

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025
NAME OF PROVIDER OR SUPPLIER Jewish Home and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 N Prospect Ave Milwaukee, WI 53202	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interviews, document review, and review of the facility policy, the facility failed to ensure narcotic counts were initialed by two nurses on all three shifts (7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM) at the change of shift to ensure the narcotic count was accurate for six of six medication carts reviewed. This failure had the potential for drug diversion.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Medication Administration, revised in July 2024, indicated . (3) At the start of each shift two nurses must count and verify narcotic count is correct and sign out on Narcotic Count Sheets (nurse leaving and nurse coming on duty or Nurse Supervisor).</p> <p>Review of the medication cart identified as 500 South on 06/12/25 at 7:41 AM with Registered Nurse (RN) 1 revealed the following:</p> <p>-06/07/25 the counting nurse at 11:00 PM did not sign off indicating the narcotic count was correct.</p> <p>Review of the medication cart identified as 500 North on 06/12/25 at 7:50 AM, with Licensed Practical Nurse (LPN) 2 revealed the following:</p> <p>-06/03/25 the recording nurse at 3:00 PM did not sign off indicating the count was correct,</p> <p>-06/04/25 the recording nurse at 11:00 PM did not sign off indicating the narcotic count was correct,</p> <p>-06/07/25 the recording nurse at 11:00 PM did not sign off indicating the narcotic count was correct,</p> <p>-06/08/25 the counting and recording nurse at 7:00 AM did not sign off indicating the narcotic count was correct,</p> <p>-06/08/25 the counting nurse at 3:00 PM did not sign off indicating the narcotic count was correct.</p> <p>Review of the medication cart identified as the 400 North cart on 06/12/25 at 8:10 AM, with LPN5 revealed the following:</p> <p>(continued on next page)</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
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-06/08/25 the counting and recording nurse at 7:00 AM did not sign off indicating the narcotic count was correct,</p> <p>-06/08/25 the recording nurse at 3:00 PM did not sign off indicating the narcotic count was correct,</p> <p>-06/08/25 the recording nurse at 11:00 PM did not sign off indicating the narcotic count was correct,</p> <p>-06/09/25 the recording nurse at 7:00 AM did not sign off indicating the narcotic count was correct.</p> <p>Review of the medication cart identified as 400 South on 06/12/25 at 8:15 AM, with LPN 4 revealed the following:</p> <p>-05/27/25 the recording nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-05/27/25 the counting and recording nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-05/28/25 the recording nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-05/31/25 the recording nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/01/25 the counting and recording nurse at 7:00 AM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/01/25 the counting and recording nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/01/25 the recording nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/02/25 the counting nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/02/25 the recording nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/04/25 the recording nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/05/25 the counting nurse at 7:00 AM did not sign the narcotic count sheet indicating the count was correct,</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-06/06/25 the counting nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/07/25 the counting nurse at 11:00 AM did not sign the narcotic count sheet indicating the count was correct.</p> <p>Review of the medication cart identified as 300 North on 06/12/25 at 8:38 AM, with LPN1 revealed the following:</p> <p>-06/04/25 the recording nurse at 7:00 AM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/07/25 the counting nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/08/25 the counting nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-6/09/25 the recording nurse at 7:00 AM did not sign the narcotic count sheet indicating the count was correct.</p> <p>Review of the medication cart identified as 300 South on 06/12/25 8:44 AM with LPN3 revealed the following:</p> <p>-05/27/25 the recording nurse at 7:00 AM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-05/29/25 the recording nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-05/29/25 the recording nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/02/25 the recording nurse at 7:00 AM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/04/25 the recording nurse at 7:00 AM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/04/25 the recording nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/07/25 the counting nurse at 3:00 PM did not sign the narcotic count sheet indicating the count was correct,</p> <p>-06/07/25 the counting and recording nurse at 11:00 PM did not sign the narcotic count sheet indicating the count was correct.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 06/12/25 at 7:41 AM, RN1 verified the narcotic count sheet was not signed on each shift for the 500 South cart.</p> <p>During an interview on 06/12/25 at 8:00 AM, LPN2 verified the narcotic count sheet was not signed on each shift for the 500 North cart. She stated the sheet should be signed with each narcotic count.</p> <p>During an interview on 06/12/25 at 8:10 AM, LPN5 verified the narcotic count sheet for the 400 North cart was not signed off by two nurses on each shift.</p> <p>During an interview on 06/12/25 at 8:15 AM, LPN4 verified the narcotic count sheet for the 400 South cart was not signed off by two nurses on each shift. She stated the count sheet was supposed to be signed during each narcotic count.</p> <p>During an interview on 06/12/25 at 8:39 AM, LPN1 confirmed the narcotic sheet for the 300 North cart was not signed by each nurse and that it should be.</p> <p>During an interview on 06/12/25 at 8:46 AM LPN3 confirmed the narcotic count sheet for the 300 South cart had not been signed on each shift for the 300 South cart.</p> <p>During an interview on 06/12/25 at 8:51 AM, the Director of Nursing (DON) confirmed the narcotic sheets were not signed off on each shift. She stated the nurses were supposed to sign the sheets during shift change when they counted the narcotics.</p>