STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER: Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE: 7500 W Dean Rd Milwaukee, WI 53223	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation, record review and interview, the facility did not ensure that 1 (R4) of 4 residents reviewed at risk for the development of pressure injuries receives care, consistent with professional standards of practice, to prevent pressure ulcers. * R4 was observed to have heels resting directly on the mattress and not wearing heel boots to offload pressure per R4's plan of care. Findings include: 1.) R4 was readmitted to the facility on [DATE] with a diagnosis that included Acute Respiratory Failure, Tracheostomy Status, Encephalopathy and Anoxic Brain Damage. R4's Annual MDS (Minimum Data Set) dated 12/29/24 documents short and long term memory problems for R4. Section G documents that R4 is dependent on facility staff for all mobility and self-care needs. Section M (Pressure Injuries) documents that R4 is at risk for the development of pressure ulcers/injuries. R4's Pressure Ulcer/Injury CAA (Care Area Assessment) dated 12/29/24, documents under the Care Plan Considerations section, At risk for pressure injury - requires monitoring and preventative measures. R4's skin integrity care plan dated as last revised on 2/10/25 documents under the Interventions section, Provide pressure relieving device(s): APM, heel lift boots. Date Initiated: 12/22/2023. On 3/4/25 at 9:24 AM, Surveyor observed R4 laying supine in bed with both heels resting directly on the mattress. Surveyor observed R4's heel boots to be sitting on a chair next to R4's bed. Surveyor noted that R4 did not have heel boots on to relieve pressure per R4's plan of care. On 3/4/25 at 10:29 AM, Surveyor observed R4 laying supine in bed with both heels resting directly on the mattress. Surveyor observed R4's heel boots to be sitting on a chair next to R4's bed. Surveyor noted that R4 did not have heel boots on to relieve pressure per R4's plan of care. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 11:25 AM, Surveyor observed R4 laying supine in bed with both heels resting directly on the mattress. Surveyor observed R4's heel boots to be sitting on a chair next to R4's bed. Surveyor noted that R4 did not have heel boots on to relieve pressure per R4's plan of care. On 3/4/25 at 12:19 PM, Surveyor observed R4's room door closed. Upon knocking, Surveyor observed R4 laying supine in bed with both heels resting directly on the mattress. Surveyor observed R4's heel boots to be sitting on a chair next to R4's bed. Surveyor noted that R4 did not have heel boots on to relieve pressure per R4's plan of care. On 3/4/25 at 12:24 PM, Surveyor informed RN (Registered Nurse)-D of the above findings. Surveyor asked RN-D if R4 is supposed to have heel boots on to relive pressure per R4's plan of care. RN-D informed Surveyor that R4 is supposed to have heel boots on to relive pressure per R4's plan of care. RN-D informed Surveyor that RN-D would put the heel boots on R4. On 3/4/25 at 1:25 PM, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. No additional information was provided as to why R4 was observed not having heels boots on to relive pressure per R4's plan of care and to prevent pressure ulcers from developing.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation, record review and interview, the facility did not ensure that 1(R4) of 1 residents with with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. * R4 was observed not to have on splints on either hand to prevent further contractures and maintain mobility. Findings include: 1.) R4 was readmitted to the facility on [DATE] with a diagnosis that included Acute Respiratory Failure, Tracheostomy Status, Encephalopathy and Anoxic Brain Damage. R4's Annual MDS (Minimum Data Set) dated 12/29/24 documents short and long term memory problems for R4. Section G documents that R4 is dependent on facility staff for all mobility and self-care needs. R4's Therapy to Recommendation form dated 9/5/24 documents, Patient to wear carrot splint on LUE (left upper extremity), resting hand splint (soft) on RUE (right upper extremity). Monitor skin integrity, soft call light on bed. R4's skin integrity care plan dated as last revised 1/6/25 documents under the Interventions section, Carrot splint on left hand/wrist. Resting hand splint on Right hand. R4's CNA (Certified Nursing Assistant) Kardex, which is used to summarize care plan interventions for R4 documents under the Personal Hygiene/Oral Care section: CONTRACTURES: The resident has contractures of the bilateral upper extremities. Resident to have carrot for the left hand and soft hand splint to the right hand. On 3/4/25 at 9:24 AM, Surveyor observed R4 laying supine in bed not wearing splints on either hand. Surveyor observed R4's carrot splint on the bedside table and a resting hand splint to be in R4's mattress and not in R4's hand. Surveyor noted that R4 did not have hand splints on per R4's plan of care. On 3/4/25 at 10:29 AM, Surveyor observed R4 laying supine in bed not wearing splints on either hand. Surveyor observed R4's carrot splint on the bedside table and a resting hand splint to be in R4's mattress and not in R4's hand. Surveyor noted that R4 did not have hand splints on per R4's plan of care. On 3/4/25 at 11:25 AM, Surveyor observed R4 laying supine in bed not wearing splints on either hand. Surveyor observed R4's carrot splint on the bedside table and a resting hand splint to be in R4's mattress and not in R4's hand. Surveyor noted that R4 did not have hand splints on per R4's plan of care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 12:19 PM, Surveyor observed R4's room door closed. Upon knocking, Surveyor observed R4 laying supine in bed not wearing splints on either hand. Surveyor observed R4's carrot splint on the bedside table and a resting hand splint to be in R4's mattress and not in R4's hand. Surveyor noted that R4 did not have hand splints on per R4's plan of care. On 3/4/25 at 12:24 PM, Surveyor informed RN (Registered Nurse)-D of the above findings. Surveyor asked RN-D if R4 was supposed to be wearing splints on both hands for R4's contractures and per R4's plan of care. RN-D informed Surveyor that R4 is supposed to be wearing splints on both hands and that RN-D would put them on R4. On 3/4/25 at 1:25 PM, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. No additional information was provided as to why the facility did not ensure R4 received appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation, record review and interview, the facility did not ensure that 1(R4) of 1 residents reviewed received adequate supervision and assistance devices to prevent accidents. * R4's call light was not observed not to be in reach and R4's room door was observed closed despite R4's plan of care documenting that R4's room door had to remain open to ensure R4's safety and supervision. Findings include: 1.) R4 was readmitted to the facility on [DATE] with a diagnosis that included Acute Respiratory Failure, Tracheostomy Status, Encephalopathy and Anoxic Brain Damage. R4's Annual MDS (Minimum Data Set) dated 12/29/24 documents short and long term memory problems for R4. Section G documents that R4 is dependent on facility staff for all mobility and self-care needs. R4's Falls CAA (Care Area Assessment) dated 12/29/24, documents under the Care Plan Considerations section, Has fall risks and requires monitoring and preventative measures. R4's Therapy to Recommendation form dated 9/5/24 documents, Patient to wear carrot splint on LUE (left upper extremity), resting hand splint (soft) on RUE (right upper extremity). Monitor skin integrity, soft call light on bed. R4's Fall Risk Scoring Tool assessment dated [DATE] documents a score of 16, indicating that R4 is at high risk for falls. R4's falls care plan dated as last revised 12/2/24 documents under the Interventions section, Keep resident door open for visualization/increased monitoring unless visitors/staff are present in resident room. R4's CNA (Certified Nursing Assistant) Kardex, which is used to summarize care plan interventions for R4 documents under the Monitoring/Safety section: Keep resident door open for visualization/increased monitoring unless visitors/staff are present in resident room. On 3/4/25 at 9:24 AM, Surveyor observed R4 laying supine in bed. Surveyor observed R4's push call light to be under R4's bed and not within reach of R4. Surveyor noted that R4 did not have a call light within reach to call for assistance if R4 required it. On 3/4/25 at 10:29 AM, Surveyor observed R4 laying supine in bed. Surveyor observed R4's push call light to be under R4's bed and not within reach of R4. Surveyor noted that R4 did not have a call light within reach to call for assistance if R4 required it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 11:25 AM, Surveyor observed R4 laying supine in bed. Surveyor observed R4 laying supine in bed. Surveyor observed R4's push call light to be under R4's bed and not within reach of R4. Surveyor noted that R4 did not have a call light within reach to call for assistance if R4 required it. On 3/4/25 at 12:19 PM, Surveyor observed R4's room door closed. Upon knocking, Surveyor observed Surveyor observed R4's push call light to be under R4's bed and not within reach of R4. Surveyor noted that R4 did not have a call light within reach to call for assistance if R4 required it. Surveyor also noted that R4's door was closed and not kept open for increased monitoring and supervision as documented in R4's falls plan of care. On 3/4/25 at 12:24 PM, Surveyor informed RN (Registered Nurse)-D of the above findings. Surveyor and RN-D walked into R4's room and opened R4's door. Surveyor asked RN-D if R4's call light was supposed to be within reach and if R4's room door was supposed to be open. RN-D informed Surveyor that R4's door shuts by itself and that R4's call light should be close to R4. On 3/4/25 at 1:25 PM, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. No additional information was provided as to why the facility did not ensure that R4 received adequate supervision and assistance devices to prevent accidents.

