

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Willowcrest Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure a Resident (R38) received the recommended dose reduction of a prescribed anti-anxiety medication. This was determined for 1 (R38) of 5 Residents reviewed.</p> <p>*On 5/8/25, Psychiatric NP (NP)-E recommended to discontinue R38's Lorazepam after a gradual dose reduction (GDR). The order to discontinue R38's Lorazepam was not completed following the recommendation on 5/8/25.</p> <p>Findings Include:</p> <p>The facility's Medication Monitoring, Medication Management, Section 8.4 last reviewed 01/24 documents:</p> <p>Policy</p> <p>.Based on a comprehensive assessment of a Resident, the facility must insure:</p> <p>-Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Procedures</p> <p>. The interdisciplinary team reviews the Resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis and wit with consideration of Resident preferences.</p> <p>3. The prescriber and the care planning team reassess the continued need for the ordered medication. Effects of the medications are documented as a part of the care planning process.</p> <p>R38 was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Peripheral Vascular Disease(circulatory condition in which narrowed blood vessels reduce blood flow to limbs), Anemia(low red blood cells or hemoglobin), and Chronic Kidney Disease (progressive damage and loss of function in the kidneys). R38 is his own person.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525413
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R38's Quarterly Minimum Data Set (MDS) completed 5/14/25 documents R38's Brief Interview for Mental Status (BIMS) score to be 15 indicating R38 is cognitively intact for daily decision making. R38 has no documented behavior or mood symptoms.</p> <p>Surveyor notes that R38 had no mood or behavior symptoms documented on the following MDS's:</p> <ul style="list-style-type: none"> -2/11/25 Quarterly MDS -11/11/24 Annual -8/13/24 Quarterly -5/13/24 Quarterly <p>R38's comprehensive care plan documents:</p> <p>At risk for changes in mood due to anxiety</p> <p>Initiated 11/25/20</p> <p>Revised 5/14/25</p> <p>Interventions implemented on 11/25/20</p> <ul style="list-style-type: none"> -Administer medications per MD orders -Assess physical/environmental changes that may precipitate change in mood -Attempt psychotropic drug reduction per MDS orders -Observe for mental/mood state changes when new medication is started or with dose changes -Offer choices to enhance sense of control <p>At risk for adverse effects due to use of antianxiety/anti-anxiety and anti-depressant medication</p> <p>Initiated 11/25/20</p> <p>Revised 7/20/22</p> <p>Interventions implemented:</p> <ul style="list-style-type: none"> -Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs <p>Initiated 11/25/20</p> <ul style="list-style-type: none"> -Psychiatrist consult and follow-up as needed <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>GDR</p> <p>Ativan 6/14/21</p> <p>7/12/21 Increase Ativan failed GDR</p> <p>11/18/21 GDR Lorazepam</p> <p>1/28/22 Increase Lorazepam dose</p> <p>4/13/22 Increase Ativan</p> <p>8/10/22 Ativan time change</p> <p>1/10/24 GDR Lorazepam</p> <p>10/10/24 GDR Lorazepam</p> <p>4/10/25 GDR Lorazepam</p> <p>5/8/25 GDR Lorazepam-revised 5/15/25</p> <p>As of June 4th, at 7:47 AM, R38's current physician orders document R38 is prescribed Lorazepam 0.5 mg one time a day related to anxiety disorder effective 4/9/25.</p> <p>Nursing staff to document targeted behaviors of excessive worry and restlessness 1 time a shift.</p> <p>Surveyor reviewed R38's Medication Administration Record (MAR) from February to June. Surveyor notes that nursing staff documented NO consistently everyday on each shift in response to R38 targeted behaviors.</p> <p>Surveyor notes R38 consistently did not demonstrate behaviors to substantiate the continued use of Lorazepam.</p> <p>On 5/8/2025, at 4:37 PM, Psych NP-E documented in a psychiatry follow-up:</p> <p>. [R38] was last seen on November 13, 2024. [R38] had been stable with no increased anxiety reported after the gradual dose reduction of Lorazepam that was implemented during the October 2024 visit.</p> <p>Staff reports [R38] continues to be stable, has not reported any symptoms of anxiety. [R38] has no concerns regarding mood or behaviors.</p> <p>Last GDR Consideration: 05/08/2025 - Next GDR Due: 08/08/2025</p> <p>Classification: Anxiolytic</p> <p>Practitioner response: I will attempt a gradual dose reduction and note in [R38's] chart: medication discontinued.</p> <p>(continued on next page)</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>GDR Status: In Progress</p> <p>GDR Status Updated On: 05/12/2025,</p> <p>***Assessment and Plan***</p> <p>*ANXIETY DISORDER, UNSPECIFIED* [R38] remains stable with occasional anxiety reported at bedtime or during night-time hours. Continuing Sertraline 50 mg daily. Will discontinue Lorazepam 0.25 mg daily. Ongoing monitoring for increased signs and symptoms of anxiety or changes in mood and behavior. If this should occur, consider increasing Sertraline .</p> <p>On 5/15/2025, at 10:23 AM, Social Services Director (SSD)-F documented that R38 was seen by Psych NP-E. Order written for GDR of Lorazepam. Refer to consult for details. Follow-up visit scheduled. Plan of care updated and behavior monitoring reviewed. IDT to monitor for needs .</p> <p>On 6/4/25, at 8:17 AM, Surveyor interviewed Psych NP-E via telephone. Psych NP-E stated R38's anxiety has been much better. Psych NP-E stated that Psych NP-E communicates any medication changes directly to the unit manager or it is communicated in the behavior meeting. Psych NP-E stated that Unit Manager (UM)-G was informed of the plan to discontinue the Lorazepam. Psych NP-E informed Surveyor that the expectation for a recommended medication adjustment or to discontinue should be completed the following day for a Resident.</p> <p>On 6/4/25, at 10:39 AM, Surveyor interviewed UM-G regarding R38's Lorazepam. UM-G doesn't recall getting a verbal order and informed Surveyor that SSD-F reviews Psych NP-E's notes. UM-G stated, I don't know whose error it is. I don't know what happened. UM-G confirmed that UM-G attends the behavior meetings on the 2nd Wednesday of the month.</p> <p>On 6/4/25, at 10:53 AM, Surveyor interviewed SSD-F regarding R38's Lorazepam and the recommendation from Psych NP-E to discontinue the medication on 5/8/25. SSD-F did not recall talking about the recommendation for discontinuing R38's Lorazepam. SSD-F confirmed they review Psych NP-E's notes every-time a Resident is evaluated. SSD-F does discuss medication changes with nursing. SSD-F did review R38's Psych NP-E's note to discontinue R38's Lorazepam and confirmed SSD-F did update R38's care plan</p> <p>On 6/4/25, at 2:36 PM, Surveyor shared the concern with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and RN/VP of Success (VP)-Q that R38's GDR to discontinue R38's Lorazepam was not initiated on 5/8/25 when Psych NP-E recommended it. DON-B stated that Psych NP-E did not write a telephone order. Surveyor shared SSD-F had reviewed Psych NP-E's notes and was aware that R38's Lorazepam should have been discontinued on 5/8/25 and that Psych NP-E had stated that they had communicated the discontinuation of R38's Lorazepam to UM-G.</p> <p>On 6/5/25, at 9:15 AM, Surveyor spoke with Psych NP-E via telephone again. Psych NP-E stated that they do not write telephone orders and that they communicate orders to either the nurse or the unit manager. Psych NP-E shared they always discuss what resident is up for a GDR in the behavior meeting.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 2 (R27 & R55) of 2 residents were notified of the reason for transfer/discharge in writing and the rate to reserve the residents bed was not documented in the Wisconsin Bed Hold and Notice of Transfer.</p> <p>Findings include:</p> <p>The facility's policy titled, Bed Hold Notice and reviewed/revised 4/23/2025 under policy documents It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic leave. Under Policy Explanation and Compliance Guidelines documents 1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifics: a. The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; b. The reserve bed payment policy in the state plan policy, if any. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility: The resident requires the services which the facility provides; The resident is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. 2. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. 3. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. 4. The facility will provide this written information to all facility residents, regardless of their payment source.</p> <p>1.) R27's diagnoses includes quadriplegia (partial or complete loss of function in all four limbs) depressive disorder, hypertension (high blood pressure), and anxiety disorder.</p> <p>R27's nurses note dated 6/26/24 at 21:45 (9:45 p.m.) written by Licensed Practical Nurse (LPN)-V documents [Name] medical NP (Nurse Practitioner) [Name] updated of resident's continued pain to ABD (abdomen) achy 7/10 pain, hypoactive bowel sounds, firm rotund abdomen with slightly raised area midline above the umbilicus. Orders obtained to send to ER (emergency room) for possible Bowel Obstruction.</p> <p>R27's nurses note dated 6/27/24 at 07:59 (7:59 a.m.) written by Registered Nurse/Unit Manager (RN/UM)-I documents admitted to [hospital initials] with dx (diagnosis): pseudo obstruction of colon.</p> <p>R27 was readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R27's Bed Hold Policy and Notice of Transfer form for date of transfer 6/26/24 documents resident unable to sign giving verbal confirmation and was witnessed by LPN-Y & LPN-V. The bed hold policy section is not completed. The resident's name, date of transfer, transferred to, time period to authorize facility to hold a room and the current daily rate is not completed. The resident or responsible party signature & date also has not been completed. There is no evidence that written bed hold policy and notice of transfer form was provided to R27 and R27's representative.</p> <p>R27's nurses note dated 11/4/24 at 19:26 (7:26 p.m.) written by Registered Nurse (RN)-X documents</p> <p>Resident c/o (complained of) abd (abdominal) pain/discomfort. Requested something for GI (gastrointestinal) upset. Writer administered simethicone and Tylenol w/ (with) no effectiveness. Writer irrigated Foley. At the time, Foley patent and draining. Resident continued to c/o pain and yell out in pain. Abd distended, hard, tender to touch. Bowel sounds present X4 (times four), hyperactive. Placed call to on call. Per [Name], send out for evaluation. management notified. Sent to [Hospital name].</p> <p>R27's nurses note dated 11/4/24 at 22:58 (10:58 p.m.) written by LPN-W documents Writer informed resident transferred to [Hospital name] at 1930 (7:30 p.m.). Writer phoned [Hospital name] ED (emergency department) RN [Name] for update. [Name] RN reports resident was administered Tylenol for abd (abdominal) pain, labs were drawn and came back WNL (within normal limits), CT (computed tomography) was completed and results show large amount of colonic air including gaseous dilation, likely pseudo obstruction. ED RN reports resident will be admitted to hospital.</p> <p>R27 was readmitted to the facility on [DATE].