3's care plan was followed at time of fall. Surveyor noted R3 did not have a fall care plan at the time of R3's fall. On 4/21/26 at 8:32 AM, Surveyor interviewed LPN-M, who was the nurse who found R3 on the floor. LPN-M stated LPN-M starts work at 6:30 AM and was completing first rounds when LPN-M found R3 on his room floor. LPN-M stated the bed was in a low position and R3 was found on his right side in the fetal position. LPN-M stated LPN-M assessed R3 and started to get vital signs. LPN-M stated R3 was alert but did not recall what had happened. LPN-M called 911. LPN-M treated R3's bleeding wound on his head and continued to monitor R3 while waiting for EMS to arrive. LPN-M stated R3's first blood pressure was low but that subsequent blood pressures were normal. LPN-M stated R3 was able to answer questions. Surveyor asked how long R3 was on the floor before being found by LPN-M. LPN-M stated, I don't know, and I have no way of knowing. LPN-M stated R3 could not tell LPN-M how long he had been on the floor. On 4/21/26 at 1:20 PM, Surveyor returned to LPN-M. Surveyor asked what LPN-M was told during morning report from the previous shift nurse. LPN-M stated the night nurse reported to LPN-M that R3 had been seen trying to self-transfer. LPN-M stated the night nurse told LPN-M R3 was wandering around the hallway outside of his room. LPN-M was also told of the seizure-like activity R3 experienced and then R3's refusal to be sent to the hospital. Surveyor noted LPN-M received morning report indicating R3 was self-transferring and wandering during the night, putting R3 at greater risk for falls. Surveyor noted facility staff could not identify when R3 was last seen or assisted and how long or an approximate time frame of how long R3 was on the floor after R3's fall. On 4/21/26 at 2:05 PM, Surveyor interviewed CNA-O. Surveyor asked what CNA staff need to do if a resident falls. CNA-O stated CNA-O would make sure the resident is safe and get the nurse. CNA-O would then assist the nurse with whatever was needed. CNA-O stated after the resident is cared for, the CNA will fill out an incident report/statement. The information included in the statement is things like if the call light was on or within reach, were there any puddles on the floor, if the resident's bathroom needs were met, and was the resident thirsty or hungry. CNA-O stated there is more but that is the kind of things listed on the statement. Surveyor asked how CNAs know what fall prevention interventions are in place for a resident. CNA-O stated they are listed in the medical record in the care plan. CNA-O stated the nurse will also let the CNAs know of any pertinent information. CNA-O stated the roster sheet has some info on it as well. Surveyor asked what a roster sheet entails. CNA-O stated the roster sheet has a list of the residents on the unit and basic information about the resident. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/21/26, Surveyor asked Director of Nursing (DON)-B if Surveyor could view R3's roster sheet. DON-B stated only current residents would have roster sheets available. Surveyor notes R3 is not a current resident. On 4/21/26 at 8:21 AM, Surveyor interviewed Registered Nurse (RN)-G. Surveyor asked what RN-G would do if a resident was found on the floor. RN-G stated RN-G would assess the resident, get vital signs and start neuro checks. Once safe, staff would get the resident off the floor. From there, RN-G would try to figure out why the resident fell. RN-G would start the risk management documentation. RN-G stated if someone else found the resident, RN-G would get a statement from them to put in the risk management document. RN-G then would enter a fall intervention. On 4/21/26 at 2:35 PM, Surveyor interviewed DON-B. Surveyor asked what the expectation is for nursing staff if a resident is found on the floor. DON-B stated the nurse should perform an assessment, complete vital signs and ensure that the resident is not in immediate distress. The nurse would complete passive range of motion to assess for injury. After initial assessment is completed, the nurse will complete the fall check list, which is completed for any fall. The nurse will complete the risk management documentation. Surveyor asked if it is an expectation that statements be collected. DON-B indicated DON-B would expect at bare minimum to enter a staff statement in the statement section of the risk management documentation. DON-B stated DON-B would expect to see statements from staff members involved like the nurse or CNA who found the resident. Surveyor asked if statements or interviews