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F 0692

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51016

Based on interview and record review, the facility failed to assess resident's hydration status and supply sufficient fluid intake to maintain proper hydration and health for 1 (R1) of 3 residents reviewed.

The facility's repeated and systemic failure to assess and address R1's hydration status and implement pertinent interventions based on such an assessment resulted in R1 being admitted to the Intensive Care Unit (ICU) for Hypernatremia, Acute Kidney Injury, and a Urinary Tract Infection. This created a finding of immediate jeopardy that began on 2/7/2025. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B were notified of the immediate jeopardy on 3/05/25 at 10:14 AM.

The immediate jeopardy was removed on 3/5/25. This deficient practice continues at a scope and severity of a D (potential for harm/isolated).

Findings include:

1.) R1 was admitted on [DATE] with diagnoses that include Malignant Neoplasm of Posterior Wall of Bladder, Dysphagia following Cerebral Infarction, Alzheimer's Dementia, Vascular Dementia, Schizophrenia, and Major Depressive Disorder.

R1's Significant Change in Condition MDS (Minimum Data Set) with an assessment reference date of 11/20/24, documents a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate impaired cognition for R1.

Section K (Swallowing/Nutritional Status) documents R1 requires a mechanically altered diet of pureed food with honey consistent liquids.

Section GG (Functional Abilities and Goals) documents R1's eating ability as substantial / maximal assist, indicating that facility staff provides more than half the effort for R1 to eat.

R1's Hydration/Nutrition care plan dated 04/06/2024, with a revision date of 12/12/2024, documents: Resident is at risk for compromise in nutrition and hydration status d/t (due to) underweight status.

Under the Goals section it documents: Resident will not have s/sx (signs and symptoms) of dehydration. Date Initiated: 04/06/2024, Target Date: 03/12/2025.