</p> <p>Surveyor reviewed R27's medical record and was unable to locate the bed hold policy and notice of transfer for R27.</p> <p>On 6/4/25, at 2:36 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Registered Nurse/Vice President (RN/VP) of Success-Q Surveyor informed staff Surveyor was unable to locate R27's bed hold policy and notice of transfer when R27 was discharged to the hospital on [DATE].</p> <p>On 6/5/25 Surveyor received a pink sticky note which documented No bed hold for November 24 date requested.</p> <p>R27's nurses note dated 3/20/25 at 23:41 (11:41 p.m.) documents Resident picked up by [ambulance name] at 2341 (11:41 p.m.).</p> <p>R27 was readmitted to the facility on [DATE].</p> <p>R27's Bed Hold Policy and Notice of Transfer dated 3/20/25 for signature documents verbal dated 3/20/25. The bed hold policy section is not completed. The time period to authorize facility to hold a room and the current daily rate is not completed. The resident or responsible party signature & date also has not been completed. There is no evidence written bed hold policy and notice of transfer form was provided to R27 and R27's representative.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) R55's diagnoses include acute and chronic respiratory failure with hypoxia (low levels of oxygen in body tissue), chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), diabetes mellitus (high blood sugar) hypertension (high blood pressure) and depression.</p> <p>R55 is her own person and shares a room with her husband, R36.</p> <p>R55's eINTERACT SBAR (situation, background, assessment, recommendation) dated 6/6/24 and written by Director of Nursing (DON)-B includes documentation of Nursing observations, evaluation, and recommendations are:to 95% but shortly after comes down to 92%, pulse remains elevated no 148, lungs no wheezing sound clear, Hgb (hemoglobin) and HCT (hematocrit) low but baseline, resident request to be sent to ER (emergency room). Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: NP (Nurse Practitioner) [Name] of [Name] Medical gives order to send resident to ER for evaluation and treatment. EMT's (emergency medical technology) [ambulance name] departed facility 2300 (11:00 p.m.) with resident on stretcher.</p> <p>[Hospital initials] RN (Registered Nurse) [Name] updated of change in condition, brief history, and resident's expected arrival.</p> <p>R55's nurses note dated 6/7/24 at 07:07 (7:07 a.m.) written by Registered Nurse/Unit Manager (RN/UM)-I documents resident admitted to [Hospital initials] ICU (intensive care unit) with dx (diagnosis) cellulitis of abdominal wall.</p> <p>R55 was readmitted to the facility on [DATE].</p> <p>R55's nurses note dated 7/8/24 at 11:54 a.m. written by LPN-K documents Routine H & H (hemoglobin and hematocrit) drawn this am (morning). Critical value of 5.5 and 21. Writer spoke with [Name] NP (Nurse Practitioner) NOR (new order received) to send pt (patient) out to [Hospital initials] ER (emergency room) for Blood Transfusion. [Name] Ambulance called to transport. Resident in good spirits and alert and oriented per baseline upon departure to hospital.</p> <p>R55's nurses note dated 7/8/2024 at 13:30 (1:30 p.m.) written by LPN-K documents Writer spoke with ED (emergency department), pt admitted with Anemia and Blood in stool.</p> <p>R55 was readmitted to the facility on [DATE].</p> <p>R55's nurses note dated 8/14/24 at 05:00 (5:00 a.m.) written by LPN-V documents Resident picked up by [Name] at 0500 for a surgery laparoscopic right hemicolectomy for a diagnosis of colon cancer. Transferred to [Hospital name] main.</p> <p>R55 was readmitted to the facility on [DATE].</p> <p>R55's nurses note dated 4/12/25 at 22:58 (10:58 p.m.) and written by LPN-Z documents Resident is on follow up for: sent to ER (emergency room). The current status is resident 911 out O2 (oxygen) in the 80s and heart rate 146 on call and DON (Director of Nursing) notified resident is own self.</p> <p>R55's nurses note dated 4/13/25 at 06:04 (6:04 a.m.) and written by LPN-Z documents resident admitted to icu (intensive care unit) with pneumonia and fever [Hospital name].</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R55 was readmitted to the facility on [DATE].</p> <p>Surveyor reviewed R55's medical record and was unable to locate a bed hold policy and notice of transfer for R55 when R55 was discharged to the hospital on 6/6/24, 7/8/24, & 8/15/24. Surveyor noted a bed hold and notice of transfer form for R55's discharge to the hospital on 4/12/25 dated 4/14/25 which documents verbal by Registered Nurse/Unit Manager (RN/UM)-I.</p> <p>On 6/3/25, at 1:46 p.m., Surveyor asked LPN-K when a resident is being transferred to the hospital is she involved with any paper work. LPN-K explained she sends the residents DNR (do not resuscitate), MARs (medication administration record), face sheet, the bed hold and labs with the paramedics.</p> <p>On 6/3/25, at 3:00 p.m., during the end of the day meeting with Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and Registered Nurse/Vice President (RN/VP) of Success-Q Surveyor informed staff Surveyor was unable to locate R55's bed hold policy and notice of transfer when R55 was discharged to the hospital on 6/6/24, 7/8/24, & 8/15/24.</p> <p>On 6/4/25, at 8:59 a.m., NHA-A informed Surveyor when she got here (October 2024) they weren't doing the bed hold policy and notice of transfer forms. NHA-A informed Surveyor they do not have the bed hold policy and notice of transfer forms for R55. NHA-A informed Surveyor some of the nurses were doing them and others were not so they did a QAPI (quality assurance performance improvement) (January 2025) and educated staff. NHA-A informed Surveyor the old form didn't have the rate so they redid their forms and the forms have the bed hold rate.</p> <p>On 6/4/25, at 9:06 a.m., Surveyor asked LPN-K if she could show Surveyor the bed hold policy and transfer notice form that she sends out. LPN-K showed Surveyor they are in a white binder at the nurses station. Surveyor noted the bed hold policy documents I hereby authorize the center to reserve a room , effective from ___ to ___ at the current daily ate of \$___ per day. If I wish to discontinue this reservation I will inform the facility immediately and such cancellation will be effective upon notification with resident or responsible party signature & date bottom of form has table heading of bed hold rates semi private room \$___ Private Room \$___. Surveyor noted the these forms do not include the daily rate.</p> <p>On 6/4/25, at 9:43 a.m., NHA-A showed Surveyor the new form and showed Surveyor this form has the daily bed hold rate. Surveyor informed NHA-A the forms the nurses are using does not have the daily bed hold rate and showed NHA-A multiple copies of the form without the rate. NHA-A stated that's not good.</p> <p>On 6/4/25, at 11:30 a.m., Surveyor asked RN/UM-I about R55's bed hold and notice of transfer form. Surveyor asked RN/UM-I if R55 was discharged on 4/12/25 why was this form dated 4/14/25. RN/UM-I stated wonder if it was a weekend, they must not of did it. Surveyor asked if the bed hold rate is provided to the resident and their representative. RN/UM-I replied no because I don't know the rates.</p> <p>On 6/5/25, at 8:36 a.m. Surveyor asked R55 when she went to the hospital in April does she remember receiving a bed hold and notice of transfer form. R55 replied no. Surveyor then showed R55 this form and asked if she received this form. R55 replied no and asked Surveyor if they are suppose to receive it. Surveyor then showed R55's husband, R36 the bed hold and notice of transfer form and asked R36 if he remembers receiving this form. R36 replied no.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 1 (R1) of 1 resident reviewed for bowel & bladder and who is incontinent of bowel receives appropriate treatment and services to monitor bowel movements.</p> <p>* R1 did not have a documented bowel movement from 2/1/25 through 2/9/25 and no bowel interventions were provided. On 2/10/25 R1 was diagnosed with a possible small bowel ileus.</p> <p>Findings include:</p> <p>R1's diagnoses includes Multiple Sclerosis (disease in which the immune system eats away at the protective covering of nerves), aphasia (language disorder that affects a person's ability to communicate), and anoxic brain damage (brain injury resulting from a complete lack of oxygen supply).</p> <p>R1's alteration bowel elimination care plan initiated & revised 3/22/18 documents the following interventions: *Administer medications per MD (medical doctor) order and observe effectiveness. Initiated 3/22/18. *Encourage to be out of bed daily. Document refusals. Initiated 3/22/18 & revised 5/7/25. *Notify MD of any changes in bowel function. Initiated 3/22/18. *Provide check and change q (every) 2-3 hours and as PRN (needed). Provide Incontinent cares as needed. Size 2 briefs. Initiated 3/22/18 & revised 5/7/25. *Record BM (bowel movements) and report abnormalities. Initiated 3/22/18 & revised 5/7/25. Report S & S (signs and symptoms) of constipation such as abdominal cramping, diarrhea, n/v (nausea/vomiting), no BM (bowel movement) for 3 days. Initiated 3/22/18.</p> <p>R1's annual MDS (minimum data set) with an assessment reference date of 5/19/25 has a BIMS (brief interview mental status) score of 0 which indicates severe cognitive impairment. R1 is dependent on staff for toileting hygiene, and requires substantial/maximal assistance to roll left & right and chair/bed to chair transfer. R1 is assessed as always incontinent of bowel and bladder.</p> <p>R1's urinary incontinence and indwelling catheter CAA (care area assessment) dated 5/22/25 under analysis of findings for nature of problem documents Urinary and bowel incontinence. Under care plan considerations documents Urinary Incontinence CAA triggered secondary to level of assist needed for toileting/incontinence needs and actual incontinent episodes. Annual assessment LTC (long term care) resident. Contributing factors impaired functional mobility, medication use, multiple sclerosis, depression, anxiety, encephalopathy (general brain dysfunction characterized by alteration in brain function), aphasia following cerebrovascular disease, adult failure to thrive, epilepsy (seizure disorder), anoxic brain damage. Risk factors include impaired skin integrity, falls, recurrent UTIs. Care plan reviewed to minimize/reduce fall risk, impaired skin integrity risk, reduce risk for UTI (urinary tract infection). Participate in therapies as ordered. Staff to continue to provide assistance per POC (plan of care). See care plan.</p> <p>Surveyor reviewed R1's bowel record and noted the following: On 1/31/25 R1 had an incontinent, watery/diarrhea, medium bowel movement. On 2/1/25, 2/2/25, 2/3/25, 2/4/25, 2/6/25, 2/7/25, 2/8/25 & 2/9/25 R1 did not have any bowel movements.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R1's bowel medications and noted the following Start date 8/18/23 MiraLax Powder (Polyethylene Glycol 3350) with directions to give 17 grams via G-tube one time a day every other day for constipation. This order was changed on 2/11/25 to provide MiraLax 17 grams once daily. Start date of 12/15/23 Senna Oral Tablet 8.6 mg (milligrams) (Sennosides) with directions to give 2 tablets via G-tube one time a day for constipation. This order was changed on 2/11/25 to give 2 tablets via G-tube every 12 hours.