are collected from staff on the previous shift with questions answered like who last saw the resident, what was the resident doing when seen, when was the resident last assisted to the bathroom. DON-B stated they do not typically do that. DON-B indicated DON-B has to prioritize what investigations get a deep dive. Surveyor asked what that meant. DON-B indicated that a fall with injury would require a more thorough investigation. Surveyor asked if DON-B was aware of R3's fall. DON-B indicated DON-B was familiar with the fall. DON-B stated the fall and investigation were complicated by the night shift staff who were agency staff and no longer work at the facility. Surveyor shared the concerns R3 was assessed by facility staff to be at high risk for falls within an hour of admission. Prevention protocol was not immediately initiated and documented on the care plan as the direction on the facility fall risk assessment documents. Facility staff documented R3 was confused and informed Surveyor in interview R3 was wandering during the night shift after seizure like activity. R3 fell and was found on the floor in R3's room. R3 sustained a major injury. R3's fall investigation was not thorough and did not include when R3 was last seen to determine how long R3 was on the floor, when R3 was last toileted, and what R3 was doing when R3 was last seen. Without a thorough investigation an accurate root cause was not identified and interventions to address the root cause could not be determined. On 4/21/26 at 3:30 PM, Surveyor informed NHA-A, DON-B, and Regional Nurse-I of the above concerns. On 4/22/26 at 7:55 AM, NHA-A and DON-B informed Surveyor the facility has a post fall document that is completed after falls that contains more information that helps guide the IDT team in determining a root cause and guides IDT team decisions for a new intervention. In R3's case, however, R3 did not return to the facility after R3's fall and this was not completed. DON-B stated the post fall document is not completed if the resident is discharged from the facility. DON-B indicated it is the facility process currently, but the facility is open to making that improvement of filling it out for every fall going forward. No further information was provided as to why the facility did not ensure R3 received adequate (continued on next page)

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	525668	A. Building B. Wing	04/22/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	supervision and assistance devices to prevent accidents. *2.) R8 was admitted to the facility on [DATE] with diagnosis that include Dementia, History of falling, Chronic Kidney Disease, Depression, Syncope and collapse, Osteoporosis, and Osteoarthritis. R8's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents, in part: R8 is severely cognitively impaired. R8 uses a wheelchair. R8 requires substantial/moderate assistance for personal hygiene, toileting, bed mobility and transfers. R8 is always incontinent of bowel and bladder. R8 has had a fall without injury since last assessment. R8's Fall risk assessment dated [DATE] documents a score of 11, indicating R8 is at high risk for falls. R8's fall care plan initiated on 2/20/24 documents the following pertinent interventions: Assist with toileting as needed. Bed in low position when occupied or when not providing direct care. Bilateral floor mats to bedsides. Body pillow in bed to simulate presence of husband in bed. Educated to call for assistance with frequent reminders. Ensure resident is wearing nonskid socks. Pillows to both sides of bed. Floor mats to both sides of bed. Follow facility fall protocol. Increase staff involved activities with resident. R8's progress note signed by Licensed Practical Nurse (LPN)-C and dated 10/21/25 at 4:30 PM, documents, in part: [R8] observed sitting on floor in TV area at [3:45 PM], tried adjusting [themselves] and slid out of chair. [R3] did not hit [R3's] head, sitting with arm cross watching TV. No apparent injuries or bruises noted. [Vital Signs Stable] and [Within Normal Limits], [Bilateral Upper Extremities] and [Bilateral Lower Extremities Range of Motion Withing Normal Limits]. Denies any pain/discomfort at this time. Hoyer lifted back to [wheelchair]. R8's Fall Risk Management document dated 10/21/25 at 3:45 PM, documents, in part: [R8] observe sliding out of chair in TV area. Resident description: I was trying to adjust myself. Mental Status-Oriented to person . Level of Consciousness-confused. Predisposing physiological factors-incontinent. No Statements found. R8's Post fall evaluation dated 10/21/25 at 