Under the Interventions section it documents:

o Monitor for s/s of dehydration

Date Initiated: 04/06/2024

o Monitor for s/s of dysphagia and aspiration

(continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date Initiated: 04/06/2024 o Obtain weights per facility protocol Date Initiated: 04/06/2024 o Provide diet as ordered Date Initiated: 04/06/2024 o Provide supplements as ordered: Magic Cup TID (3 times a day) Date Initiated: 04/06/2024 o RD (Registered Dietician) to assess nutrition needs and make recommendations as necessary. Date Initiated: 02/19/2024 o Offer meal substitute if resident consumes less than 50% of meal Date Initiated: 04/06/2024, revision 2/19/25. R1's Dehydration/Fluid Maintenance Care Area Assessment Summary (CAAS) dated 12/11/24 documents under the Care Plan Considerations section: R1 triggered CAA d/t (due to) pneumonia. R1's fluid status is monitored closely. No s/sx (signs and symptoms) of dehydration at this time. Nursing to continue to monitor R1's fluid status and for s/sx of dehydration. R1's Basic Metabolic Panel (BMP) (a blood test providing insights into dehydration, metabolism, electrolyte balance, and organ function) results, dated 11/25/24, documents R1's Blood Urea Nitrogen (BUN) level was documented to be 39. BUN normal levels are (6 to 23). R1's Sodium (NA) level was documented to be 151. NA normal levels are (136-145). R1's Chloride (CL) level was documented to be 120. CL normal levels are (98-107). Surveyor noted that at the bottom of R1's BMP order .dated 11/26/24 Will see tomorrow per Advanced Practice Nurse Practitioner (APNP)-G. R1's Nurse Practitioner note dated 11/27/24 and written by APNP-G documents under the Assessment and Plan section: Dehydration: Encourage hydration. Repeat BMP. Continue to monitor fluid status and electrolytes. No new orders were placed. R1's Basic Metabolic Panel (BMP) result dated 12/02/24, documents R1's BUN level to be 30. R1's Sodium (NA) level was documented to be 152. R1's Chloride (CL) level was documented to be 120. No new orders were placed. Surveyor noted that at the bottom of R1's BMP order .dated 12/2/24 N.N.O (no new orders) per APNP-G. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Nurse Practitioner note dated 12/4/24 and written by APNP-G documents under the Assessment and Plan section: Dehydration: Encourage hydration. Repeat BMP. Continue to monitor fluid status and electrolytes. Surveyor noted that no new orders for a BMP to be repeated were placed. Surveyor was unable to locate a BMP completed for R1 on 12/4/24. R1's Nurse Practitioner note dated 12/6/24 and written by APNP-G documents under the Assessment and Plan section: Dehydration: Encourage hydration. Repeat BMP. Continue to monitor fluid status and electrolytes. Surveyor noted that no new orders for a BMP to be repeated were placed. Surveyor was unable to locate a BMP completed for R1 on 12/6/24. R1's Nurse Practitioner note dated 12/13/24 and written by APNP-G documents under the Assessment and Plan section: Dehydration: Encourage hydration. Repeat BMP. Continue to monitor fluid status and electrolytes. Surveyor noted that no new orders for a BMP to be repeated were placed. Surveyor was unable to locate a BMP completed for R1 on 12/13/24. R1's Nurse Practitioner note dated 12/20/24 and written by APNP-G documents under the Assessment and Plan section: Dehydration: Encourage hydration. Repeat BMP. Continue to monitor fluid status and electrolytes. Surveyor noted that no new orders for a BMP to be repeated were placed. Surveyor was unable to locate any fluid and electrolyte monitoring in R1's medical record. R1's nursing note dated 2/7/25 at 10:13 AM, documents: Situation: The changing condition reported on this CIC (change in condition). Evaluation are/were tired, weak, confused or drowsy at the time of evaluation R1s. Vital signs, Weight and blood sugar were blood pressure 141 / 97 on 2/7/25 at 10:16 AM position: sitting right arm. Pulse 52 on 2/7/25 at 10:17 AM Pulse type: Regular. Respirations on 2/7/25 at 10:17 AM. Temperature 98 on 2/7/25 at 10:18 AM Route: Tympanic. Weight 99 pounds on 2/3/25 at 5:35 PM Scale: wheelchair. Pulse oximetry 98% on 2/7/25 at 10:19 AM Method: Oxygen via mask. Blood glucose 154 on 11/13/24 at 9:38 AM . Resident patient is in the facility for long term care. Relevant medical history is cancer, active chemo or radiation therapy dementia. Code status do not resuscitate and advanced directives are in place. R1 had the following medication changes in the last week. R1 is on Coumadin warfarin. Outcomes of physical assessment: positive findings reported on R1 evaluation for this change of condition were: Mental status evaluation: Increased confusion. Example Disorientation. Functional status evaluation: General weakness. Nursing observations, evaluation and recommendation are CNA provided activities of daily living (ADLs) . R1, per usual, stated R1 didn't look herself. Vital signs were taken by writer Blood pressure 141 / 97, pulse 52, Respirations 20 Temperature 98 axillary. Pulse oxygenation at 98% per nasal cannula at 2 liters. Resident was sitting up in wheelchair at the dining room table. Staff was assisting in giving fluids and writer noticed the fluids were drooling from the side of R1's mouth. R1, more lethargic than usual self. Writer updated R1's family/power of attorney (POA) at this time. Primary care provider feedback. Primary care provider responded with the following feedback. A Recommendations. Monitor condition and contact nurse practitioner if needed be. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B New testing orders: C New intervention orders. Oxygen if available. R1's nursing note dated 2/7/25, at 11:14 AM, documents: Certified Nursing Assistant (CNA) provided activities of daily living to R1 per usual, stated R1 didn't look like herself. Vital signs were taken by writer Blood pressure 141 / 97, pulse 52. Respirations 20, Temperature 98 axillary. Pulse oxygenation at 98% per nasal cannula at 2 liters. R1 was sitting up in wheelchair at the dining room table. Staff was assisting in giving fluids and writer noticed the fluids were drooling from side of R1's mouth. R1 more lethargic than usual self. Writer updated family/POA at this time. Updated Nurse Practitioner continue to monitor condition and call if needed. R1's nursing note dated 2/7/25, at 11:45 AM, documents: Medications were drooling out of mouth. R1's nursing note dated 2/7/25, at 1:39 PM, documents: Spoke with family. Family given an update on residents, weight loss and change of condition. Staff will continue to monitor. R1's nursing note dated 2/7/25, at 6:55 PM, documents: R1 sent to hospital per family request stated that she (R1) does not look good and that she (R1) is not responding to them as normal. They feel she (R1) was unresponsive, wanted her (R1) to be evaluated. MD updated awaiting response. Family/POA aware and was present with rest of family. R1 sent out via Ambulance with two attendants. Blood pressure 122 / 62, Respirations 18, Pulse 87. Oxygen saturation 99% on 2 liters per nasal cannula. Director of Nursing updated. R1's hospital note titled History of Present Illness dated 2/7/25, at 9:10 PM, documents: R1 is a 78 Y female with a history of HFrEF (EF 11%) R1 has a cardiac ejection fraction of 11% (meaning R1's heart has poor ability to pump blood), LV thrombus on apixaban, schizophrenia, CKD (chronic kidney disease), dementia, stroke, and hypertension who presented to hospital Emergency Department (ED) via Emergency Medical Service (EMS) from R1's assisted living facility for confusion and altered mental status. The patient is minimally responsive & nonverbal without any family at bedside, so History and Physical Information (HPI) is obtained from ED documentation. Family stated that R1 lives in a nursing home and they were called today because R1 seemed less responsive and interactive to them. (R1) Has a history of dementia and stroke. Son states R1 does not talk much at baseline. However, when R1 sees him will always seem excited and alert. Today was lethargic with her mouth open and not talking to anyone. EMS (Emergency Medical Service) reported a fever from R1's nursing home. R1 does not walk around her facility at baseline. Son states R1's mouth is very dry and R1 looked very dehydrated to them. They are not sure the last time the staff checked on R1. In the ED (Emergency Department), multiple laboratory abnormalities were noted & most significant levels were for Na (Sodium) level was 186, normal levels are (136-145), CL (Chloride) level was >140, normal levels are (98-107), BUN (blood urea nitrogen) level was 110, normal levels are (6 to 23), Creatinine level was 2.97, normal levels are (0.50-110). Urinalysis (UA) was consistent with UTI. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The patient received 1 Liter Normal Saline; 2 Grams ceftriaxone, & is subsequently being admitted to the intensive care unit (ICU) for further management of R1's hypernatremia & urinary tract infection (UTI) . Assessment and plan: R1 is a 78 Y female with a history of HFrEF (EF 11%) R1 has a cardiac ejection fraction of 11% (meaning heart has poor ability to pump blood), LV thrombus on apixaban, schizophrenia, CKD, dementia, stroke, and hypertension admitted to (hospital) 2/7/25 with hypernatremia, UTI and encephalopathy. Hypernatremia: - 1 Liter NS (normal saline) administered in ED for volume depletion. - 5.8L free water deficit. - Continue hydration with D5W (dextrose 5% water). - Insert Dobbhoff (feeding tube) & initiate free water flushes. - Patient has lost 25 lbs. in 3-6 months time. Nutrition consult in AM. - Monitor I/Os (intake and output). - Serial Sodium. UTI (Urinary Tract Infection): - Not overtly septic appearing, lactic acid reassuring. - Skin warm & well perfused. - We'll avoid bolus fluid resuscitation given significant heart failure history, continue ongoing maintenance fluids. - Continue daily ceftriaxone. Acute kidney injury, CKD (chronic kidney disease): - Baseline creatinine appears to be 0.8 to 1, 2.97 on presentation. - Expect prerenal due to hydration. anticipate resolution with ongoing water repletion. - Hold PTA ACE/ARB. - Avoid potential nephrotoxins. - Avoid radiocontrast if possible. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Avoid NSAIDs. - Avoid Phosphate based enemas and laxatives. - Renally dose adjust medications to GFR (glomerular filtration rate). - Strict Intake and Output. - Could consider phrenology consult. HFrEF, LV thrombus, Stroke: - Hold apixaban initially to account for renal function. - Continue apixaban & clopidogrel. - No PTA diuretics on history - Monitor, could consider repeat echo. Toxic metabolic encephalopathy: - Existing dementia diagnosis noted. - Expect resolution back to baseline with treatment of hypernatremia and UTI. Surveyor reviewed R1's fluid intake for the months of December 2024, January 2025, and February 2025 in the facility's electronic medical record system. Surveyor reviewed all the fluid intake information available in the electronic medical record system for R1, including any fluid recorded for meals and snacks. Surveyor noted R1's December 2024 documented daily fluid intake averaged 680.25 milliliters. Surveyor noted R1 had no documentation of fluid intake on 12/1/24. Surveyor noted no snack time fluid intake documented for R1 from 12/1/24 through 12/11/24, and on 12/14/24, 12/17/24, 12/21/24, 12/22/24, and 12/26/24. Surveyor noted R1's January 2025 documented daily fluid intake averaged 871 milliliters. Surveyor noted R1 had 3 dates documenting lower daily fluid totals: 1/13/25 R1 received 200ML, 1/21/25 R1 received 120 ML, and 1/23/25 R1 received 240 ML. Surveyor noted R1's February 2025 documented daily fluid intakes are as follows: on 2/1/25 R1 received 960 ML, on 2/2/25 R1 received 920 ML, on 2/3/25 R1 received 840 ML, on 2/4/25 R1 received 680 ML, on 2/5/25 R1 received 600 ML. On 2/6/25, R1 had no documentation of receiving fluid for the day. On 2/7/25, R1 had no documentation of receiving fluid for the day. R1 left for the hospital at 06:55 PM on 2/7/25. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor attempted to located how much fluid R1 should receive daily in the facility's electronic medical system. The only daily fluid assessment that documented how much daily fluid R1 should receive was from a dietary assessment completed on 2/7/22. The 2/7/22 dietary assessment documented that R1's daily fluid intake goal was 1525 milliliters (ML). On 3/4/25, at 10:38 AM, Surveyor interviewed Dietician (DT)-F regarding R1's daily fluid intake goals. Surveyor informed DT-F that Surveyor has been unable to locate daily fluid intake recommendations for R1. Surveyor informed DT-F that Surveyor was unable to locate any documentation on what R1's daily fluid intake goals should be before and after R1's 2/7/25 hospitalization for hypernatremia, acute kidney injury, and UTI. DT-F informed Surveyor that based on a 25-30 milliliter (ML) per kilogram (KG) formula, R1 should receive 1100ML to 1400 ML of fluid daily. Surveyor informed DT-F that Surveyor could not locate R1's fluid intake recommendation in R1's medical record. DT-F informed Surveyor DT-F could not locate any recent recommendations for R1's daily fluid intake in R1's medical record. DT-F informed Surveyor the last recommendation in R1's record is from 2/7/22. Surveyor asked DT-F with R1's dehydration diagnosis in December 2024 and R1's identified hydration concerns, why would fluid evaluations and daily fluid recommendations for R1 not be completed since 2/7/22. DT-F informed Surveyor DT-F could not answer that question because DT-F had only been covering this facility for another dietician since 2/20/25. Surveyor asked DT-F that in DT-F's professional opinion what should have been done for R1's specific fluid deficit concerns. DT-F informed Surveyor that high risk residents like R1 should be a weekly review for fluid intake and a monthly interdisciplinary team (IDT) review. DT-F informed Surveyor that it looked like the focus had been on R1's nutrition only and not specifically R1's fluid deficits. DT-F informed Surveyor the team would usually look at fluid intake more closely as part of R1's weight loss but in R1's case that wasn't done. DT-F informed Surveyor that DT-F could not locate any documented fluid specific intakes being reviewed in R1's record. Surveyor asked DT-F if dietary staff were aware of R1's BMP results on 11-25-24 that showed an elevated BUN, Chloride, and Sodium levels for R1 and APNP-G's written concern with dehydration and pushing fluids. DT-F informed Surveyor that DT-F was not informed of R1's dehydration concerns documented by APNP-G. DT-F informed Surveyor that this information was not communicated to the dietary department based on what DT-F could see in R1's dietary notes. DT-F informed Surveyor DT-F wasn't at the facility during that time and could not speak to that information. Surveyor asked DT-F if DT-F felt that APNP-G's fluid concerns should have been communicated to dietary and daily fluid goals provided for R1. DT-F informed Surveyor DT-F could see nothing in R1's dietary notes that R1 was flagged for specific dehydration or fluid deficit concerns. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor asked DT-F how dietary staff would expect communication from the facility about fluid deficits or dehydration concerns for residents. DT-F informed Surveyor that dietary staff would expect to be notified of fluid deficits and dehydration from the facility's care partners, staff, and during the IDT meetings. Surveyor asked DT-F if there was anything in R1's notes or if dietary was informed about APNP-G's recommendation to monitor and push fluids on R1. DT-F informed Surveyor that DT-F assumed fluid concerns for R1 would have been discussed in the IDT meetings, but DT-F could not find information in R1's record confirming dehydration concerns were discussed. Surveyor asked DT-F when DT-F started to cover dietary was the fluid deficit or dehydration concern for R1 mentioned. DT-F informed Surveyor that weight loss and nutritional concerns for R1 has been the focus in the dietary notes and not R1's hydration status. DT-F was not informed about any specific dehydration or fluid concerns for R1. Surveyor asked DT-F if DT-F was aware of the 2/29/25 dehydration assessment placing R1 at risk for dehydration. DT informed Surveyor DT-F was not aware of that assessment. On 3/4/25, at 2:50 PM, Surveyor interviewed APNP (Advanced Practice Nurse Practitioner)-G regarding R1's Dehydration diagnosis and daily fluid intake goals. Surveyor asked APNP-G if APNP-G was aware that no new BMP tests were done on R1 after 12-2-24, and it is documented in APNP-G's plan and assessment that R1 was to have a repeat BMP test. APNP-G informed Surveyor just because APNP-G writes repeat BMP in R1's notes, it was a reminder to APNP-G to watch this issue closely for R1. Surveyors asked APNP-G how the staff would know R1 would not get a repeat BMP, as it was in written in APNP-G's 11/27/24 note to repeat a BMP and a BMP test was done.APNP-G informed Surveyors APNP-G would have put the order in the facility's order system application. Surveyors asked APNP-G if APNP-G wanted the staff to monitor R1's fluid and electrolytes that APNP-G documented as part of R1's plan and assessment. APNP-G informed Surveyor that R1's dehydration diagnosis was a clinical diagnosis of symptoms, and with R1's sodium being elevated APNP-G expected the facility to monitor R1's fluid and electrolytes. Surveyor asked APNP-G how staff would know which interventions APNP-G wrote for R1 in APNP-G's December 2024 notes that included repeat BMP, encourage fluids, and monitor fluid and electrolytes were to be implemented when no orders for any interventions were entered into the system. APNP-G could not speak to that at the time but reiterated to Surveyor R1's sodium was elevated so APNP-G expected the facility to monitor R1's fluid and electrolytes. Surveyor asked APNP-G what APNP-G would expect R1 to receive for a daily fluid goal. APNP-G informed Surveyor that APNP-G could not speak to that, but APNP-G expected that dietary should be involved in establishing the daily fluid goals for R1. Surveyor asked APNP-G if a dietary consultation was ordered for R1's fluid intake concerns. APNP-G informed Surveyor that a dietary consult was not ordered by APNP-G, but if the staff had told APNP-G that R1 wasn't drinking fluids, APNP-G would have repeated the order for R1's BMP test. Surveyor asked APNP-G how the staff would know when to inform APNP-G without fluid goals or parameters set for R1. APNP-G informed Surveyor APNP-G would still expect the staff to push fluids because R1's sodium was high, and it is the facility's responsibility to get dietary involved. Surveyor asked APNP-G if APNP-G was aware that the facility tracked R1's fluid intake during meals and snacks in the electronic medical record. APNP-G informed Surveyor that APNP-G had not seen R1's fluid intake documentation from the electronic medical record. Surveyor asked APNP-G how APNP-G determined R1's dehydration diagnosis noted in APNP-G's note dated 11/27/24. APNP-G informed Surveyor R1's elevated BMP results and elevated Sodium is a specific symptom of dehydration. APNP-G informed Surveyor that a focus on R1's weight loss and nutritional intake concerns was ongoing. (continued on next page)