</p> <p>Surveyor noted R1's as needed bowel medication with a start date of 1/20/18 of Milk of Magnesia Suspension 7.75% (Magnesium Hydroxide) Give 30 ml via G-tube every 24 hours as needed for constipation if no BM in 8 shifts. Start date of 1/1/18 Dulcolax Suppository 10 mg (Bisacodyl) Insert 10 mg rectally every 24 hours as needed for constipation use if no results from MOM (milk of magnesia). Review of R1's February 2025 MAR (medication administration record) reveals these as needed bowel records were not administered from 2/1/25 through 2/9/25 when R1 did not have any bowel movements.</p> <p>Surveyor reviewed nursing notes from 2/1/25 through 2/9/25 and did not note any documentation of bowel interventions or R1's physician being notified of R1 not having a bowel movement during this time period.</p> <p>R1's physician note late entry dated 2/10/25 & created on 3/11/25 by Advance Practice Nurse Prescriber (APNP)-O includes documentation of .HPI (History of Present Illness): [AGE] year-old female seen at [facility name] in LTC for acute care visit for concerns of vomiting and high tube feeding residual. The provider was called by the nurse to evaluate the patient over concerns of vomiting last night and also today. Residual was checked and was greater than 1,000 cc (cubic centimeters). The nurse stopped the tube feeding and is concerned about possible aspiration.</p> <p>Seen in her room. Bowel sounds are minimal. Lungs clear at this time. She endorses nausea when asked. Bowel sounds minimal. No pain with palpation. Orders to continue to hold tube feeding.</p> <p>Blood pressures are elevated-- usually blood pressures are soft. Denies pain or any concerns when asked. Primarily nonverbal, but can nod yes to simple questions. No seizure activity. No falls. Unable to get further details from her due to mentation. Limited exam due to same. Poor historian .Gastrointestinal: Abdomen is slightly distended. Bowel sounds minimal to all quadrants. No pain with palpation. G-tube in place. Site looks good.</p> <p>APNP-O's progress note with a late entry of 2/11/25 & created on 3/11/25 documents .Imaging done and reviewed: - KUB (kidneys, ureter's, bladder) showed the bowel gas pattern shows diffuse small bowel ileus. Distal small bowel obstruction is not excluded in the body of the stomach. No definite abnormal calculi or masses. Osseous structures are intact Gastrointestinal: Abdomen is slightly distended. No audible bowel sounds to LUQ (left upper quadrant) and LLQ (left lower quadrant). Hyperactive bowel sounds to RUQ (right upper quadrant) and RLQ (right lower quadrant). No pain with palpation. G-tube in place. Site looks good Diagnoses attached to this encounter: Ileus, unspecified .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician progress note dated 2/12/25 documents Bowel sounds present in all quadrants but remain slightly sluggish to LUQ. Had two large BMs overnight after previous adjustments to bowel regimen. Await KUB results. If ileus is resolved plan to restart tube feeding at half rate and increase by 10 cc (cubic centimeters) q (every) 8 (as tolerated) until at goal. If ileus is resolved, ok to discontinue IVF (intravenous fluid), IV, and daily KUB. If ileus is not resolved, will switch fluids to D (dextrose)5/45 at 50 cc/hr (cubic centimeters per hour) due to increased sodium levels and continue daily KUB until ileus resolved.</p> <p>On 6/5/25, at 8:28 a.m., Surveyor asked Licensed Practical Nurse (LPN)-P if the facility has a bowel program. LPN-P explained she looks on the dash board which usually shows when resident does not have a bowel movement in 24, 48 & 72 hours. LPN-P informed Surveyor they would give MiraLax, Senna plus and depending on the order mom (milk of magnesia). LPN-P informed Surveyor she would assess the resident after 48 & 72 hours max (maximum) and give something.</p> <p>On 6/5/25, at 8:39 a.m., Surveyor asked LPN-K if there is a bowel program at the facility. LPN-K informed Surveyor residents without bowel movements shows up on the dash board and if a resident doesn't have a BM for three days they would give MOM or suppository.</p> <p>On 6/5/25, at 9:07 a.m. Surveyor asked Registered Nurse/Unit Manager (RN/UM)-I if there is a bowel program at the facility. RN/UM-I replied yes and explained they have clinical alerts based on CNA (Certified Nursing Assistant) documentation will alert if there is no BM in 48 & 72 hours. RN/UM-I informed Surveyor they would administer PRN (as needed) bowel medication what ever is ordered. Surveyor informed RN/UM-I R1 did not have a bowel movement from 2/1/25 through 2/9/25 and Surveyor did not note any PRN bowel medications were administered during this time. RN/UM-I informed Surveyor she will get back to Surveyor.</p> <p>On 6/5/25, at 10:53 a.m., Surveyor met with RN/UM-I and Director of Nursing (DON)-B. RN/UM-I informed Surveyor prior to those dates (2/1/25 through 2/9/25) R1 was on a bowel regimen every other day of MiraLax Powder & Senna 2 tablets daily. After the incident R1's MiraLax powder was changed to daily, Senna 2 tablets every 12 hours and fiber. Surveyor informed RN/UM-I & DON-B Surveyor was unable to locate any bowel interventions during the time period when R1 did not have a bowel movement. DON-B informed Surveyor she did go through the February MAR and there were no PRNs given and there was also a couple times when PM (evening) shift did not complete their charting. Surveyor asked DON-B for the facility's bowel monitoring policy.</p> <p>On 6/5/25, at 11:55 a.m., DON-B informed Surveyor they do not have a bowel policy.</p> <p>On 6/5/25, at 12:07 p.m. Registered Nurse/Vice President (RN/VP) of Success-Q showed Surveyor included in their batch orders are Dulcolax Suppository 10 mg daily as needed, Fleet enema 7-19 gram/118 ml insert 1 application rectally as needed for constipation and Milk of Magnesia Suspension 7.75% 30 ml by mouth as needed for constipation daily. RN/VP of Success-Q explained they have these as needed bowel medications in their batch orders so the nurses don't have to type the orders in.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interview, and record review the facility did not ensure 1 (R1) of 6 residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>R1 was assessed to have limited range of motion on one side for R1's upper extremities and both sides for lower extremities. There is no care plan for range of motion to prevent further decrease and range of motion was not observed during cares.</p> <p>Findings include:</p> <p>The facility's policy titled, Prevention of Decline in Range of Motion and reviewed/revised 02/02/2023 under Policy Explanation and Compliance Guidelines documents 3. Appropriate Care Planning a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: i. Appropriate services (specialized rehabilitation, restorative, maintenance). ii. Appropriate equipment (braces or splints). iii. Assistance as needed (active assisted, passive, supervision). c. Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner. d. Interventions will be documented on the resident's person-centered care plan. Documentation should include, but not limited to: i. Type of treatments; ii. Frequency and duration of treatments; iii. Measurable objectives; iv. Resident goals. e. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record. f. Modifications to the plan of care will be made as needed. g. The resident/resident's representative will be included in the development of the restorative/rehabilitation care plan and provided the risks and benefits of the treatments.</p> <p>R1's diagnoses includes Multiple Sclerosis (disease in which the immune system eats away at the protective covering of nerves), aphasia (language disorder that affects a person's ability to communicate), and anoxic brain damage (brain injury resulting from a complete lack of oxygen supply).</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed R1's current care plans and noted the following care plans for R1: Activities initiated 5/27/22 & revised 2/11/24, ADL (activities daily living) self care deficit initiated 6/256/18 & revised 5/22/25, Actual Communication deficit initiated 4/22/19 & revised 5/22/25, Alteration in visual acuity initiated 3/22/28 & revised 5/22/25, Advanced directives initiated 2/14/25, Potential for elopement initiated 6/6/24, Cognitive loss initiated 11/8/17 & revised 5/22/25, Alteration in elimination initiated 6/19/18 & revised 7/13/23, At risk for falls initiated 3/22/18 & revised 5/22/25, Potential for behaviors initiated 11/8/17 & revised 6/20/24, Bowel elimination alteration initiated & revised 3/22/18, Nutrition initiated 9/27/23 & revised 5/15/25, Risk for alteration in hydration initiated 6/8/22 & revised 5/22/25, Pain initiated 3/22/18 & revised 5/22/25, I have things I really enjoy and are important to me initiated & revised 11/8/17, At risk for skin integrity initiated 11/25/19 & revised 5/22/25, Potential for dental or oral cavity health problem initiated & revised 5/22/25, Patient shows little potential for discharge to the community initiated 11/8/17, Need for feeding tube initiate d& revised 3/12/22, At risk for infection initiated & revised 4/1/24, At risk for changes in mood initiated 11/8/17 & revised 2/22/23, Potential for infection initiated 12/24/17 & revised 1/3/18, Neurological deficiencies initiated 3/22/18 & revised 5/22/25, Cardiac disease initiated & revised 10/15/20, Anticonvulsant therapy initiated 2/13/19 & revised 10/17/21, Use of seatbelt initiated & revised 10/11/18, Monitor for s/s (signs/symptoms) of grief initiated & revised 7/25/23, Antianxiety medication initiated 11/13/23 & revised 5/15/25, at risk for alteration in skin integrity initiated 3/22/18 & revised 5/22/25, and Lump (L) (left) breast, lateral initiated & revised 5/28/25.</p> <p>Surveyor noted none of these care plans have interventions that address range of motion for R1.</p> <p>R1's annual MDS (minimum data set) with an assessment reference date of 5/19/25 has a BIMS (brief interview mental status) score of 0 which indicates severe cognitive impairment. Under the section functional limitation in range of motion for upper extremity (shoulder, elbow, wrist, hand) assesses impairment on one side and lower extremity (hip, knee, ankle, foot) assesses impairment on both sides.</p> <p>R1's Visual/Bedside Kardex Report as of 6/2/25 under the resident care section documents *Ensure a stuffed animal is placed in bed with resident. *Ensure glasses are worn as appropriate. * Monitor-Eyeglasses. The other sections of activities, bladder/bowel, bathing, behavior/mood, bed mobility, communication, eating/nutrition, monitors, mobility, infection control, personal hygiene/oral care, safety, skin, transferring, and toileting does not address range of motion for R1.</p> <p>On 6/3/25, at 10:38 a.m., Surveyor asked Rehab Director (RD)-M if R1 is in therapy. RD-M informed Surveyor R1's therapy ended 9/13/24. Surveyor asked RD-M what is the process for range of motion recommendations. RD-M informed Surveyor if there is a change that is affecting cares or mobility this would trigger a therapy screen. RD-M informed Surveyor they looked at R1 on 4/24/25 for just a therapy screen which showed nothing beyond her usual. Surveyor asked RD-M would nursing determine what range of motion exercises a resident would be provided. RD-M replied if not on program. Surveyor asked RD-M if a resident is not on therapy and on the MDS is identified as having impairments of range of motion on either one side or both sides for upper and/or lower extremities who would determine what interventions would be implemented so the residents contractures don't decline. RD-M informed Surveyor usually changes noted on the MDS, the IDT (interdisciplinary team) talk about if it's changes (sic) or stable & what needs to be done.