STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525172	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home and Care Center	1414 N Prospect Ave Milwaukee, WI 53202

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49845 Based on interview and record review, the facility did not ensure 1 of 3 sampled residents (R2) was free from significant medication errors. * R2 received a medication, Morphine, on 05/26/2024, which is not on R2's Medication Administration Record (MAR) and is not prescribed to R2. After administration, this medication required close monitoring of R2's physiological status. *R2 had orders for Clonazepam, oral tablet, 0.5mg to be given two times per day (AM and PM) for Anxiety. On 05/21/2024, R2 received 1 mg of Clonazepam during the PM medication pass instead of 0.5mg as prescribed. Findings include: The facility policy titled, Medication Administration with a last revision date of 05/10/2023, documents, in part: Policy: medications will be administered to residents as prescribed by persons lawfully authorized to do so in a manner consistent with the infection prevention and standards of practice. Personnel authorized to administer medications do so only after they familiarized themselves with the medication. The facility has sufficient staff to allow the administering of medications without unnecessary interruptions. Procedure: 3. Prior to administration, the medication and dosage schedule on the MAR is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physicians orders are checked for correct dosage schedule. Administration: 2. Medications are administered in accordance with written orders of the attending physician or physician extender. Medications are administered at the time they are prepared. Medications are not pre-poured. 5. Medications are administered without unnecessary interruptions. 7. Residents are identified before medication is administered. Methods of identification include: a. Checking identification band b. Tracking photograph attached to medical record. c. Asking resident to say and/or spell his/ her name d. If necessary, verify resident identification with other facility personnel. 11. Medications supplied for one resident are never administered to another resident. (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 0760 Level of Harm - Actual harm Residents Affected - Few	The facility policy, titled Medication Errors, with a last revision date of 05/10/2023, documents in part, Policy: it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Procedure: 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders. b. Per manufacturer specifications regarding the preparation and administration of the drug or biological. c. In accordance with accepted standards and principles which apply to professionals providing services. 2. The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events. 3. Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines: a. Resident's Condition: if the resident's condition requires rigid control, such as strict intake and output measurement, daily weights, or monitoring of lab values. c. Frequency of Error: if an error is occurring repeatedly such as an omission of a resident's medication several times. 7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medication, dose, route, and time of administration; b. Right resident and right documentation. 8. If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible. b. Monitor and document the resident's condition, including response to medical treatment or nursing interventions. c. Document actions taken in the medical record. Per The National Institute of Health (NIH), National Library of Medicine (NLM), National Center for Biotechnology Information (NCBI), titled Morphine, with a last update of 05/22/2023, documents in part, Respiratory depression is among the more serious adverse reactions of Morphine and can also affect the cardiovascular system. Morphine can also affect the cardiovascular system and reportedly can cause flushing, bradycardia, hypotension, and syncope. Monitoring . Other essential parameters requiring monitoring include mental status, blood pressure, respiratory drive, and misuse/overuse. Although it may seem intuitive, it is also important to monitor what other medications a patient is taking. This list includes but is not limited to prescription medications. All patients taking morphine should understand the need to avoid any other substances that could lead to respiratory depression. These medications include but are not limited to alcohol, additional opioids, benzodiazepines, and barbiturates. Patients