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F 0692

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Surveyor asked APNP-G when R1 showed up to the hospital with elevated BMP results would APNP-G agree it was not just from R1 occasionally not drinking enough water. APNP-G informed Surveyor APNP-G would agree with the assessment that R1 was in a significant fluid deficit. APNP-G informed Surveyor that R1 was at risk for fluid deficit before the hospitalization on [DATE]. Surveyor asked APNP-G if APNP-G agrees without a current fluid assessment with daily fluid goals set for R1, staff would not have guidelines on how to meet R1's current fluid needs. APNP-G informed Surveyor daily fluid intake goals should be set for R1 but expects the dietician to be the one setting R1's daily fluid goals.

APNP-G informed Surveyor that APNP-G can't be at the facility all the time and expects that dietary and the facility take some of the responsibility for R1's hydration status. APNP-G informed Surveyor if the staff did not inform APNP-G that R1 had an issue with hydration, there is nothing that APNP-G could have changed for R1. Surveyor asked APNP-G if daily fluid goals for R1 would help staff in knowing what to communicate to the medical providers. APNP-G informed Surveyor that R1 should have daily fluid goals, but dietary should be setting those fluid goals.

On 3/4/25, at 1:21 PM, Surveyor interviewed Director of Nursing (DON)-B and Nursing Home Administrator (NHA)-A. Surveyor informed NHA-A of Surveyor's concerns about R1's dehydration diagnosis by APNP-G on 11/27/24 and the lack of communication between R1's care team with no comprehensive system to monitor R1's daily fluid intake. Surveyor informed NHA-A R1 had a lack of a specific hydration care plan before and after R1's hospitalization for hypernatremia, elevated BMP laboratory tests, and acute kidney disease. Surveyor informed NHA-A this failure caused R1 to be hospitalized on [DATE] with a 5.8-liter free water deficit causing R1 to stay in the ICU related to R1's 11% injection fraction requiring the hospital to carefully monitor R1's administered fluid replenishment.

Surveyor asked DON-B did the facility review R1's fluid and dehydration issues noted in APNP-G's note documented on 11/27/24. DON-B informed Surveyor that DON-B had reviewed APNP-G's note, the facility felt R1 had a change of condition when R1 had declined in R1's ability to feed herself, and R1 developed a food bolus causing R1's hospitalization just prior to APNP-G's note in November 2024. Surveyors asked DON-B what plan for R1 was implemented after APNP-G diagnosed R1 with dehydration in R1's Nurse Practitioner note dated 11/27/24. DON-B informed Surveyor in the facility's weekly meeting R1 and all at risk residents' nutrition and dehydration concerns and other issues are reviewed. Surveyor asked DON-B if R1's dehydration diagnosis was reviewed in these meetings. DON-B informed Surveyor that DON-B could honestly say the team never discussed R1's specific fluid or dehydration concerns outside of R1's overall meal intakes. DON-B informed Surveyor the team focused on preventing R1's weight loss and overall nutrition and not specifically R1's dehydration.

Surveyor asked DON-B if DON-B was aware of the Nurse Practitioner notes written by APNP-G on the dates of 12/4/24, 12/6/24, 12/13/24, and 12/20/24 documenting expectation that staff should encourage fluid and monitor fluid and electrolytes for R1. DOB-B informed Surveyor that the facility was aware of R1's dehydration diagnosis and fluid monitoring written by APNP-G. Surveyor asked DON-B if DON-B was aware that APNP-G also documented repeating a BMP test for R1 in the Nurse Practitioner notes written on 12/4/24, 12/6/24 and 12/13/24. DOB-B informed Surveyor that the facility was aware of R1's repeat BMP documentation in APNP-G's notes, but that APNP-G had not put in an order for the BMP.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON-B informed Surveyor that communication issues with APNP-G have been a problem as well as clarifying what APNP-G's expectations are compared to what APNP-G's writes in R1's notes. DON-B informed Surveyor the facility has requested that APNP-G be more specific with APNP-G's expectations when writing notes, because the notes that APNP-G writes often give direction to staff without orders placed into the system. Surveyor asked DON-B if the nursing and IDT teams looked at the fluid intakes Surveyor noted in the electronic medical record for meals and snacks. DON-B informed Surveyor the nursing or IDT team had not reviewed those intake records, that the weekly team reviews had been focused on the weight loss and R1's overall meal intake. DON-B informed Surveyor that R1's fluid intakes were not looked at specifically. Surveyor asked DON-B if DON-B was aware that there had been no daily fluid goal expectations documented for R1 since a dietary note on 2/7/22. DON-B acknowledged there was no current daily fluid goals in R1's plan of care. DON-B informed Surveyor that there is a communication issue with APNP-G, and the facility is having difficulty getting specific parameters from APNP-G. Surveyor asked DON-B if the IDT team was aware that on 2/19/25 a dehydration risk assessment was done for R1 documenting that R1 is at risk for dehydration. DON-B informed Surveyor that DON-B was aware of R1's 2/19/25 dehydration risk assessment. DON-B informed Surveyor that DON-B was aware no specific fluid intake changes in the hydration part of R1's care plan had been implemented. Surveyor asked DON-B why the daily fluid intake in the electronic medical record documented by the nursing assistants is not reviewed by the licensed nursing staff. DON-B informed Surveyor it was an oversight, but R1's intakes in the electronic medical record would be reviewed going forward. DON-B informed Surveyor that while it is not an excuse, the team focuses hard on R1s nutrition and preventing R1's weight loss. DON-B informed Surveyor that R1's family has been resistant to anything around tube feeding or placing R1 in hospice. DON-B informed Surveyor the medical providers have spoken to family repeatedly about R1's decline. DON-B informed Surveyor the family declined Speech Therapy treatment and doesn't want any permanent interventions for R1. On 3/4/25, at 6:49 PM, Surveyor asked Medical Director-H how facility staff is supposed to distinguish between recommendations made by APNP-G and what APNP-G is writing to remind APNP-G what to monitor for R1. Medical Director-H informed Surveyor that there is a problem with the way APNP-G is writing notes for R1, as nursing staff would have a hard time distinguishing between recommendations that APNP-G is using to remind APNP-G to monitor for R1, and what nursing staff at the facility are supposed to do. Medical Director-H emphasized to Surveyor that if APNP-G had specific orders for R1, APNP-G would put an order in the system so that nursing staff could execute the order. Medical Director-H informed Surveyor that there is problem with the communication between APNP-G and nursing staff at the facility as recommendations written by APNP-G are not being followed and that nursing staff is unable to distinguish between what APNP-G is using to remind APNP-G to monitor for R1 and what APNP-G expects nursing staff at the facility to do. (continued on next page)