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/3/25, at 11:02 a.m. Surveyor met with Registered Nurse/MDS Coordinator (RN/MDS Coordinator)-T and Registered Nurse/Resident Care Management Specialist (RN/RCMS)-S. Surveyor inquired about functional limitations in range of motion. RN/RCMS-S informed Surveyor therapy does their quarterly screens and if noticed it's worse would be (sic) referring the resident to therapy as a team. Surveyor asked who would be responsible for range of motion care plan. RN/MDS Coordinator-T informed Surveyor that would come from therapy and if there is something specific therapy would train on the specifics to staff. Surveyor asked if the facility has a restorative program. RN/MDS Coordinator-T replied we currently don't have any residents on a restorative program.</p> <p>On 6/4/25 at 9:54 a.m. after placing PPE (personal protective equipment) on until 10:22 a.m., Surveyor observed Certified Nursing Assistant (CNA)-H and Admissions Coordinator/Certified Nursing Assistant (AC/CNA)-R wash, provide incontinence cares, dress, and transfer R1 into the wheelchair. During this observation Surveyor did not observe CNA-H or AC/CNA-R provide range of motion to R1.</p> <p>At 10:20 a.m., during this observation, Surveyor asked CNA-H if he does range of motion for R1. CNA-H replied no, therapy does that.</p> <p>On 6/4/25 at 11:35 a.m., Surveyor informed Registered Nurse/Unit Manager (RN/UM)-I R1's annual MDS 5/19/25 identified R1 as having functional range of motion impairment for upper extremity one side and lower both sides and inquired about range of motion for R1. RN/UM-I informed Surveyor R1 is pretty independent with moving around her arms and there is not a specific range of motion program for R1. Surveyor informed RN/UM-I Surveyor doesn't understand what the facility is doing so R1's limitations in range of motion do not decline. RN/UM-I replied we don't have a restorative program so I can't really answer that question other than if we see a decline in ADL (activities daily living) then we do refer them to therapy for further evaluation. Surveyor informed RN/UM-I range of motion is not included on the CNA Kardex and there is no care plan that addresses range of motion for R1.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure 1 (R20) of 1 resident with an indwelling catheter receives appropriate treatment & services.</p> <p>* Multiple observations were made of R20's indwelling catheter bag not covered and on the floor with no barrier.</p> <p>Findings include:</p> <p>R20 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease, muscle weakness and urinary retention (inability to fully empty bladder). R20 requires use of a urinary catheter for bladder elimination.</p> <p>R20's care plan with an initiation date of date of 7/5/2024, with a revision date of 4/16/2025, documents Use of indwelling foley catheter .foley needed due to: retention hospice care terminal condition. Documented interventions include: Do not allow tubing or any part of drainage system to touch the floor .store collection bag inside a dignity bag holder on bed/wheelchair catheter care Q (every) shift.</p> <p>On 6/02/2025 at 9:29 AM, Surveyor observed R20's catheter bag uncovered, resting on floor next to R20's bed with approximately 150 cc (cubic centimeters) of urine in bag.</p> <p>On 6/02/2025 at 11:20 AM, Surveyor observed R20's catheter bag uncovered, resting on floor next to R20's bed with approximately 150 cc of urine in bag.</p> <p>On 6/02/2025 at 1:40 PM, Surveyor observed R20's catheter bag uncovered, hanging on R20's bed with approximately 50 cc of urine in bag.</p> <p>On 6/4/2025 at 10:50 AM, Surveyor interviewed Director of Nursing (DON)-B who stated catheter drainage bags should have a cover over them for dignity purposes. Surveyor shared Surveyor's multiple observations on 6/2/2025 of R20's catheter drainage system observed being uncovered. The facility was unable to provide additional information at this time</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observation, interview, and record review the facility did not ensure 1 (R1) of 1 residents observed with tube feeding medication received the appropriate treatment and services to prevent complications.</p> <p>R1 did not have tube flushed prior to medication administration.</p> <p>Findings include:</p> <p>The facility's policy titled, Medication Administration Enteral Tubes and dated 01/25 under Policy documents The nursing care center assures the safe and effective administration of enteral formulas and medications. Section of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician, dietitian and pharmacist. Under Guidelines documents 11. Enteral tubes are flushed with at least 15ml (milliliter) of water before administering any medications and after medications have been administered.</p> <p>R1's diagnoses includes Multiple Sclerosis (disease in which the immune system eats away at the protective covering of nerves), aphasia (language disorder that affects a person's ability to communicate), anoxic brain damage (brain injury resulting from a complete lack of oxygen supply) and dysphagia (difficulty swallowing).</p> <p>R1's physician order dated 12/4/17 documents May crush medications and administer per GT (Gastrostomy Tube).</p> <p>R1's annual MDS (minimum data set) with an assessment reference date of 5/19/25 has a BIMS (brief interview mental status) score of 0 which indicates severe cognitive impairment. R1 was not assessed for eating and yes is marked for tube feeding while a resident.</p> <p>On 6/3/25, at 11:23 a.m., Surveyor observed Licensed Practical Nurse (LPN)-K prepare R1's medication which consisted of Biotene dry mouth moisturizing spray, Vitamin D 25 mcg (microgram) one tablet, fiber powder 5 ml (milliliter), and Clear Lax 17 grams. LPN-K crushed R1's Vitamin D tablet & added water, added 8 ounces of water to R1's fiber and 4 ounces of water to R1's Clear Lax.</p> <p>At 11:32 a.m., LPN-K placed on PPE (personal protective equipment), entered R1's room placed the medication on a towel which was on top of the over bed table, went into the bathroom & washed her hands. LPN-K placed gloves on, informed R1 she was going to give her medication, and raised the head of the bed & height up.</p> <p>At 11:36 a.m. LPN-K administered one spray of Biotene, told R1 to close her mouth, removed her gloves, washed her hands, and placed gloves on.</p> <p>At 11:37 a.m. LPN-K informed R1 she was going to listen to her tummy and checked placement of R1's tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 11:39 a.m. LPN-K administered R1's vitamin D via G tube, added a little water to the medication cup, administered the rest of R1's Vitamin D and then flushed the G tube with 20 ml of water. Surveyor observed LPN-K did not flush R1's G-tube with water prior to administering R1's Vitamin D.</p> <p>LPN-K administered R1's Clear Lax via G-tube, flushed the G-tube with 40 ml of water, administered R1's fiber and flushed the tube with 20 ml.</p> <p>At 11:44 a.m., LPN-K informed Surveyor at 12:00 p.m. she will hook up R1's tube feeding and give her an additional 75 cc of water.</p> <p>At 11:47 a.m., LPN-K removed her gloves, washed her hands, placed gloves on, and changed R1's shirt.</p> <p>On 6/3/25, at 1:49 p.m., Surveyor asked LPN-K why she didn't flush R1's G-tube before giving R1 Vitamin D. LPN-K replied brain block and nerves. LPN-K informed Surveyor she flushed in between meds (medication), gave the correct meds and flushed after.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Willowcrest Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 3821 S Chicago Ave South Milwaukee, WI 53172	

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not provide the necessary respiratory care and services for 1 (R55) of 1 residents receiving oxygen therapy.</p> <p>R55's oxygen was observed during the survey to be set at 4L (liter)/minute. R55's physician orders is for 3L/minute.</p> <p>Findings include:</p> <p>The facility utilizes [Name] Respiratory Services manual as their oxygen policy. Page 15 includes documentation of Flow Rate Selector. The flow rate selector permits you to set the flow rate your doctor has prescribed.</p> <p>R55's diagnoses includes asthma (condition in which the airways narrow, swell, and may produce extra mucus which can make breathing difficult), anxiety disorder, acute and chronic respiratory failure with hypoxia (low level of oxygen in body tissues), and dependence on supplemental oxygen.</p> <p>R55's at risk for respiratory impairment care plan initiated 3/22/23 & revised 12/29/23 includes an intervention of * Administer oxygen per MD (medical doctor) orders (2-3L/min (liters per minute) via nasal cannula) initiated 3/22/23 and revised 6/17/24.</p> <p>R55's physician orders dated 4/16/25 documents Oxygen at 3 L/min (three liters per minute) via nasal cannula every shift.</p> <p>R55's quarterly MDS (minimum data set) with an assessment reference date of 4/22/25 has a BIMS (brief interview mental status) score of 15 which indicates cognitively intact. Oxygen therapy is checked for yes while a resident.</p> <p>On 6/2/25, at 9:50 a.m., Surveyor observed R55 sitting in a wheelchair receiving oxygen via nasal cannula.</p> <p>On 6/2/25, at 1:03 p.m. Surveyor observed R55 sitting in a wheelchair in her room receiving oxygen via nasal cannula. Surveyor informed R55 Surveyor is going to check what her oxygen is set at. R55 informed Surveyor she receives 3 liters. Surveyor observed R55's oxygen is set at 4 liters and the oxygen tubing is dated 5/29/25.</p> <p>On 6/2/25, at 3:20 p.m. Surveyor observed R55 sitting in a wheelchair in her room receiving oxygen via nasal cannula. Surveyor observed R55's oxygen is still set at 4 liters.</p> <p>On 6/3/25, at 7:35 a.m., Surveyor observed R55 sitting in a wheelchair in her room receiving oxygen via nasal cannula. Surveyor observed R55's oxygen is set at 4 liters. R55 informed Surveyor she had a good night and had the window open.</p> <p>On 6/3/25 at 9:52 a.m. Surveyor observed R55 sitting in a wheelchair in her room receiving oxygen via nasal cannula. Surveyor observed R55's oxygen is set at 4 liters. R55 informed Surveyor she is going out for an eye doctors appointment this afternoon.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/3/25 at 11:54 a.m. Surveyor observed R55 sitting in a wheelchair in her room receiving oxygen via nasal cannula. R55 informed Surveyor she will be leaving for the doctors in about 45 minutes. Surveyor observed R55's oxygen is set at 4 liters.</p> <p>On 6/4/25, at 7:47 a.m., Surveyor observed R55 sitting in a wheelchair wearing a gown in her room. Surveyor observed R55's oxygen is set at 4 liters.</p> <p>On 6/4/25, at 9:09 a.m. Surveyor asked Licensed Practical Nurse (LPN)-K what R55's oxygen should be set at. LPN-K replied three, three liters. Surveyor asked LPN-K to accompany Surveyor to R55's room. Surveyor informed LPN-K R55's oxygen has been set at 4 liters. LPN-K went over to R55's oxygen concentrator, adjusted the oxygen to 3 liters and confirmed R55's oxygen had been set at 4 liters.