STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525413	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcrest Health Services	3821 S Chicago Ave South Milwaukee, WI 53172

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** 38146 Based on the comprehensive assessment of a resident, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for 1 (R1) of 3 residents reviewed. The facility did not notify the physician of R1's low blood pressures as ordered. Findings include: R1 was admitted on [DATE] with diagnoses that included Parkinson's Disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, anxiety, Dementia, Bipolar, Schizoaffective Disorder, Gastric Ulcer and Chronic Kidney Disease stage 3. R1 was hospitalized on [DATE] for a change in condition, low blood pressure, low heart rate and altered mental status. She readmitted to the facility on [DATE]. The hospital discharge summary dated 11/4/24 documented: Patient found to have acute kidney injury and signs of dehydration. Patient was given IV (intravenous) fluids with resolution. Ultimately suspect patient's dehydration was a consequence of use of home diuretic. Therefore patient's diuretic was changed to daily as needed with indications for edema and/or 2 pound weight gain of water weight. Surveyor noted the order for PRN Furosemide was not clarified and was transcribed on the MAR (Medication Administration Record) for 40 mg (milligrams) daily, which was administered from 11/5/24 through 11/8/24. On 11/7/24 at 11:30 PM, R1 sustained a fall. Vital signs documented her blood pressure to be 88/43. The physician was notified, and 2 separate progress notes documented orders to recheck blood pressure in 1 hour and notify if has risen, and recheck blood pressure in 1 hour, if not improving call physician back. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility completed neurological checks on R1 throughout the night which included blood pressure check. R1's blood pressure varied throughout the night, however the systolic did not rise above 98 and diastolic did not rise above 63. The initial blood pressure at the time of the fall was 88/43. 1 hour later R1's blood pressure was 88/57. The next morning, at 5:15 AM, R1's blood pressure was 86/56. There was no evidence the physician was notified after 1 hour as ordered, or at any time throughout the night regarding R1's low blood pressures. R1 sustained another fall the following day at 2:30 PM with no injuries. R1's blood pressure at the time of the fall was 90/37 and she was sent to the emergency room . On 3/4/25 at 1:25 PM, Surveyor spoke with DON (Director of Nursing)-B about R1's Furosemide order. DON-B reported the order should have been changed because it is too vague and PRN Furosemide is not usually a good order because it's too subjective. DON-B reported she could not confirm or deny that the nurse who entered the order spoke with the physician to inform that the facility does not do PRN Furosemide and got the order changed. DON-B provided lab results dated 11/7/24 which documented R1's BUN (Blood urea nitrogen) and Creatinine (assessment of kidney function) was improved and within normal limits. Surveyor reviewed R1's blood pressures throughout the night following the fall on 11/7/24 and the orders to notify the physician if not improving. Surveyor asked for evidence the physician was notified as ordered. DON-B was unable to provide any additional information. On 3/5/25 at 11:45 PM, Surveyor advised NHA (Nursing Home Administrator) and DON-B of concern regarding R1's Furosemide order and R1's low blood pressures throughout the night with no evidence the physician was notified as ordered. No additional information was provided at the time of survey exit.