10:26 PM, documents, in part: Date/Time of fall: 10/21/25 at 3:45 PM. Fall was witnessed . Fall location: TV lounge area. Activity at the time of fall: Adjusting [themself] and slid out of chair. Reason for fall: scooting down in chair . No injury. R8's care plan summary note dated 10/22/25 at 5:57 AM documents, [Power of Attorney] agreed to pay monthly fee for Broda chair. Administrator order[d] chair [and] will be delivered 10/22/25. R8's Progress note dated 10/27/25 at 12:17 AM, documents: [Interdisciplinary Team (IDT)] team met to review 10/21/25 fall. Broda chair implemented as intervention. No further concerns at this time. Care plan updated. Surveyor noted the facility investigation into R8's fall did not document what R8 had on R8's feet, when R8 was last seen before the fall, or when R8 was last assisted with incontinence care. The investigation did not document why R8 was shifting in R8's chair, for example, was R8's brief soiled, was R8 reaching for something, or was R8 in pain and was shifting to reposition. Surveyor noted the facility did not complete a thorough investigation to determine the root cause. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/21/26 at 8:57 AM, Surveyor interviewed LPN-C. Surveyor asked if LPN-C could inform Surveyor what happened when R8 fell on [DATE]. LPN-C stated LPN-C was walking by and noted R8 leaning forward. LPN-C came around the corner and R8 had slid to the floor. LPN-C stated R8 was more fidgety and restless but stated R8 had just returned from an activity. LPN-C stated R8 had shoes on at the time of the fall but was unsure of when R8 was last toileted. Surveyor asked what documentation needs to be completed after a resident has a fall. LPN-C stated the risk management document needs to be filled out. LPN-C stated there is a fall checklist to complete as well. Surveyor asked if statements are collected from staff that may have witnessed the fall or been assigned to care for the resident. LPN-C stated the 2 CNAs that are working the unit should give statements. The statements are entered into the risk management document or given to unit supervisor or Director of Nursing (DON)-B. On 4/21/26 at 8:10 AM, 8:45 AM, 9:15 AM and 10:02 AM, Surveyor noted on each observation, R8 was observed in a low bed on R8's back. Surveyor observed R8 had a fall mat on R8's left side of the bed but did not have a fall mat on R8's right side of bed per fall care plan interventions. Surveyor observed R8 did not have a body pillow in bed to simulate presence of husband in bed per fall care plan intervention. Surveyor observed R8 did not have pillows on both sides of the bed per fall care plan intervention. On 4/21/26 at 2:35 PM, Surveyor interviewed DON-B. Surveyor asked what the expectation is for nursing staff if a resident is found on the floor. DON-B stated the nurse should perform an assessment, complete vital signs and ensure the resident is not in immediate distress. The nurse would complete passive range of motion to assess for injury. After initial assessment is completed, the nurse will complete the fall check list, which is completed for any fall. The nurse will complete the risk management documentation. Surveyor asked if it is an expectation statements be collected. DON-B indicated DON-B would expect at bare minimum to enter a staff statement in the statement section of the risk management documentation. DON-B stated DON-B would expect to see statements from staff members involved like the nurse or CNA who found the resident. Surveyor asked if statements or interviews are collected from staff on the previous shift with questions answered like who last saw the resident, what was the resident doing when seen, when was the resident last toileted. DON-B stated they do not typically do that. DON-B indicated DON-B has to prioritize what investigations gets a deep dive. Surveyor asked what that meant. DON-B indicated a fall with injury would require a more thorough investigation. Surveyor asked if fall care plan interventions should be followed by staff. DON-B indicated they should be followed. Surveyor informed DON-B of the concerns R8 was assessed to be at high risk for falls and fell on [DATE]. The facility did not complete a thorough investigation to determine a root cause and to allow for fall prevention interventions that address the root cause of the fall to be implemented. Surveyor asked if DON-B had any thoughts on R8's fall that occurred on 10/21/25. DON-B stated it was witnessed and there was no injury. DON-B stated the intervention of a Broda chair has proven effective since R8 has not fallen