</p> <p>On 6/4/25, at 9:12 a.m., Surveyor informed Registered Nurse/Nurse Manager (RN/UM)-I of the observations of R55's oxygen not being set according to physician orders. Surveyor observed R55's oxygen set at 4 liters when R55's physician orders are for 3 liters.</p> <p>No additional information was provided to Surveyor as to why R55's oxygen was not being administered according to physician orders.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure 1 (R22) of 1 resident reviewed for post traumatic stress disorder (PTSD) received culturally competent, trauma informed care in accordance with professional stands of practice and accounting or resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of R1.</p> <p>R22 has a diagnoses of PTSD. R22's PTSD care plan is not person centered and does not include what R22's PTSD is related to, triggers for R22 and the interventions are not person centered.</p> <p>Findings include:</p> <p>The facility's policy titled, Trauma Informed Care and reviewed/revise 10/18/22 under Policy Explanation and Compliance Guidelines documents 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as reviewing documentation such as the history and physical, consultation notes, or information received from family/responsible party 4. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. 5. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: a. Experiencing a lack of privacy or confinement in a crowded or small space. b. Exposure to loud noises, or bright/flashing lights. c. Certain sights, such as objects that are associated with their abuser. d. Sounds, smells, and physical touch. 6. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. 7. The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.</p> <p>The facility assessment under services provided for mental health and behavior for specific cares & practices documents Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities.</p> <p>R22 was admitted to the facility on [DATE]. Diagnoses includes PTSD (post traumatic stress disorder), bipolar disorder (mental health condition that causes extreme mood swings), anxiety, depressive disorder and dementia.</p> <p>R22 has an activated power of attorney.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R22's behavior systems CAA (care area assessment) dated 7/31/24 under analysis of findings for nature of problem documents Mood- Affective disorder, Major depressive disorder, Dementia, Bipolar. Will call out hello at times to have a need met. Under care plan considerations documents refer to care plan.</p> <p>R22's Psychologist-U note dated 10/31/24 under assessment & plan documents * F43.11 - Post-traumatic stress disorder, acute *: While not explicitly addressed in today's visit, patient has a history of PTSD. On 09/30/2024, plan was to incorporate trauma-informed care approaches in future sessions. Will continue to monitor for any trauma-related symptoms during future visits and address as needed.</p> <p>R22's Psychologist-U's visit dated 12/13/24 with R22 under assessment & plan documents * F43.11 - Post-traumatic stress disorder, acute *: Patient expressed feelings of being a [NAME] for not serving in Vietnam. Provider reminded the patient of his attempt to serve and that he was rejected due to his mental health history, reassuring him that he was not a [NAME]. On 10/31/2024, plan was to incorporate trauma-informed care approaches and monitor for trauma-related symptoms.</p> <p>R22's Trauma-Informed Care Observation dated 12/26/24 completed by Social Services Coordinator (SSC)-G under description documents PTSD dx (diagnosis) given during stay by [Psychologist-U name] Psychology Acute. Under observation details for question #2 Have you ever experienced, witnessed, learned about a serious accident (e.g. car accident, boat accident, train wreck, plane crash, work accident, home accident, recreational accident, fire/explosion, etc)? personally experienced is answered. #4 Have you ever experienced, witnessed, learned about a life-threatening illness or injury (e.g. cancer, heart attack, AIDS (acquired immunodeficiency syndrome), leukemia, multiple sclerosis, etc.)? Witnessed is answered. #5 Have you every experienced, witnessed, learned about a physical assault (e.g. attached, hit, beaten up, etc.)? Personal experienced is answered. #5a. Was a weapon involved? Yes is answered. #6 Have you ever experienced, witnessed, learned about a sexual assault (e.g. rape, attempted rape, made to perform a sexual act via force or threat of harm, etc). Other is answered. Under the section experience, for the question did any of these events bother you. Yes is answered. Under comment on events resident was bothered by documents Personal experience - acute PTSD. Under the section Effects. For the question how long were you bothered by the event(s), other is answered. For 1a Other documents comes and goes in severity. #2 How much did the event(s) bother you emotionally? Very much is answered. #3 What are the triggers that remind you of the event (e.g. loud noises, confined spaces, bath tubs, hot surfaces, sirens, etc.)? documents verification in mood, psych, cognition. #4 How do you react when you are reminded of the event(s)? documents Mad. Surveyor noted this trauma informed care observation does not indicate what the event/events were.</p> <p>R22's at risk for retraumatization of past event or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress mental disorder, PTSD care plan initiated 12/26/24 documents one intervention of Refer to Psychology as indicated initiated 12/26/24.</p> <p>R22's quarterly MDS (minimum data set) with an assessment reference date of 5/7/25 documents a BIMS (brief interview mental status) of 14 which indicates cognitively intact. R22's mood score is 00 and R22 is assessed as not having any behavior. Yes is marked for PTSD.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R22's Visual/Bedside Kardex Report as of 6/2/25 under the section Behavior/Mood documents * Behavior 1: Assess need Intervention #1: offer food, fluid or snack. Intervention #2: offer to reposition or change of location. Intervention #3: 1:1 conversation with him offer reassurance staff is here. calls out Hello frequently, respond to Hello. * If strategies are not working , leave (if safe to do so) and reapproach later. * Monitor and document all behaviors. Report behavior changes. Target behaviors: Sadness; Restlessness, Withdrawn/impulse behavior, Anger. * Non-Pharm (pharmacological) Interventions for behavior: 1. Address in a calm manner. 2. Attempt to orientate to place and time. 3. Allow patient to express feelings /frustrations. 4. Offer activities of choice. 5. Provide emotional support to resident as needed. * Target Behavior: Impulsive/loud verbal outbursts. Intervention #1: Redirect. Intervention #2: Use calm approach and soft tone of voice. Intervention #3: Assess needs/remove from common area.</p> <p>Surveyor noted there is not a section which address R22's PTSD including what was R22's trauma and what are the triggers & interventions for this trauma.</p> <p>The social service note dated 6/3/25 at 11:31 a.m. by SSC-G documents SW (social worker) met with resident while he was outside/courtyard. Listening to music and singing along. He was appropriate, and presented himself and happy and looking forward to his upcoming birthday. He Denied any current distress or upset. Discussed the recent Brewers winning as well.</p> <p>On 6/4/25 at 11:49 a.m. Surveyor met with Social Service Coordinator (SSC)-G to discuss R22. Surveyor asked SSC-G what could she tell Surveyor about R22's PTSD. SSC-G replied there are variations of his expressions through course of time. Sometimes (sic) expresses things related to PTSD, other times not expressive. Surveyor asked SSC-G what triggers R22. SSC-G replied not sure if anything specific, one thing familiar contact at times. Surveyor asked SSC-G if Surveyor was a Certified Nursing Assistant (CNA) how would Surveyor know what R22's PTSD is, what are R22's triggers and what should the Surveyor do. SSC-G informed Surveyor R22 will have episodes of anxiety & agitation as well as a history of mental illness, psych & cognitive. Surveyor asked SSC-G to look into R22's PTSD and get back to Surveyor as Surveyor is not understanding what events staff should not talk to R22 about, what are his triggers and what staff should do if R22 becomes agitated.</p> <p>On 6/5/25 Surveyor was provided with an updated at risk for retraumatization care plan revised 6/4/25 & visual/bedside Kardex report as of 6/5 25 for R22.</p> <p>R22's at risk for retraumatization of past event, related to unresolved childhood trauma/abuse by his father or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress, Mental disorder, PTSD created 12/26/24 and revised 6/4/25 documents interventions of Refer to psychology as indicated initiated 12/26/24 and Resident may demonstrate variations in mood/mood instability when they have a triggered response to past trauma, such as reminders of his father. To de-escalate the resident, encourage participation in activities of choice, healthy coping techniques - deep breathing. Initiated 6/4/25.</p> <p>R22's Visual/Bedside Kardex Report as of 6/5/25 now includes a Trauma Informed Care section which documents * Resident may demonstrate variation in mood/mood instability wen they have a triggered response to past trauma, such as reminders of his father. To de-escalate the resident encourage participation in activities of choice, healthy coping techniques - deep breathing.</p> <p>(continued on next page)</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/25, at 9:03 a.m., Surveyor asked Certified Nursing Assistant (CNA)-H if he is caring for R22. CNA-H replied yes. Surveyor asked CNA-H if R22 has PTSD. CNA-H replied that I wouldn't know. Surveyor asked CNA-H if there are any topics he shouldn't speak with R22 about. CNA-H replied no and informed Surveyor they usually talk about sports.</p> <p>On 6/5/25, at 9:04 a.m. Surveyor asked CNA-L if there are any topics she shouldn't speak to R22 about. CNA-L replied we don't really get that deep, he doesn't talk about personal things. Surveyor asked CNA-L if she knew if R22 has PTSD. CNA-L informed Surveyor R22 has good days & bad days and yells out at times. Surveyor asked CNA-L if she knew why R22 yells out. CNA-L replied no, knows he gets upset.</p> <p>On 6/5/25, at 9:10 a.m., Surveyor asked Registered Nurse/Unit Manager (RN/UM)-I what she could tell Surveyor about R22's PTSD. RN/UM-I replied I don't know the specifics why, he has the diagnosis. Know has bipolar, ya I don't know the specifics, I would have to look it up. Surveyor asked RN/UM-I if Surveyor was a CNA how would Surveyor know what triggers R22 and what to do. RN/UM-I informed Surveyor R22 pretty much directs the conversation. RN/UM-I informed Surveyor it should be on R22's Kardex what shouldn't be discussed. RN/UM-I informed Surveyor she will have to look into this a little more and get back to Surveyor.</p> <p>On 6/5/25, at 10:41 a.m., Surveyor met with RN/UM-I and Director of Nursing (DON)-B regarding R22. RN/UM-I informed Surveyor the CNAs monitor R22 behavior and follow the care card. RN/UM-I informed Surveyor they added PTSD to the care card based on conversations with the social workers. RN/UM-I informed Surveyor R22 really drives the conversation and staff never brings up PTSD from the past. Surveyor informed RN/UM-I and DON-B Surveyor spoke with staff who didn't know what events they should not discuss with R22 and what triggers R22. Surveyor informed RN/UM-I and DON-B Surveyor noted R22 is seen by Psychologist-U who documents R22 has PTSD. Surveyor asked if Psychologist -U has discussed what R22's trauma is, what are his triggers and if Psychologist-U has suggested any interventions. RN/UM-I & DON-B informed Surveyor they don't even see Psychologist-U.