STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525490	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aria of Waukesha	1451 Cleveland Ave Waukesha, WI 53186

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure each resident receives adequate supervision to prevent accidents for 1 of 3 residents (R1) reviewed for accidents/supervision. The facility did not correctly assess R1's risk for elopement and, thus, did not implement interventions to monitor and supervise R1 to prevent R1 from eloping from the facility. The facility had gaps in the monitoring of the main entrance of the building once the alarm system was turned off and before the area was staffed for the day, allowing R1 to leave the facility unnoticed by staff. R1 was returned to the facility 8 hours later when his family found him 20 miles away from the facility. The facility's failure to provide adequate supervision allowed for R1 to elope from the facility, which created a finding of immediate jeopardy that began on 8/25/25. Surveyor notified Director of Nursing (DON)-B, Nursing Home Administrator (NHA)-A, Regional Chief Innovations Officer-C, Regional Director of Quality Assurance-E, and Regional Director of Operations-D of the immediate jeopardy on 10/9/25 at 12:15 pm. The immediate jeopardy was removed on 9/26/25. The deficient practice continues at a scope and severity of D as the facility continues to implement its action plan. Findings include:The facility's policy and procedure titled Elopement Prevention and Missing Resident Policy last revised 8/8/2025, documents in part: Procedure:A. Elopement PreventionThe following section outlines the facility approach for elopement risk assessments, strategies for the prevention of elopement, staff training and education, and the Quality Assurance process:Assessments and Plan of Care:-Upon admission or re-admission, all residents will be assessed for elopement risk utilizing the Elopement Risk Assessment form.-A comprehensive elopement prevention plan of care will be developed for each resident identified as at risk for elopement.-Residents at risk for elopement will be reassessed quarterly and with a significant change of condition in conjunction with the MDS (Minimum Data Set) schedule.Routine Procedures: .-Should an exit alarm sound, staff shall immediately respond and determine the cause of the alarm. If no reason can be found, the Supervisor shall be notified, and an account of all residents identified to be at risk for elopement shall be performed.R1 was admitted to the facility on [DATE] with diagnoses that include:Encephalopathy (a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form), cognitive communication deficit (difficulty with communication that stems from impaired thinking skills, such as memory, attention, and problem-solving, rather than from physical speech problems), Vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), and Psychotic disturbance, mood disturbance, and anxiety (distinct but often co-occurring mental health issues that can include a loss of reality, emotional dysregulation, and excessive worry.)R1's 5-day Minimum Data Set (MDS) with an assessment reference date of 6/9/25, documents a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The MDS documents R1 was assessed to have no behavioral concerns exhibited during the look back period.R1's hospital admission paperwork dated 5/29/25, documents: PMH (Primary Medical History) of multi-infarct dementia, . has been living with his daughter for the last few months. Here with encephalopathy, was found crawling on the floor. Per ED (Emergency Department) Daughter cannot care for him anymore asking for higher level of care. Called patient's ex-wife to corroborate history: stated daughter was taking care of patient. Patient had a stroke around Christmas and has dementia now. Daughter is POA. Ex-wife stated patient had been yelling, falling off the bed, wanted to leave home, said it was difficult to work with patient. Called daughter (POA): patient has been acting up, had not been taking medication. Had been agitating, yelling at the door, jumps off the bed, broke the bed guard, bruises from crawling, worse at night. Tantrum every morning. This has started about March. Argues with daughter and family. At baseline is disoriented, fluctuating.Surveyor notes R1 was agitated while living in the community and wanted to leave home. This information was provided to the facility upon R1's admission and demonstrated R1's potential for increased agitation and elopement risk when transferred to a new environment at the facility.On 6/2/25, upon admission, R1's Elopement Risk Evaluation was completed. The facility form documents a score of 4 or more requires action unless the resident is not ambulatory.R1 was assessed to receive a score of 2.0, indicating not at risk for elopement. Two points were assessed related to: Relevant diagnosis/impaired cognition - Alzheimer's, Dementia, Schizophrenia, Traumatic Brain Injury, short-term or long-term memory problems, impaired decision-making skills.Surveyor notes R1 should have also been marked yes for Mobility Status - independently mobile via ambulation, w/c (wheelchair) or with assistive device which would be one point, as