since the fall. On 4/21/26 at 3:40 PM, Surveyor informed Nursing Home Administrator (NHA)-A, DON-B and Regional Nurse-I of the above concerns and the concern that fall care plan interventions were observed not to be in place on multiple observations. On 4/22/26 at 7:55 AM, NHA-A and DON-B provided additional information to Surveyor including an Addendum to the post fall evaluation. The document was hand signed by LPN-C on 4/21/26 at 6:30 PM. Surveyor noted the post fall evaluation document was printed out. In the section documenting contributing factors, there is handwritten check marks indicating yes or no answers. The contributing factor section of the document includes pertinent questions like: Recent change in environment, fluid (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	spilled on floor, clutter on floor, poor lighting, was wheelchair involved, Footwear at the time of the fall, etc. Surveyor noted the post fall evaluation was not completed at the time of R8's fall and these answers in the contributing factors section were all left blank on 10/21/25 and are now handwritten in on 4/21/26. Surveyor noted included in the additional information was an addendum to LPN-C's statement documented: [R3] was in [R3's] chair, just coming back from an activity. [LPN-C] was going down the hallway and when [LPN-C] looked back to look at [R8], [R8] was reaching forward and scooting out of the wheelchair and [LPN-C] immediately responded. By the time LPN-C got to [R8], [R8] was sitting on [R8's] bottom watching tv on the floor with [R8's] arms crossed. [LPN-C] evaluated [R8] and [R8's] [family member] was there witnessing. [R8's] shoes were on [R8's] feet. [LPN-C] updated the doctor that day. No skin issues. No concerns. Connected with the DON and intervention was Broda chair for comfort due to fidgeting behavior. Surveyor noted LPN-C documented R8 was reaching forward. Surveyor noted LPN-C documented R8 had shoes on and had returned from an activity. Surveyor noted LPN-C also documented the intervention put in place was due to fidgeting behavior. Surveyor noted initially facility staff documented the fall occurred from adjusting in R8's chair. Surveyor noted in the addendum provided, facility staff documented R8 was fidgety and reaching forward however the investigation does not address the cause of the fidgety or leaning forward behavior. On 4/22/26 at 11:20 AM, after reviewing all provided documentation, Surveyor returned to NHA-A, DON-B and Regional Nurse-I and informed facility leaders of the continued concern R8's fall was not thoroughly investigated in October of 2025 to determine a root cause. DON-B indicated R8's fall investigation needed some work and DON-B acknowledged that. NHA-A stated facility staff look at the entire person, thoughtfully enter new interventions and noted that R8's intervention has been effective. No further

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 2 (R7 & R1) of 2 residents reviewed for parenteral fluids are administered in accordance with physician orders and comprehensive person-centered care plan.*R7 was admitted to the facility on [DATE] with a PICC (Peripherally Inserted Central Catheter) which is a soft, thin, flexible tube in a vein used to administer IV (Intravenous) medications and fluids. The facility did not obtain physician orders or create a care plan for R7's PICC line until 4/14/26.*Physician orders for R1's PICC line were not followed on 1/29/26, 2/5/26, 2/7/26, 2/11/26, and 2/16/26.Findings include:The facility's policy titled, Central Venous Catheter Care and Dressing Changes revised March 2022 under Purpose documents The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. Under General Guidelines documents 1. Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled). 5. Assess central venous access devices with each infusion and at least daily: a. Visually inspect the entire infusion system (solution, administration set and dressing); b. Check expiration dates of the infusion, dressing, and administration set; c. Assess the patency of the vascular access device; d. Palpate and inspect the skin, dressing and securement device for signs of complications, including: (1) dislodgement; (2) redness; (3) tenderness; (4) swelling; (5) infiltration; (6) induration; (7) elevated body temperature; or (8) drainage. e. Ask the resident if he or she is experiencing pain, tingling or numbness; f. Remove any non-transparent dressing and visually inspect the insertion site if any signs or symptoms of complication are present. 