</p> <p>On 6/5/25, at 11:06 a.m., Surveyor met with Social Service Director (SSD)-F to discuss R22 as SSG-G is not working today. Surveyor asked SSD-F if she has any contact with Psychologist-U. SSD-F replied no other than accessing the notes. Surveyor informed SSD-F R22's trauma care plan didn't include what are the trauma events, what triggers and what interventions should be implemented. SSD-F informed Surveyor she can't speak on that. Surveyor asked SSD-F if there is anything she can tell Surveyor about R22's PTSD. SSD-F informed Surveyor she does have interactions with R22. Surveyor asked SSD-F if she reviews Psychologist-U's notes. SSD-F informed Surveyor they read their own notes and indicated R22 is not her resident. SSD-F informed Surveyor Psychologist-U always follows up on his own patients. Surveyor asked SSD-F if Psychologist-U attends their behavior meetings or IDT (interdisciplinary team) meetings. SSD-F replied no. Surveyor asked SSD-F if she has utilized Psychologist-U for any person centered interventions. SSD-F replied no, have not.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure medications were accurately administered and controlled drugs were reconciled for 1 (R174) of 1 residents reviewed for medication error.</p> <p>R174 had an order for hydrocodone-acetaminophen 5-325 mg every four hours as needed for pain. On 5/24/2025 at 10:53 PM and on 5/25/2025 at 5:42 AM, Licensed Practical Nurse (LPN)-C administered Zolpidem (Ambien) 5 mg (a hypnotic) instead of the ordered hydrocodone-acetaminophen 5-325 mg. The medication error was not identified at the change of shift from night shift to day shift on 5/25/2025 when the narcotic medications were to be reconciled with the narcotic count sheets.</p> <p>Findings include:</p> <p>The facility policy and procedure titled Medication Administration General Guidelines dated 1/2024 documents:</p> <p>PROCEDURES</p> <p>Medication Preparation: .</p> <p>3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and 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 prescriber's orders are checked for the correct dosage schedule. Apply a direction change sticker to label if directions have changed from the current label.</p> <p>Medication Administration: .</p> <p>9. Verify medication is correct three (3) times before administering the medication.</p> <p>a. When pulling medication package from med cart</p> <p>b. When dose is prepared</p> <p>c. Before dose is administered.</p> <p>R174 was admitted to the facility on [DATE] with diagnoses of multiple fractures of the ribs on the left side, severe protein-calorie malnutrition, cognitive communication deficit, heart failure, adult failure to thrive, anemia, radiculopathy (the nerve in the spinal column is compressed causing pain, numbness, and weakness) of the lumbar region, spondylosis (degeneration of the spinal disks causing compression) of the cervical and lumbar region, and low back pain.</p> <p>F174's admission Minimum Data Set (MDS) assessment dated [DATE] documented R174 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11 and had frequent severe pain.</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 - Few</p>	<p>R174 had orders for the following medications on admission from the hospital:</p> <ul style="list-style-type: none"> -Zolpidem Tartrate (Ambien) 5 mg daily at bedtime for insomnia. -Lidocaine External Patch 4%: apply to left rib topically daily for pain, remove after 12 hours. -Meloxicam 7.5 mg daily for pain. -Gabapentin 200 mg twice daily for neuropathy. -Biofreeze Roll-On External Gel 4%: apply to neck, upper trapeziuses, and left knee three times daily for pain. -Acetaminophen 650 mg every 4 hours as needed for pain. -Hydrocodone-Acetaminophen 5-325 mg every for hours as needed for pain 6-10 on the pain scale. <p>R174's Opioid Use related to Pain Care Plan was initiated on 5/22/2025 with the interventions:</p> <ul style="list-style-type: none"> -Administer medications as ordered. -Encourage adequate fluid intake. -Monitor bowel habits and implement bowel regimen as ordered. -Monitor for side effects. -Monitor for signs and symptoms of a potential drug overdose; administer Narcan per facility protocol. <p>R174's Pain/Potential for Pain Care Plan related to low back pain, radiculopathy in the lumbar region, spondylosis of the lumbar and cervical region, and left rib fractures was initiated on 5/23/2025 with the following interventions:</p> <ul style="list-style-type: none"> -Administer pain medication per physician orders. -Encourage/assist to reposition frequently to position of comfort. -Implement non-drug therapies to assist with pain and monitor for effectiveness. -Notify the physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective. -Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. <p>R174's At Risk for Adverse Effects related to the use of Hypnotic Medication Care Plan was initiated on 5/22/2025 with the following interventions:</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 - Few</p>	<p>-Report adverse effects such as burning or tingling in hands/feet, changes in appetite, constipation, diarrhea, dizziness, drowsiness, dry mouth or throat, headache, stomach complaints, tremors, or weakness.</p> <p>-Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs.</p> <p>-Non-pharmacological interventions for behaviors: address in a calm manner, attempt to orientate to place and time, allow resident to express feelings or frustrations and provide reassurance as needed, provide assistance as needed, family visits, offer activities of choice, provide emotional support to resident as needed, offer to close door and curtains to facilitate sleep.</p> <p>-Reduce environmental noise/distractions to facilitate sleep.</p> <p>-Sleep assessment per facility guidelines.</p> <p>On 5/24/2025 at 6:00 PM on the Medication Administration Record (MAR), LPN-D signed out and administered Hydrocodone-Acetaminophen 5-325 mg to R174 for complaints of rib pain.</p> <p>On 5/24/2025 at 8:00 PM, LPN-D administered R174's scheduled dose of Ambien 5 mg and documented on the MAR.</p> <p>On 5/24/2025 at 10:53 PM on the MAR, LPN-C signed out Hydrocodone-Acetaminophen 5-325 mg when R174 requested pain medication. LPN-C documented on 5/25/2025 at 12:07 AM that the medication was effective with a pain rating of 3 on a scale of 1-10.</p> <p>On 5/25/2025 at 1:34 AM on the MAR, LPN-C signed out and administered Acetaminophen 650 mg for complaints of pain. At 3:24 AM, LPN-C documented the Acetaminophen was effective with a pain rating of 4.</p> <p>On 5/25/2025 at 4:23 AM in the progress notes, LPN-C documented R174 was up most of the night with complaints of pain and all pain medications were administered; R174 fell asleep at approximately 3:30 AM.</p> <p>On 5/25/2025 at 5:42 AM on the MAR, LPN-C signed out Hydrocodone-Acetaminophen 5-325 mg when R174 requested pain medication. At 6:27 AM, LPN-D documented the Hydrocodone-Acetaminophen was ineffective with a pain rating of 10.</p> <p>On 5/25/2025 at 7:15 AM in the progress notes, LPN-D documented R174 was complaining of uncontrolled pain and demanding to go to the hospital. R174 appeared to have an altered mental status and LPN-D was unable to redirect R174. R174 was unsafe to transfer from the bed to a wheelchair and was agitated and yelling. LPN-D contacted the physician and received orders to send R174 to the hospital for evaluation and treatment.</p> <p>On 5/25/2025 at 10:56 AM in the progress notes, LPN-C documented LPN-C administered two doses of Ambien instead of the Hydrocodone-Acetaminophen 5-325 mg.</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 - Few</p>	<p>On 5/25/2025 at 11:08 AM in the progress notes, LPN-D documented LPN-C was made aware of the medication error and the Nurse Practitioner was notified.</p> <p>R174's Controlled Substance Records for Ambien and Hydrocodone-Acetaminophen were reviewed. LPN-C had documented one Hydrocodone-Acetaminophen was administered on 5/24/2025 at 10:53 PM and one Hydrocodone-Acetaminophen was administered on 5/25/2025 at 5:50 AM. The Controlled Substance Record for Hydrocodone-Acetaminophen documented 22 doses were available on the narcotic card at the end of the third shift on 5/25/2025 at 6:30 AM while the card had 24 doses. The Controlled Substance Record for Ambien documented 26 doses were available on the narcotic card at the end of the third shift on 5/25/2025 at 6:30 AM while the card had 24 doses. Surveyor noted when the narcotics were reconciled from the third shift to the first shift on 5/25/2025, the counts would not have matched. The error was not discovered at the change of shift. Surveyor noted the narcotics were not reconciled accurately.</p> <p>In a phone interview on 6/4/2025 at 7:33 AM, Surveyor asked LPN-C to recall the events of 5/24/2025 into 5/25/2025 with R174 receiving the wrong medication. LPN-C stated LPN-C was really tired that day and was really not there mentally like LPN-C should have been. LPN-C stated R174 was a new resident, so LPN-C had to get acquainted with R174 really quickly. LPN-C stated half of the unit has long term care residents and the other half has rehab residents so there is a lot of change over of residents on the rehab side. LPN-C stated R174 had complaints of pain and LPN-C gave R174 what LPN-C thought was R174's pain pill. LPN-C stated R174 could have a pain pill every 4 hours and grabbed the wrong medication twice. LPN-C was not sure if R174 had received a sleeping pill earlier on 5/24/2025.</p> <p>In an interview on 6/4/2025 at 1:53 PM, LPN-D stated LPN-D discovered R174's medication error at about 9:30 AM on 5/25/2025. LPN-D stated LPN-D arrived at the facility on 5/25/2025 at 6:00 AM and the night shift nurse, LPN-C, told LPN-D that R174 was up all night complaining of pain, pain, pain. LPN-D stated LPN-D had given R174 an Ambien the night before and LPN-C said LPN-C had given two Hydrocodone-Acetaminophen. LPN-D stated LPN-D saw the narcotic book and that Ambien had been given instead of Hydrocodone-Acetaminophen. LPN-D stated when LPN-D went in to assess R174, R174 had an altered mental status and was in unretractable pain. LPN-D stated R174 requested to go to the hospital. LPN-D stated R174 came back to the facility between 12 Noon and 12:30 PM. LPN-D stated R174 was not lethargic at any time and must have had an adverse reaction to the Ambien. LPN-D stated R174 rated the pain 10 out of 10.