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F 0692

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Surveyor informed Medical Director-H that APNP-G was not aware of the daily fluid intake for R1 since R1 had not had a daily fluid intake goal assessment completed since 2/7/22. Medical Director-H informed Surveyor that he could not speak to why APNP-G was not aware of the daily fluid intake for R1 and stated that nursing had failed to do a more recent daily fluid goal assessment on R1. Medical Director-H informed Surveyor that going forward the facility would establish better communication between APNP-G and nursing staff and that the facility would complete a quality assurance review of the incident.

On 3/4/25 at 7:09 PM, Surveyor informed NHA-A of the above findings. NHA-A informed Surveyor that the facility would complete a root cause analysis of R1's fluid issues and attempt to find out if there were any other issues involving R1's fluid intake.

No additional information was provided as to R1's daily fluid intake needs or why R1 did not receive enough fluids prior to being hospitalized on [DATE].

The facility's repeated and systemic failure to assess and address R1's hydration status and implement pertinent interventions based on such an assessment resulted in R1 being admitted to the Intensive Care Unit (ICU) for Hypernatremia, Acute Kidney Injury and a Urinary Tract Infection created a reasonable likelihood for serious harm, thus leading to a finding of immediate jeopardy

The immediate jeopardy was removed on 3/5/25 when the facility completed the following:

- All facility nursing staff educated on fluid intake documentation, monitoring, change of condition, hydration assessments and when to update provider. -

- Nurse Practitioner educated on monitoring change of condition, making clear orders to nursing staff, and communication process with nursing staff.

- Dietician educated on implementation of fluid intake goals, clear communication with nursing staff, and monitoring for residents at risk for dehydration.

- All training noted above to be completed by next working shift. Any nurses/CNAs who do not complete the competency will not be scheduled until completed.

- Competencies and education will be conducted by nursing management and/or a nurse who has passed the competency education and has been designated to give education.

- The facility reviewed and updated plan of care for all residents at risk for dehydration. Monitoring includes tracking system in Point Click Care, weekly dietician meetings, nurse manager/DON audit oversight, daily review of charting and fluid intake for at risk residents in stand up.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Facility reviewed policy and procedure for hydration. Policy updated to include: 1. The dietician or consulting dietician will work together with staff to identify residents at risk for fluid deficit or with specific fluid intake needs. 2. The dietician will determine the optimal fluid intake amount for residents at risk and will communicate that to the nursing staff with a breakdown of recommended fluid amounts per shift, per meal, per med pass, and/or water pass. 3. The dietician and staff will monitor for the subsequent development, progression and/or resolution of fluid deficit or fluid restrictions in all at-risk individuals to ensure appropriate interventions and/or follow up continues. 4. The dietician will participate in weekly Nutritional at Risk meetings and maintain on-going dialogue