6. Measure the length of the external central vascular access with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion. 8. For PICCs, measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep-vein thrombosis.1.) R7 was admitted to the facility on [DATE] with diagnoses which includes malignant neoplasm (cancerous tumor) of endometrium (inner lining of uterus), and malignant ascites (accumulation of cancer cell containing fluid in the abdomen).R7's hospital labs and imaging include documentation of IR (interventional radiology) venous access PICC placement dated 4/2/26 under narrative documents VAT placed 4 French Double Lumen Solo PICC at bed side; L (left) arm basilic. Arm circ (circumference) 28 cm (centimeters). PICC length 42 cm at hub externally.R7's clinical admission assessment with an effective date of 4/6/26 at 19:02 (7:02 p.m.), under the Special Care section includes 17. PICC Line - Care Profile, 32. Length of PICC, 33. PICC solution, 34. PICC location, 35. PICC patency, 36. PICC patency - Other, & 37. PICC site. Surveyor noted none of these items have been completed. R7's skin check note dated 4/6/26 at 19:02 (7:02 p.m.), written by Registered Nurse (RN)-K documents Skin: Skin warm & dry, skin color WNL (within normal limits) and turgor is normal. Resident does not have an external device. Foot evaluation completed. Skin Issues: Skin Issue: #001: Skin issue has not been evaluated. Location: Buttocks - generalized. Issue type: Other skin issue. Other skin issue description: pink, blanchable skin Wound was present on admission. Skin Issues Noted: pink, blanchable buttocks. BUE (bilateral upper extremities) bruising; resident states That's from the IV (intravenous) and pokes Skin issue education: Change clothing/briefs. Skin issue education: Turn every 2 hours. Skin issue education: Change/shift positions frequently. Surveyor noted this skin check does not include R7's PICC line.R7's nurses note dated 4/6/26 at 23:42 (11:42 p.m.), written by RN-K documents Resident is a [age and sex] admitted to [facility's initials], Rehab East, Room [number] on 4/6/26 at 1619 (4:19 p.m.) from [Name] hospital. Arrived to [facility's initials] via ambulance; arrived to unit on stretcher accompanied by EMS (emergency medical services). Admitting diagnosis: weakness. Resident alert and oriented x (times) 4, able to make needs known to staff. Pleasant and cooperative; relaxed and calm. Fall education provided; resident states (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understanding of fall education. Call light education provided; resident states understanding of call light education. Resident states she will use call light to call for help when needed. Resident oriented to: [facility's initials], unit, room, TV remote, bed remote, food service, call light. admission paperwork reviewed with resident; resident states understanding of admission paperwork; admission paperwork signed by resident. Code preference discussed with resident; resident states understanding of code preference discussion Resident signs code preference. Code preference: Full code/CPR (cardiopulmonary resuscitation). Zyprexa consent reviewed with resident; resident states understanding of Zyprexa consent; consent signed by resident. [Medical Doctor (MD)-L's name] notified of resident's admission to unit; discharge summary and medication list reviewed by [MD-L's name]. No new orders. See PCC (point click care) charting for admission clinical assessment, skin assessment, Braden scale score, and elopement evaluation score. Surveyor noted this nurse's note does not include R7's PICC line.Medical Doctor (MD)-L's post-acute care admission history and physical dated 4/7/26 under assessment and plan for Endometrial serous carcinoma includes PICC line placed 4/2.R7's skin check dated 4/9/26 at 13:40 (1:40 p.m.), does not include documentation of R7's PICC line.R7's admission MDS (minimum data set) with an assessment reference date of 4/9/26 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact.Surveyor reviewed R7's physician orders when R7 was admitted on [DATE] and noted there are no orders for monitoring and care of R7's PICC line and a care plan was not developed until 4/14/26, eight days after admission.Surveyor reviewed R7's physician orders for R7's PICC line orders and noted orders dated 4/14/26 document Sodium Chloride 0.9% Use 10 milliliters intravenously two times a day for flush PICC line. Change PICC line dressing and injection caps weekly every evening shift every Tue (Tuesday) and Monitor LUE (left upper extremity) PICC line for signs and symptoms of infection two times a day. Surveyor noted there is not an order to measure the length