</p> <p>In an interview on 6/5/2025 at 8:13 AM, Surveyor asked LPN-D for clarification of how narcotic medications are reconciled between shifts and how the medication error was not discovered until 9:30 AM that morning. LPN-D stated the count was right at the end of the shift and could not understand how that could have been because the numbers would not have been right. LPN-D stated the narcotic drawer is counted whenever a new staff member takes over the cart, so it is counted at the beginning/end of the shift and, like yesterday when LPN-D left at 8:00 PM, the drawer is counted at that time. LPN-D stated the narcotic book had sheets in order of #1 and #2 and the medication cards were in order of #2 and #1. LPN-D stated the Ambien card should have been the first card instead of the second card. LPN-D stated LPN-D is always counting the narcotics and the cards to make sure they match and when LPN-D looked at the narcotic book at about 9:00 AM on 5/25/2025, LPN-D realized the count was wrong. LPN-D stated LPN-D called LPN-C as soon as LPN-D found the error and asked LPN-C what color was the Hydrocodone-Acetaminophen that LPN-C administered. LPN-C told LPN-D it was a little pink pill, which was the Ambien. LPN-D stated LPN-D had LPN-C come back in to write up the medication error and make a notation in R174's chart.</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 - Few</p>	<p>On 6/5/2025 at 8:33 AM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R174 received two doses of Ambien instead of the ordered Hydrocodone-Acetaminophen on 5/24/2025 and 5/25/2025 and the narcotic count at the change of shift did not alert LPN-C or LPN-D that medication errors had occurred. DON-B stated education had been done with LPN-C since the incident.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on interview and record review the facility did not ensure 1 (R22) of 5 residents medication was adequately monitored.</p> <p>R22's physician order for Metoprolol Tartrate 100 mg (milligrams) twice daily includes instructions to hold the medication if R22's systolic blood pressure is less than 120. R22's blood pressure is not being taken to ensure R22's systolic blood pressure is above 120 prior to administering this medication.</p> <p>Findings include:</p> <p>R22's diagnoses includes hypertension (high blood pressure).</p> <p>R22's physician dated 3/4/25 documents Metoprolol Tartrate Oral Tablet 100 mg (milligrams) (Metoprolol Tartrate). Give 1 tablet by mouth every morning and at bedtime for HTN (hypertension) hold for systolic &lt; (less than) 120.</p> <p>Surveyor reviewed R22's April 2025 MAR (Medication Administration Record), May 2025 MAR, & June 2025 MAR. Surveyor noted included on these MARs with a start date of 3/4/35 documents Metoprolol Tartrate Oral Tablet 100 MG (Metoprolol Tartrate). Give 2 tablet by mouth every morning and at bed time for htn hold for systolic &lt; 120. Surveyor noted under the section Hours documents BP (blood pressure) AM (morning) 06 and BP HS (hour sleep) 20. Surveyor noted daily for April 2025, May 2025, & June 2025 for BP there is an X. The times are checked with initials indicating Metoprolol Tartrate was administered.</p> <p>Surveyor noted under R22's weight/vitals tab documents the following blood pressure readings:</p> <p>On 4/1/2025 at 10:19 a.m. R22's blood pressure was 147/87 mmHg (millimeters of mercury).</p> <p>On 4/21/2025 at 19:11 (7:11 p.m.) R22's blood pressure was 132/82 mmHg.</p> <p>On 4/22/2025 at 18:37 (6:37 p.m.) R22's blood pressure was 128/78 mmHg.</p> <p>On 4/29/2025 at 14:00 (2:00 p.m.) R22's blood pressure was 146/72 mmHg.</p> <p>On 5/3/2025 at 14:38 (2:38 p.m.) R22's blood pressure was 153/83 mmHg.</p> <p>On 5/5/2025 at 07:57 (7:57 a.m.) R22's blood pressure was 140/88 mmHg.</p> <p>On 6/4/25, at 7:42 a.m., Surveyor asked Licensed Practical Nurse (LPN)-J if a physician orders a medication with vitals signs where would these vital signs be documented. LPN-J explained in PCC (pointclickcare) there will be a message indicating vital signs needed and you can't sign for the medication until vital signs are entered. Surveyor asked if these vital signs would be in the MAR. LPN-J replied yes.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/25, at 8:15 a.m., Surveyor asked LPN-K if a physician ordered blood pressure to be taken for a medication where would this be documented. LPN-K replied in the MAR. Surveyor then showed LPN-K R22's May 2025 MAR and June 2025 MAR which does not have R22's blood pressure. Surveyor informed LPN-K Surveyor also reviewed the weight/vital sign tab for R22's blood pressure. Surveyor asked LPN-K if there is any where else Surveyor she look to locate R22's blood pressure was taken prior to Metoprolol being administered. LPN-K replied no.</p> <p>On 6/4/25, at 9:13 a.m., Surveyor informed Registered Nurse/Unit Manager (RN/UM)-I Surveyor had reviewed R22's April 2025 MAR, May 2025 MAR, & June 2025 MAR and there is no evidence R22's blood pressure was taken prior to administration of R22's Metoprolol Tartrate 100 mg. RN/UM-I looked in R22's electronic medical record. RN/UM-I then informed Surveyor when Nurse Practitioner (NP)-N put in the order she didn't put supplemental documentation to take R22's blood pressure so the nurses were not alerted with each administration to the the blood pressure.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were free of significant medication errors for 1 (R174) of 1 resident reviewed with a medication error.</p> <p>R174 had an order for hydrocodone-acetaminophen 5-325 mg every four hours as needed for pain and Zolpidem (Ambien) 5 mg daily at bedtime for insomnia. On 5/24/2025, R174 received the scheduled dose of Ambien. On 5/24/2025 at 10:53 PM and on 5/25/2025 at 5:42 AM, Licensed Practical Nurse (LPN)-C administered Ambien 5 mg (a hypnotic) instead of the ordered hydrocodone-acetaminophen 5-325 mg. R174 received three doses of Ambien within 10 hours and R174 was sent to the hospital for altered mental status and complaints of intractable pain.</p> <p>Findings include:</p> <p>The facility policy and procedure titled Medication Administration General Guidelines dated 1/2024 documents:</p> <p>PROCEDURES</p> <p>Medication Preparation: .</p> <p>3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and 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 prescriber's orders are checked for the correct dosage schedule. Apply a direction change sticker to label if directions have changed from the current label.</p> <p>Medication Administration: .</p> <p>9. Verify medication is correct three (3) times before administering the medication.</p> <p>a. When pulling medication package from med cart</p> <p>b. When dose is prepared</p> <p>c. Before dose is administered.</p> <p>R174 was admitted to the facility on [DATE] with diagnoses of multiple fractures of the ribs on the left side, severe protein-calorie malnutrition, cognitive communication deficit, heart failure, adult failure to thrive, anemia, radiculopathy (the nerve in the spinal column is compressed causing pain, numbness, and weakness) of the lumbar region, spondylosis (degeneration of the spinal disks causing compression) of the cervical and lumbar region, and low back pain.</p> <p>F174's admission Minimum Data Set (MDS) assessment dated [DATE] documented R174 had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 11 and had frequent severe pain.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R174 had orders for the following medications on admission from the hospital:</p> <ul style="list-style-type: none"> -Zolpidem Tartrate (Ambien) 5 mg daily at bedtime for insomnia. -Lidocaine External Patch 4%: apply to left rib topically daily for pain, remove after 12 hours. -Meloxicam 7.5 mg daily for pain. -Gabapentin 200 mg twice daily for neuropathy. -Biofreeze Roll-On External Gel 4%: apply to neck, upper trapeziuses, and left knee three times daily for pain. -Acetaminophen 650 mg every 4 hours as needed for pain. -Hydrocodone-Acetaminophen 5-325 mg every for hours as needed for pain 6-10 on the pain scale. <p>R174's Opioid Use related to Pain Care Plan was initiated on 5/22/2025 with the interventions:</p> <ul style="list-style-type: none"> -Administer medications as ordered. -Encourage adequate fluid intake. -Monitor bowel habits and implement bowel regimen as ordered. -Monitor for side effects. -Monitor for signs and symptoms of a potential drug overdose; administer Narcan per facility protocol. <p>R174's Pain/Potential for Pain Care Plan related to low back pain, radiculopathy in the lumbar region, spondylosis of the lumbar and cervical region, and left rib fractures was initiated on 5/23/2025 with the following interventions:</p> <ul style="list-style-type: none"> -Administer pain medication per physician orders. -Encourage/assist to reposition frequently to position of comfort. -Implement non-drug therapies to assist with pain and monitor for effectiveness. -Notify the physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective. -Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. <p>R174's At Risk for Adverse Effects related to the use of Hypnotic Medication Care Plan was initiated on 5/22/2025 with the following interventions:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Report adverse effects such as burning or tingling in hands/feet, changes in appetite, constipation, diarrhea, dizziness, drowsiness, dry mouth or throat, headache, stomach complaints, tremors, or weakness.</p> <p>-Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs.</p> <p>-Non-pharmacological interventions for behaviors: address in a calm manner, attempt to orientate to place and time, allow resident to express feelings or frustrations and provide reassurance as needed, provide assistance as needed, family visits, offer activities of choice, provide emotional support to resident as needed, offer to close door and curtains to facilitate sleep.</p> <p>-Reduce environmental noise/distractions to facilitate sleep.</p> <p>-Sleep assessment per facility guidelines.</p> <p>On 5/24/2025 at 6:00 PM on the Medication Administration Record (MAR), LPN-D signed out and administered Hydrocodone-Acetaminophen 5-325 mg to R174 for complaints of rib pain.</p> <p>On 5/24/2025 at 8:00 PM, LPN-D administered R174's scheduled dose of Ambien 5 mg and documented on the MAR.</p> <p>On 5/24/2025 at 10:53 PM on the MAR, LPN-C signed out Hydrocodone-Acetaminophen 5-325 mg when R174 requested pain medication. LPN-C documented on 5/25/2025 at 12:07 AM that the medication was effective with a pain rating of 3 on a scale of 1-10. Surveyor noted LPN-C administered Ambien 5 mg instead of Hydrocodone-Acetaminophen 5-325.</p> <p>On 5/25/2025 at 4:23 AM in the progress notes, LPN-C documented R174 was up most of the night with complaints of pain and all pain medications were administered; R174 fell asleep at approximately 3:30 AM.</p> <p>On 5/25/2025 at 5:42 AM on the MAR, LPN-C signed out Hydrocodone-Acetaminophen 5-325 mg when R174 requested pain medication. At 6:27 AM, LPN-D documented the Hydrocodone-Acetaminophen was ineffective with a pain rating of 10. Surveyor noted LPN-C administered Ambien 5 mg instead of Hydrocodone-Acetaminophen 5-325.</p> <p>On 5/25/2025 at 7:15 AM in the progress notes, LPN-D documented R174 was complaining of uncontrolled pain and demanding to go to the hospital. R174 appeared to have an altered mental status and LPN-D was unable to redirect R174. R174 was unsafe to transfer from the bed to a wheelchair and was agitated and yelling. LPN-D contacted the physician and received orders to send R174 to the hospital for evaluation and treatment.</p> <p>On 5/25/2025 at 10:56 AM in the progress notes, LPN-C documented LPN-C administered two doses of Ambien instead of the Hydrocodone-Acetaminophen 5-325 mg.</p> <p>On 5/25/2025 at 11:08 AM in the progress notes, LPN-D documented LPN-C was made aware of the medication error and the Nurse Practitioner was notified.