can become apneic at lower doses if combining morphine with any of these substances. Morphine (an opioid medication) is a Schedule II controlled substance, regulated by The Drug Enforcement Administration (DEA). Each category, of the five schedules of controlled substances, includes the substances' ability to cause harm. The schedules range from Schedule I (high) to Schedule V (low). The Food and Drug Administration (FDA) document, titled, Drug Safety Communications, dated 08/31/2016, documents in part, FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning. The FDA label for Morphine, titled, Highlights of prescribing information, MORPHINE SULFATE tablets, for oral use CII Initial U.S. Approval: 1941, documents in part, Contraindications- Significant respiratory depression. DRUG INTERACTIONS- Serotonergic Drugs: Concomitant use may result in serotonin syndrome. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	1.) R2 was admitted to the facility on [DATE] with a diagnoses that includes heart failure, depression, schizoaffective disorder, anxiety, and respiratory failure. R2's most recent annual Minimum Data Set (MDS), dated [DATE], documents R2 requires oxygen therapy. R2 had the following medication orders in place for May of 2024: Celexa, Clonazepam, Ergocalciferol, Gabapentin, Lasix, Melatonin, Primidone, Risperdal, Seroquel, Tylenol, Depakote Sprinkles, and Acidophilus. Surveyor noted that R2's medications, Celexa, is a Selective Serotonin Reuptake Inhibitor (SSRI) and R2's Clonazepam is a benzodiazepines. First medication error: Surveyor reviewed R2's electronic health record (EHR) and noted a progress note for a medication error on 05/21/2024. The progress note documents that on 05/21/2024, R2 received a double dose of her ordered Clonazepam. R2's EHR, administration record for May 2024, documents R2 had an order for Clonazepam 0.5mg two times per day (AM and PM). Surveyor reviewed the document provided by NHA (Nursing Home Administrator)-A, titled, Drug Error Report, with no date that documents: R2 was given Clonazepam 1 mg instead of Clonazepam 0.5mg at 04:34 PM by LPN (Licensed Practical Nurse)-G. Notifications on 05/21/2024 were made to Supervisor at 08:30 PM, Physician notified at 09:30 PM and family notified at 09:40 PM. Explanation of event documented, checked dosage in MAR but pulled from wrong card. Both cards next to each other. Corrective action taken, Clonazepam 1 mg card will be marked HS ONLY. No new orders. Surveyor noted that after the medication error that was no documentation that R2's vitals were monitored. On 08/22/2024 at 08:44 AM, Surveyor interviewed UM (Unit Manager)-D. UM-D informed surveyor that she recalls the medication error on 05/21/2024 and stated LPN-C made a medication error with R2's Clonazepam at 04:34 PM and that she was notified of this error at 08:30 PM. UM-D stated she went and preformed a full assessment of R2 at that time she was notified. UM-D was unable to find documentation in the chart of UM-D full assessment. UM-D presented surveyor with the first set of full vitals obtained following the medication error. The full set of vitals that were obtained on 05/21/2024, at 09:55 PM were: temperature 97.5 degrees Fahrenheit (F), heart rate 75 beats per minute (bpm), respirations 18, oxygen saturation (sp02) 93% on nasal cannula and blood pressure (b/p) 120/69. UM-D informed Surveyor that R2 was then monitored for 3 days every shift. UM-D stated she performed verbal training with LPN-C as to paying better attention to the medication cards being pulled. UM-D stated yearly training is preformed to all nursing staff on medication administration and reporting of medication errors. Surveyor noted that R2 had no specific orders for monitoring of R2 and no orders to obtain vital signs, to monitor R2 were documented in R2's Medication Administration Record (MAR)/ Treatment Administration Record (TAR) or progress notes after this medication error occurred. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Second medication error: Surveyor reviewed a progress noted, dated 05/27/2024, at 06:11 AM, that documents, Resident is alert and orient but drowsy. New order from [Nurse Practitioner] from Optum noted. Vital signs every hour X12 hours then q shift X 24 hours. Check neuro status at time of vital sign check. Resident noted to have decreased Bp and Spo2 R/T med error. [NAME] called 2 times this shift to check on resident's VS. verbal order to increase resident's oxygen via concentrator to 4 lpm d/t Spo2 @ 90% on 2L. O2 increased, and Pox increased to 94% via nasal cannula. Resident remained alert and responsive to verbal and tactile stimuli. Bp and Spo2 is within normal range at this time. Denies any pain or discomfort at this time. Surveyor reviewed the document provided by NHA-A, titled, Drug Error Report, with no date that documents in part: Date error occurred 05/26/2024 at 08:14 PM by Agency LPN-C. Supervisor notified on 05/26/2024 at 10:50 PM, Physician notified on 05/26/2024 at 11:30 PM and family notified on 05/27/2024 at 08:00 AM. Brief explanation or error- gave Morphine 30 mg instead of Clonazepam 1 mg in error. Explanation/statement of nurse making error- was pulling medications for another resident and needed to go to the restroom, then stopped and pulled medication for R2 and gave wrong medication. At the same time an ambulance was picking up another resident. Physician orders related to error: give 480 ml of fluid now, recheck vitals 30 mins and call Optum, vitals every hour for 12 hours then every shift for 24 hours. Corrective action documents see above. Date of counseling to nurse 05/31/2024 at 10:49 PM. Indicate how this error could have been prevented: complete one task at a time. Surveyor noted on R2's MAR/TAR the following order, 480 ml of fluid now. Recheck vital signs 30 min after and call Optum on call at [PHONE NUMBER] with update one time only for 1 Day -Start Date- 05/26/2024 2330 and documents, given at 03:16 AM b/p 94/59, temperature 97.3, pulse 80, respirations 18 and O2 90%. Surveyor noted the order was documented on R2's MAR/Tar as completed at 0316 hours. No documentation of Optum update, and no further new orders were located. Surveyor noted on R2's MAR/TAR the following order, Vital signs every hour X12 hours then q shift X 24 hours. Check neuro status at time of vital sign check every hour for 12 Administrations -Start Date- 05/27/2024 0000 and documents the following on 05/27/2024: 0000- b/p 79/50, temperature 97.4, pulse 76, respirations 19 and O2 92% 0100- b/p 88/42, temperature 97.1, pulse 85, respirations 19, and O2 93% 0200- b/p 85/51, temperature 96.9, pulse 90, respirations 18, and O2 91% 0300- b/p 94/59, temperature 97.3, pulse 80, respirations 18, and O2 90% 0400- b/p 98/63, temperature 97, pulse 75, respirations 18, and O2 91% 0500- b/p 98/58, temperature 97.6, pulse 77, respirations 19, and O2 94% 0600- b/p 108/69, temperature 97.7, pulse 75, respirations 19, and O2 95% (continued on next page)

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	525172	A. Building B. Wing	08/22/2024

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F 0760 Level of Harm - Actual harm Residents Affected - Few	0700- b/p 112/64, temperature 98.3, pulse 82, respirations 18, and O2 92% 0800- b/p 126/69, temperature 98, pulse 85, respirations 20, and O2 92% 0900- b/p 130/74, temperature 98.1, pulse 83, respirations 18, and O2 92% 1000- b/p 119/64, temperature 98, pulse 82, respirations 18, and O2 91% 1100- b/p 122/62, temperature 98, pulse 82, respirations 18, and O2 92% Surveyor calculated the Mean Arterial Pressure (MAP) for R2, using the formula MAP= 2(DBP) + SBP/3, for the first 4 documented blood pressures. At 0000 hours, R2's MAP was 59 mmHg, 0100 was 57 mmHg, 0200 was 62 mmHg and at 0300 R2's MAP was 70 mmHg. According to The National Institute of Health (NIH), National Library of Medicine (NLM), National Center for Biotechnology Information (NCBI) document, titled Low Blood Pressure, documents low blood pressure is defined as a blood pressure reading less then 90/60 millimeters of mercury (mmHg). According to The National Institute of Health (NIH), National Library of Medicine (NLM), National Center for Biotechnology Information (NCBI) document, titled Physiology, Mean Arterial Pressure, documents, To perfuse vital organs requires the maintenance of a minimum MAP of 60 mmHg. Surveyor noted a progress note, dated 05/27/2024, at 10:19 PM, documents Resident being monitored for medication error. VSS. Very lethargic this shift. No c/o pain or discomfort. Appetite good. Will monitor. Surveyor noted a change in condition progress note, dated 05/28/2024, which documents in part. Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Fever At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 104/49 - 5/28/2024 20:20 Position: Sitting r/arm - Pulse: P 92 - 5/28/2024 20:20 Pulse Type: Regular - RR: R 22.0 - 5/28/2024 20:20 - Temp: T 99.3 - 5/28/2024 20:20 Route: Forehead (non-contact) - Weight: W 256.0 lb - 5/3/2024 13:34 Scale: Standing - Pulse Oximetry: O2 94.0 % - 5/28/2024 20:20 Method: Oxygen via Nasal Cannula . Nursing observations, evaluation, and recommendations are:Upon taking resident's vitals at dinner time, writer noticed that resident was febrile. After informing supervisor, writer was informed to remove resident from dinner table and to give her Tylenol after supper. An hour after Tylenol was administered, resident's temporal temperature decreased to 98.3. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A. Recommendations: B. New Testing Orders: C. New Intervention Orders: - Other - Tylenol Surveyor noted a change in condition progress note dated 05/29/2024, at 11:55 AM, documents, Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change)Seems different than usual Tired, Weak, Confused, or Drowsy At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 86/58 - 5/29/2024 10:21 Position: Sitting l/arm - Pulse: P 103 - 5/29/2024 10:21 Pulse Type: Regular - RR: R 20.0 - 5/29/2024 10:21 - Temp: T 98.0 - 5/29/2024 10:21 Route: Forehead (non-contact) - Weight: W 256.0 lb - 5/3/2024 13:34 Scale: Standing - Pulse Oximetry: O2 86.0 % - 5/29/2024 10:20 Method: Oxygen via Nasal Cannula - Blood Glucose: BS 22.0 - 9/24/2022 08:14 . Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Increased confusion(e.g. disorientation) - Functional Status Evaluation: General weakness - Behavioral Status Evaluation: - Respiratory Status Evaluation: Other respiratory changes - Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50 - Abdominal/GI Status Evaluation: - GU/Urine Status Evaluation: - Skin Status Evaluation: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	- Pain Status Evaluation: Does the resident/patient have pain? No - Neurological Status Evaluation: Nursing observations, evaluation, and recommendations are:after breakfast, res. noted to have increased lethargy, weakness. Leaning to R side of W/c, repositioned. Lungs clear. Abd. soft round with + BS. Res. denies pain. HR elevated, B/P decreased, POX decreased. Oxygen increased to 2.5 L/min. Ate fair for bkft. [NAME], NP updated. NOR. POA [NAME] updated. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: CXR, labs, UA C&S per [NAME], NP B. New Testing Orders: - Blood Tests Urinalysis or culture X-ray Surveyor noted orders placed to rule out an infectious process, but no documented evidence of infection process causing R2's change in condition. Surveyor noted that per Drugs.com, Morphine and Celexa(citalopram) has a moderate drug to drug interaction and documents the following, Applies to: Morphine Sulfate SR (morphine), Celexa (citalopram) Using morphine together with citalopram can increase the risk of a rare but serious condition called the serotonin syndrome, which may include symptoms such as confusion, hallucinations, seizures, extreme changes in blood pressure, increased heart rate, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiffness, tremor, incoordination, stomach cramp, nausea, vomiting, and diarrhea. Severe cases may result in coma and even death. Surveyor noted per Drugs.com, Clonazepam and Morphine have a major drug to drug interaction and documents the following, Applies to: Clonazepam, Morphine Sulfate SR (morphine) Using narcotic pain or cough medications together with other medications that also cause central nervous system depression can lead to serious side effects including profound sedation, respiratory distress, coma, and even death. Surveyor noted that per Drugs.com, morphine and Gabapentin have a major drug to drug interaction and documents, Applies to: Morphine Sulfate SR (morphine), Gabapentin Using narcotic pain or cough medications together with other medications that also cause central nervous system depression such as Gabapentin can lead to serious side effects including respiratory distress, coma, and even death. Surveyor noted that per Drugs.com, Morphine and risperidone have major drug to drug interactions and documents, Applies to: Morphine Sulfate SR (morphine), Risperdal (risperidone) Using narcotic pain or cough medications together with other medications that also cause central nervous system depression can lead to serious side effects including profound sedation, respiratory distress, coma, and even death. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Surveyor noted that per Drugs.com, morphine and quetiapine have a major drug to drug interaction and documents, Applies to: Morphine Sulfate SR (morphine), Seroquel (quetiapine) Using narcotic pain or cough medications together with other medications that also cause central nervous system depression such as quetiapine can lead to serious side effects including respiratory distress, coma, and even death. On 08/21/2024 at 10:46 AM Surveyor interviewed UM-E. UM-E stated in the event of a medication error the resident will be monitored for signs and symptoms, put on the 24 hour board monitor vitals update physician and family. UM-E stated that for R2, her vitals were monitored for both medication errors, and for the second medication error, R2 was given water and felt fine. UM-E stated the form for medication error reporting was filled out on PM shift. On 08/21/2024 at 10:55 AM, Surveyor interviewed DON (Director of Nursing)-B who stated the unit manager will notify the physician and family once a medication error has been reported. DON-B stated the medication error reports are brought to QAPI (Quality Assurance and Performance Improvement) and it will be discussed whether teaching needs to be completed. DON-B stated the 5 rights are expected to be completed prior to medication administration, which include right patient, right route, right dose, right time and expiration dates. On 08/21/2024 at 01:30 PM, Surveyor interviewed RN-F who stated she is unsure of how agency nursing staff is trained on medication administration and medication error reporting. RN-F stated she has worked at the Facility for 7 years and does not recall the new employee orientation and states they are retrained annually. RN-F stated, the Facility did not provide training or education after the medication errors for R2, that she recalls. On 08/22/2024 at 07:42 AM, Surveyor interviewed NHA-A. NHA-A stated hired employees will receive annual training on medication administration and medication error reporting. NHA-A stated agency nursing staff are not provided the policy and/or procedure for medication administration or medication error reporting with orientation packet. NHA-A states training after both medication errors was provided to the nurses who made the medication errors, and no other staff were trained. NHA-A informed Surveyor that she could not locate Agency LPN-C's orientation check list at that time. NHA-A provided Surveyor with a document titled, Agency RN/LPN Orientation Check List. Surveyor noted, the policy and/or procedure for medication administration and medication error reporting was not listed on the document check list. On 08/22/2024 at 08:44 AM, Surveyor interviewed UM-D. UM-D who states she was notified on 05/26/2024 at 10:50 PM by the Agency LPN-C that a medication error occurred. UM-D states Agency LPN-C stated she think she gave R2 Morphine instead of Clonazepam. UM-D states Agency LPN-C then went and checked the medication cards and confirmed she gave R2 the wrong medication. UM-D states Agency LPN-C then notified the physician and family while UM-D went to assess R2. UM-D states she preformed an assessment on R2 at 11:00 PM on 05/26/2024 and states orders were put in for R2 to receive 480 ml of oral fluids, which UM-D gave before she left her shift, between 10:30 PM and 11:00 PM. UM-D states orders were also to perform neuro checks, vitals every hour and R2 was put on the board for 72 hours. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 08/26/2024 at 01:08 PM, NHA-A sent an email to Surveyor with the following documentation, titled, Medication Error, dated 05/21/2024 at 09:15 PM. Surveyor noted Mental Status Assessment was not completed on the form. NHA-A also sent a document, titled, Skilled Charting, dated 05/21/2024 at 09:55 PM, surveyor noted the vital sign documented for most recent blood sugar is from 09/24/2022, and the respiratory assessment section documents WDL but with no indication R2 was on oxygen. On 08/26/2024 at 01:08 PM, NHA-A sent an email to Surveyor with the following documentation, titled, Medication Error, dated 05/26/2024, at 10:49 PM. Surveyor noted Mental Status Assessment was not completed on the form. NHA-A also sent a document, titled, Skilled Charting, dated 05/26/2024 at 10:50 with a lock date of 05/27/2024 at 10:23 PM. Surveyor noted under the respirations vital sign, documents O2 of 95% and respirations 18 on 05/27/2024 at 06:49 PM, blood glucose 22 on 09/04/2022. All other vital signs documented with a date of 05/26/2024 at 11:41 PM. Surveyor noted under Medicare Summary of report, documents R2 was given a wrong medication at 2014. Nurse noted at 2250 when doing shift count with night nurse. R2 easily arousable denied nausea and lightheadedness. Vitals stable. No additional information was provided as to why the facility did not administer medications in accordance with prescribers orders, manufactures specifications and professional standards which resulted in R2 requiring rigid control and monitoring of R2's level of consciousness, oxygen saturation, blood pressure, temperature, and lab values.