of R7's PICC line and arm circumference to assess for edema and possible DVT (deep vein thrombosis).On 4/20/26, at 9:58 a.m., Surveyor observed R7 sitting in a personal type of recliner in R7's room. R7 explained to Surveyor this is the beginning of her third week at the facility and was diagnosed with cervical cancer at the hospital. Surveyor asked R7 if she has a PICC line. R7 replied yes, thinks for infusions. R7 explained she had one infusion and wanted to speak to the social worker as she goes to [name of hospital] stand alone clinic for infusions. Surveyor asked R7 what staff do for her PICC line. R7 informed Surveyor they flush it every day. On 4/20/26, at 2:19 p.m., Surveyor informed Licensed Practical Nurse (LPN)-E R7 was admitted to the facility on [DATE] and asked if she knew why there weren't any orders for R7's PICC line until 4/14/26. LPN-E replied I'm not sure.On 4/21/26, at 10:03 a.m., Surveyor observed sitting in a personal type recliner with her legs up and knees bent. Surveyor asked R7 if her PICC line was flushed today. R7 replied yes and last night. Surveyor asked R7 if she was admitted to the facility with the PICC line. R7 replied yes explaining she received the PICC line at [name of hospital]. R7 showed Surveyor her PICC line site which has a dressing dated 4/14.On 4/21/26, at 10:10 a.m., Surveyor asked Licensed Practical Nurse (LPN)-M if she flushed R7's PICC line this morning. LPN-M replied yes explaining she flushes the line when she does R7's medications. Surveyor asked LPN-M if she knew why the weren't any order relating to R7's PICC line until 4/14/26 when R7 was admitted on [DATE]. LPN-M informed Surveyor she didn't know.On 4/21/26, at 10:15 a.m., Surveyor asked Unit Manager/Registered Nurse (UM/RN)-D when a resident is admitted who is responsible for the resident's orders. UM/RN-D informed Surveyor the nurse whoever is on the shift would complete the orders. Surveyor asked who ensures the orders are complete. UM/RN-D informed Surveyor the unit managers typically. Surveyor informed UM/RN-D R7 was admitted on [DATE] and there were no orders for R7's PICC line until 4/14/26. Surveyor asked UM/RN-D if she knew why there weren't any orders until eight days after admission. UM/RN-D replied I would have to look to get you exact information, that is used for chemotherapy. Surveyor asked UM/RN-D to investigate this and get back to Surveyor.On 4/21/26, at 11:45 a.m., Director of Nursing (DON)-B asked to speak to Surveyor regarding R7's PICC line. DON-B informed Surveyor upon admission there were no orders (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the hospital for dressing change, R7 wasn't on IV medication and it's their hope the hospital provides orders. Surveyor asked if the hospital doesn't include orders for PICC line is it his expectation the nurse would get orders from the doctor. DON-B replies yes. DON-B informed Surveyor he did contact the hospital for them to investigate why there were no orders for R7's PICC line. DON-B informed Surveyor part two of the story is the expectation is when R7 came in under the skin check should have been documented the PICC line which it did not. DON-B informed Surveyor the two nurses that performed the skin check received coaching and they did a skin sweep. Surveyor informed DON-B R7's clinical admission assessment dated [DATE] PICC line section was not completed. DON-B informed Surveyor this is typically completed by the PM (evening) nurse. Surveyor asked if anyone reviews this assessment. DON-B informed Surveyor it's the responsibility of the nurse manager. DON-B informed Surveyor R7's PICC line should have been picked up with the skin assessment.2.) R1 was readmitted to the facility on [DATE] and discharged on 2/25/26.Diagnoses include infection and inflammatory reaction due to internal left hip prosthesis, presence of left artificial hip joint, presence of left artificial knee joint, hypertension (high blood pressure), depression (serious mood disorder that causes a persistent feeling of sadness and a loss of interest in activities, interfering with daily life), and anxiety disorder (group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life).R1's physician progress note dated 1/23/26 under subjective documents [R1's name] is a [age and sex] with multiple comorbidities and recent 1. Left total hip arthroplasty antibiotic and antifungal spacer. 2. Left total knee arthroplasty rigid antibiotic spacer. 3. Left femur periprosthetic fracture. 