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor noted R174 had 15 mg of Ambien administered from 5/24/2025 at 8:00 PM to 5/25/2025 at 5:42 AM. Doses of Ambien higher than 10 mg can raise the risk of side effects such as feeling drowsy, confused, sleeping deeply, or even a coma, or have paradoxical effects (the opposite effects as one would anticipate) such as increased arousal, agitation, or a heightened sense of alertness.</p> <p>In a phone interview on 6/4/2025 at 7:33 AM, Surveyor asked LPN-C to recall the events of 5/24/2025 into 5/25/2025 with R174 receiving the wrong medication. LPN-C stated LPN-C was really tired that day and was really not there mentally like LPN-C should have been. LPN-C stated R174 was a new resident, so LPN-C had to get acquainted with R174 really quickly. LPN-C stated half of the unit has long term care residents and the other half has rehab residents so there is a lot of change over of residents on the rehab side. LPN-C stated R174 had complaints of pain and LPN-C gave R174 what LPN-C thought was R174's pain pill. LPN-C stated R174 could have a pain pill every 4 hours and grabbed the wrong medication twice. LPN-C was not sure if R174 had received a sleeping pill earlier on 5/24/2025.</p> <p>In a phone interview on 6/4/2025 at 8:25 AM, Surveyor reviewed R174's administration of three doses of Ambien 5 mg over 10 hours with Psychiatric Nurse Practitioner (NP)-E to see what a normal reaction to 15 mg of Ambien would be. NP-E stated NP-E would expect the resident to be sleeping. Surveyor shared with NP-E the agitation and severe pain R174 experienced on 5/25/2025 in the early morning hours. NP-E stated sometimes with Ambien, individuals can do things they are not aware of because of the mental state they are in, such as sleepwalking and that sort of behavior.</p> <p>In an interview on 6/4/2025 at 1:53 PM, LPN-D stated LPN-D arrived at the facility on 5/25/2025 at 6:00 AM and the night shift nurse, LPN-C, told LPN-D that R174 was up all night complaining of pain, pain, pain. LPN-D stated LPN-D had given R174 an Ambien the night before and LPN-C said LPN-C had given two Hydrocodone-Acetaminophen. LPN-D stated LPN-D saw the narcotic book and that Ambien had been given instead of Hydrocodone-Acetaminophen. LPN-D stated when LPN-D went in to assess R174, R174 had an altered mental status and was in unretractable pain. LPN-D stated R174 requested to go to the hospital. LPN-D stated R174 came back to the facility between 12 Noon and 12:30 PM. LPN-D stated R174 was not lethargic at any time and must have had an adverse reaction to the Ambien. LPN-D stated R174 rated the pain 10 out of 10. Surveyor noted R174 did not receive pain medication to alleviate R174's pain.</p> <p>Review of R174's hospital record for 5/25/2025 documented R174 presented to the emergency room with rib pain and altered mental status. R174 denied having any pain while in the emergency room. R174 presented with some hallucinations and the initial concern was for a urinary tract infection or other infection however, additional information was given that showed R174 was given 3 inadvertent Ambien for a total of 15 mg and suspect that is the cause of R174's symptoms. R174 was in no distress.</p> <p>On 6/5/2025 at 8:33 AM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R174 received three doses of Ambien over a 10 hour period causing altered mental status and an evaluation in the emergency room. DON-B stated LPN-C has been educated on proper medication administration.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based upon interview and record review, the facility did not ensure the mandatory staffing data, submitted for the first quarter of 2025 (October 1- December 31), was accurate.</p> <p>During review of the payroll-based-journal (PBJ) staffing data for the facility, the facility was triggered for excessively low weekend staffing. This had the potential to affect all 67 residents.</p> <p>Findings include:</p> <p>Review of the facility PBJ data, as part of the survey offsite process, indicates during the first quarter of the federal fiscal year 2025 (October 1- December 31) the facility was triggered for excessively low weekend staffing.</p> <p>Based on the Facility Assessment, the Facility is licensed for 100 residents. Maximum residents per unit is 44 residents each on North and East units. The census based range for staffing requirements on day shift is 4 nurses and 6-8 aides, evening shift is 4 nurses and 6-8 aides and, night shift is 2 nurses and 3-4 aides.</p> <p>Surveyor conducted a review of the daily staff schedules from October 1, 2025, to December 31, 2025. Surveyor noted both Licensed Nurses and Certified Nursing Assistants (CNAs) were present on each shift and for each unit. When call-ins happened, it was indicated on the schedule and it also was documented who replaced the call-in, if applicable.</p> <p>Surveyor also conducted a review of the daily staffing postings for the three days at survey (6/2/25, 6/3/25, 6/4/25) and the last 30 days of schedules (5/1/25 to 6/1/25) and verified both Licensed Nurses and Certified Nursing Assistants (CNAs) were present on each shift and for each unit. When call-ins happened, it was indicated on the schedule and it also was documented who replaced the call-in, if applicable.</p> <p>On 06/02/25 at 10:13 AM, Facility census is 67 and daily post of schedule lists:</p> <p>Day shift 6:00am to 2:00pm 7 CNA's, 4 LPNS's and 1 RN</p> <p>Evening shift 2:00pm to 10:00pm 7 CNA's, 2 LPN's and 2 RN</p> <p>Night shift 10:00pm to 6:00am 4 CNA's, 2 LPN's and 1 RN</p> <p>Total: 18 CNA's, 7 LPN's and 4 RN's</p> <p>On 06/03/25 at 09:56 AM, Facility census is 67 and daily post of schedule lists:</p> <p>Day shift 6:00am to 2:00pm 8 CNA's, 4 LPNS's and 1 RN</p> <p>Evening shift 2:00pm to 10:00pm 8 CNA's, 3 LPN's and 1 RN</p> <p>Night shift 10:00pm to 6:00am 4 CNA's, 1 LPN's and 1 RN</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Willowcrest Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Total: 20 CNA's, 8 LPN's, 3 RN's</p> <p>On 06/04/25 at 10:26 AM, Facility census is 67 and daily post of schedule lists:</p> <p>Day shift 6:00am to 2:00pm 8 CNA's, 4 LPNS's and 1 RN</p> <p>Evening shift 2:00pm to 10:00pm 8 CNA's, 3 LPN's and 1 RN</p> <p>Night shift 10:00pm to 6:00am 4 CNA's, 1 LPN's and 1 RN</p> <p>Total: 20 CNA's, 8 LPN's, 3 RN's</p> <p>On 06/04/25 at 10:30 AM, Surveyor interviewed Scheduler-DD who stated she determines staffing by census and acuity. Surveyor asked if Scheduler-DD is aware the facility triggered for excessively low weekend staffing first quarter of 2025 and Scheduler-DD stated she is aware but cannot understand why as she has always had the adequate and required staffing during this time. However, Scheduler-DD stated she does know that the nursing unit manager is included in the reportable staffing during the week but there is not a unit manager at facility on weekends.</p> <p>On 06/04/25 at 12:35 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B and [NAME] President of Success (VP of Success)-Q regarding the PBJ staffing report indicating excessively low staffing on the weekends for first quarter of 2025.</p> <p>Surveyor asked why they were triggering for low weekend staffing and NHA-A stated she identified there was an issue with their reporting of the hours and how staff were coded. NHA-A identified the issue in February of 2025 for the fiscal year quarter 1 with dates 10/1/24 to 12/31/24. NHA-A stated, the Facility did an audit on the reportable hours and discovered the training/orientation hours were not captured in reporting. Also, the unit managers and Infection Control Nurse are coded as direct patient care during the week and since they do not work the weekend, the direct care hours were showing a significant drop. NHA-A stated the facility has initiated a Process Improvement plan to also address this issue of the reporting of weekend staffing, wage package analysis, orientation process and more.</p>

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NAME OF PROVIDER OR SUPPLIER Willowcrest Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 3821 S Chicago Ave South Milwaukee, WI 53172	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on Observation, Interview and Record Review, the facility could not provide adequate proof of implementing an effective water management plan. This deficient practice had the ability to affect 67 of 67 residents residing at the facility at the time of this recertification survey.</p> <p>*The facility could not provide documentation of weekly temperature testing or weekly flushing logs for the vacant south unit (rooms 101-123).</p> <p>Findings include:</p> <p>Surveyor reviewed the Facility's Water Management Program Policy with a implementation date of 7/16/2022. The Facility's Water Management Program Policy documents the following: .3.) A risk assessment will be conducted by the water management team annually to identify where legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems .4.) Data to be used for completing the risk assessment may include but are not limited to: water system schematic/description, Legionella environmental assessment, Resident infection control surveillance data (i. e. culture results), environmental culture results, rounding observation data, water temperature logs, water quality reports from drinking water provider, community infection control surveillance data (i.e. health department data).</p> <p>Surveyor reviewed the facility's provided map of their floor plan. Surveyor noted that resident rooms on the south unit (101-123) are currently vacant.</p> <p>Surveyor reviewed the Facility's Water Management Plan with a documented review date of 1/20/2025. Per the facility's Water Management plan, the water management program team consists of Nursing Home Administrator (NHA)-A, Director of Nursing (DON)-B, Infection Preventionist-AA and Maintenance Director-BB.</p> <p>On 6/4/2025 at 8:15 AM, Surveyor met with NHA-A and Infection Preventionist-AA. Surveyor requested to see documentation of the facility's water management risk assessment, including rounding observation data and water temperature logs. NHA-A informed Surveyor that Maintenance Director-BB is no longer employed at the facility and that they will need to locate documentation of rounding observation data and temperature logs.</p> <p>On 6/4/2025 at 9:20 AM, NHA-A provided Surveyor with rounding observation data for the previous six months (January 2025-June 2025) for vacant rooms on the 200 and 300 units. Surveyor asked NHA-A to provide rounding observation data for the south unit (rooms 101-123) for the previous six months (January 2025-June 2025).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/4/2025 at 11:15 AM, Surveyor met with NHA-A. NHA-A informed Surveyor that the facility's south unit (rooms 101-123) observation data for weekly flushing and temperature logs was not completed by Maintenance Director-BB or Maintenance Assistant-CC. NHA-A provided Surveyor with an In-Service Training record with a date of 6/4/2025 for Maintenance Assistant-CC. The In-Service Training record documents that education was provided to Maintenance Assistant-CC regarding the importance of maintaining logbook documentation for water management. Surveyor shared concern that there was no documented monitoring of weekly temperature testing or weekly flushing to the facility's south unit (rooms 101-123) from January 2025 to June 2025. The facility did not provide any additional information to Surveyor at this time.</p>