4. History of fungal and poly microbial infection left total hip arthroplasty, left femoral plate fixation. Major procedures: (see full procedure/operative note(s) for details). Procedures: Left arthroplasty femur total Wound Class: Contaminated - Incision Closure: Deep and Superficial Layers. Left removal hardware knee with cement spacer - Wound Class: Contaminated - Incision Closure: Deep and Superficial layers. Left - Arthroplasty hip revision (posterior approach) to total femur- patient was sent out to the hospital because of brownish tannish drainage from let hip incision. Patient was evaluated underwent washout of incision followed by closure. She has been put on vancomycin as she tested positive for staph epi dermatitis infection to the wound along with Pseudomonas. Currently on cefepime and vancomycin. Transferred back to facility for ongoing care. Work with PT (physical therapy) OT (occupational therapy) no other nursing concerns denies any chest pain diaphoresis palpitation all hospital records were reviewed.Surveyor reviewed R1's physician orders and noted the following orders:*Change injection caps weekly w/(with) PICC (peripherally inserted central catheter) line dressing change in the evening every Thu (Thursday) with a start date of 1/22/26.*Change PICC line dressing weekly in the evening every Thu (Thursday) with a start date of 1/22/26.*Monitor PICC line site every shift for signs & symptoms of infection every shift + = s/sx (signs/symptoms) of infection noted - = No s/sx of infection noted with start date of 1/22/26.*Flush PICC line lumens every shift w/10ml (with 10 milliliters) normal saline every shift with a start date of 1/22/26.*Measure PICC external catheter length (cm) (centimeter) with weekly dressing change in the evening every Thu, Notify MD (medical doctor) of change in length with a start date of 1/22/26.*Measure PICC line arm (left) circumference 3in (inches) above the insertion site Q (every) shift. Every shift notify MD of change in length with a start date of 1/29/26.Surveyor reviewed R1's January 2026 TAR (treatment administration record) and noted on 1/29/26 change injection caps weekly with PICC line dressing change in the evening every Thursday, Change PICC line dressing weekly in the evening every Thursday, Measure PICC external catheter length (cm) with weekly dressing change in the evening every Thursday, Measure PICC line arm (left) circumference 3 in above the insertion site every shift and Monitor PICC line site every shift for signs and symptoms of infection are all blank for the evening shift. Treatments completed have a check mark with the nurse's initial on the TAR.Surveyor reviewed R1's progress note for 1/29/26 and did not locate any documentation as to why R1's PICC physician orders were not followed.Surveyor reviewed R1's February 2026 TAR. On 2/1/26 Monitor PICC line site every shift for (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs and symptoms of infection is blank for the night shift. On 2/5/26 change injection caps weekly with PICC line dressing change in the evening every Thursday, Change PICC line dressing weekly in the evening every Thursday, Measure PICC external catheter length (cm) with weekly dressing change in the evening every Thursday, Measure PICC line arm (left) circumference 3 in above the insertion site every shift for the evening and night shift, Flush PICC line lumens every shift with 10 ml normal saline is blank for the evening & night shift and Monitor PICC line site every shift for signs and symptoms of infection for the evening shift are blank.On 2/7/26 Flush PICC line lumens every shift with 10 ml normal saline, Measure PICC line arm (left) circumference 3 inches above the insertion site every shift and Monitor PICC line site every shift for signs and symptoms are blank for the night shift.On 2/11/26 Monitor PICC line site every shift for signs and symptoms of infection is blank for the day shift. On 2/16/26 Measure PICC line arm (left) circumference 3 inches above the insertion site every shift and Monitor PICC line site every shift for signs and symptoms of infection are blank for the day shiftSurveyor reviewed R1's progress notes for 2/5/26, 2/7/26, 2/11/26, & 2/16/26 and did not locate any documentation as to why R1's PICC physician orders were not followed.On 4/22/26, at 11:53 a.m., Surveyor asked Unit Manager/Registered Nurse (UM/RN)-F what is the expectation when a nurse completes a treatment for a resident. UM/RN-F informed Surveyor it would be in the TAR or a note if it was a one-time treatment. The expectation is that the nurse signs it out. Surveyor informed UM/RN-F of the multiple dates R1's PICC orders in January & February that were not initialed as being completed.

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	04/22/2026

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** Based on interview and record review the facility did not provide pharmaceutical services ensuring medications were available to be administered as ordered by their physician for 1 (R4) of 3 residents.*R4 has an order to receive Potassium Chloride Crys ER (Extended Release) Oral Tablet Extended Release 10 MEQ for Hypokalemia effective 12/9/25. R4 did not receive this medication on 12/27, 12/28, and 12/29/25.Findings Include:The facility policy titled, Providing Pharmacy Products and Services, dated 6/1/24, documents: . Applicability: This policy 1.0 sets forth procedures relating to the provision of Pharmacy Products and Services in accordance with the Pharmacy Services Agreement.Procedure1. Pharmacy will provide facility with the facility-specific pharmacy information placard which details how facility staff can contact pharmacy twenty-four hours a day, seven days a week.2. If orders for medications are received from physician/prescriber when pharmacy is closed, facility staff should take the following steps:2.1 Remind physician/prescriber that pharmacy is closed and that a delay in medication therapy can be prevented by using a medication that is included in facility's emergency supply.2.2 If a medication cannot be substituted, ask physician/prescriber if the medication therapy can be initiated the next morning. 2.2.1 If it is possible to initiate the medication therapy the next morning, facility staff should document the conversation with the prescriber and include the start time in the order.2.3 If a medication is considered essential and cannot be substituted or delayed, contact the emergency number provided by the pharmacy.R4 was admitted to the facility on [DATE] with diagnoses including Hyperlipidemia (high levels of fat particles in blood), Hyperosmolality (elevated concentration of solutes such as sodium, glucose, or urea in blood plasma), Hypernatremia (deficit of total body water relative to sodium causing dehydration and neurological dysfunction).R4's admission Minimum Data Set (MDS) completed 12/21/25 documents R4's Brief Interview for Mental Status (BIMS) score to be 8 indicating R4 demonstrated moderately impaired skills for daily decision making. On 12/27/25, at 10:51 AM, Licensed Practical Nurse (LPN)-C documents: . Writer called pharmacy and spoke with [name] in regard to Potassium Chloride crystal ER 10mg when will it be delivered. [Name] indicated that it was delivered on 12/23 at 1437 (2:37 PM) signed by LPN-G. Writer checked west cart and med room medication not found. Updated on call for facility physician (MD)-H updated and gave verbal okay to give when medication arrive.Surveyor reviewed R4's physician orders. Effective 12/9/25, R4 was to receive Potassium Chloride Crys ER Oral Tablet Extended Release 10 MEQ for Hypokalemia. Surveyor reviewed R4's Medication Administration Record (MAR) and noted R4 did not receive Potassium Chloride on 12/27, 12/28, and 12/29/25.On 4/21/26, at 3:03 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the process for medication delivery from the pharmacy. DON-B explained if a medication is not available then the first step is for the nurse to check in contingency. The second step is to call the pharmacy and contact the provider to get an intervention. DON-B stated all nurses were educated on the process in October of 2025. DON-B shared the expectation that no resident goes without their prescribed medication. Surveyor shared the concern R4 did not receive Potassium Chloride 12/27-12/29/25. DON-B was unaware R4 went without Potassium Chloride and stated that is concerning especially because most likely R4 was also on a diuretic. DON-B stated R4's Health Care Power of Attorney (HCPOA) should have been notified that R4 did not receive Potassium Chloride for three days. On 4/21/26, at 3:46 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Regional Nurse (RN)-I, and DON-B that R4 did not receive R4's Potassium Chloride for three days. On 4/22/26, at 8:11 AM, DON-B informed Surveyor the expectation of the process when a medication is not available is crystal clear to the nurses. DON-B shared performance improvement plan (PIP) was initiated back in October 2025, and DON-B started re-educating nurses last night on the process to follow when a medication is not available. Surveyor notes the re-education includes establishing a root cause of the issue, notify the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and HCPOA, and document in the progress notes. The process must be followed each and every time the medication is unavailable.On 4/22/26, at 11:50 AM, Surveyor reviewed the concern of R4 not receiving Potassium Chloride for three days.