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36161 Based on observation, record review and interview, the facility did not ensure that 1 (R4) of 1 residents reviewed that are fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. * R4 was observed to recieve enteral feeding with the head of the bed at less than 30 degrees. Findings include: 1.) R4 was readmitted to the facility on [DATE] with a diagnosis that included Acute Respiratory Failure, Tracheostomy Status, Encephalopathy and Anoxic Brain Damage. R4's Annual MDS (Minimum Data Set) dated 12/29/24 documents short and long term memory problems for R4. Section G documents that R4 is dependent on facility staff for all mobility and self-care needs. R4's Feeding Tube CAA (Care Area Assessment) dated 12/29/24, documents under the Care Plan Considerations section, Ongoing use of tube feeling and NPO status. Staff provide all nutrition and hydration needs. R4's nutritional alteration care plan dated as initiated 12/22/23 documents under the Interventions section, Hold feeding when giving care, turning and repositioning. Resume when complete and HOB (head of bed) up. R4's CNA (Certified Nursing Assistant) Kardex, which is used to summarize care plan interventions for R4 documents under the Eating/Nutrition section: Resident is NPO (nothing by mouth) requiring tube feeding. R4's physician order dated 10/18/24 documents, Every 6 hours . JEVITY 1.5 474mL (militers) (2 cans) via bag orsyringe bolus and 100 mLflushes before and after feeding. On 3/4/25 at 12:19 PM, Surveyor observed R4's room door closed. Upon knocking, Surveyor observed R4's tube feeding running to gravity and the head of the bed of R4 to be less than 30 degrees. On 3/4/25 at 12:24 PM, Surveyor informed RN (Registered Nurse)-D of the above findings. Surveyor and RN-D walked into R4's room and observed R4 receiving enteral feeding with the head of the bed elevated approximately 20 degrees and not at least 30 degrees as documented in R4's plan of care. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor asked RN-D if R4's head of bed was elevated at least 30 degrees while R4 received enteral feeding. RN-D informed Surveyor that R4's head of bed was not elevated at least 30 degrees and proceeded to adjust R4 and raise the head of the bed above 30 degrees while R4 recived enteral feeding. On 3/4/25 at 1:25 PM, Surveyor informed NHA (Nursing Home Administrator)-A and DON (Director of Nursing)-B of the above findings. No additional information was provided as to why the facility did not ensure R4 received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 38829 Based on interview and record review, the facility did not develop, implement, and maintain an effective training program for all facility and contracted staff consistent with their expected roles and based on the facility assessment for 8 of 8 facility staff. * Dietary Aide (DA)-J, Housekeeper (HK)-K, Registered Nurse (RN)-I, Registered Dietitian (RD)-L and Certified Nursing Assistants (CNA) CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not have documentation that they completed the required training. This practice had the potential to affect all 59 Residents in the facility. Findings include: The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation 1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the Resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. 6. Required training topics include the following: a. Effective communication with Residents and family(direct care staff) b. Resident rights and responsibilities c. Preventing abuse, neglect, exploitation or misappropriation of Resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of Resident property (2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of Resident property (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(3) Dementia management and Resident abuse prevention d. Elements and goals of the facility QAPI program e. The infection prevention and control standards, policies and procedures f. Behavioral health g. Compliance and Ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating 5 or more facilities) 7. Training requirements are met prior to staff providing services to Residents, annually, and as necessary based on the facility assessment. Based on the outcome of the facility assessment, additional training be needed. 8. Completed training is documented by staff development coordinator, or his or her designee and includes: a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment e. Hours of training completed . The facility's Facility Assessment last reviewed July 2024 documents: .The facility utilizes all professionals indicated to determine what resources are needed, what training is required to provide competent care and any other factor involved in determining if the facility can care for the potential Resident. The facility's human resources department and Interdisciplinary team is involved in developing and providing or accessing education and training for staff and ensuring competent staff with the skill sets necessary to care for the population. .Staff training/education and competencies A competency approach is used to determine the knowledge and skills required among staff and contracted employees. .on-going monitoring of staff care and work conducted to ensure Residents are able to maintain or attain their highest practicable physical, functional, mental and psychosocial well-being and meet current professional standards of practice . .Education and Training -New employee orientation schedule (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0940

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

-Annual education and training

.Competencies Obtained/Evaluated Education Provided for CNAs

-Annual skills checks through staff development

-As needed training from vendor, professional group or other for new/unique skill sets required for member care

-Minimum of 12 credit hours per year .

On 3/17/25, at 11:51 AM, Surveyor randomly selected 8 facility staff and 1 contracted employee for review. Surveyor reviewed the employee records DA-J, HK-K,RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required education and training within the year based on hire date.

DA-J - date of hire 5/24/23

HK-K - date of hire 3/7/07

RN-I - date of hire 2/21/24

RD-L - contract effective 1/24/23

CNA-M - date of hire 5/22/23

CNA-N - date of hire 4/6/23

CNA-O - date of hire 6/7/23

CNA-P - date of hire 5/20/22

CNA-Q - date of hire 9/20/23

On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having the required education and training. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them.

On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required trainings for employees DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. DES-R explained that DES-R is only responsible for coordinating topics for orientation of new employees.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required education and trainings for all employees. DON-B stated there is no system in place for keeping track of educational training for the employees. DON-B is aware that staff have not received the required educational training in the year identified. DON-B confirmed that the facility has no formal program in place for all required training's to be completed for DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. DON-B stated that there is no specific education/training coordinator in place at the facility. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee training documents that still need to be filed in employee files. DON-B informed Surveyor that DON-B was unaware that RD-L, as a contracted employee needed to received the required educational trainings provided by the facility. DON-B understands the concern that there is no documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required education and trainings required. On 3/17/25, at 3:45 PM, NHA-A and DON-B was informed of the concern that the facility has no formal effective training program for all required trainings of all staff. Additional information was requested, if available. At the time, no further information has been provided as to why DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required education and trainings. The facility did not provide any additional information in regards to the development of a formal effective training program and the facility has not been maintaining records of staff required trainings at this time. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed the additional information and notes that documentation is evident the facility does not have a process for maintaining records of staff receiving required trainings at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 38829 Based on interview and record review, the facility did not ensure 6 of 6 direct staff chosen at random received effective communication training. * Registered Nurse (RN)-I, Registered Dietitian (RD)-L, and Certified Nursing Assistants (CNA) CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not receive effective communication training. This practice had the potential to affect all 59 Residents in the facility. Findings Include: The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation .1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the Resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. 6. Required training topics include the following: a. Effective communication with Residents and family(direct care staff) b. Resident rights and responsibilities c. Preventing abuse, neglect, exploitation or misappropriation of Resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of Resident property (2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of Resident property (3) Dementia management and Resident abuse prevention (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	d. Elements and goals of the facility QAPI program e. The infection prevention and control standards, policies and procedures f. Behavioral health g. Compliance and Ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating 5 or more facilities) 8. Completed training is documented by staff development coordinator, or his or her designee and includes: a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment e. Hours of training completed . On 3/17/25, at 11:51 AM, Surveyor randomly selected 6 direct care staff and 1 contracted employee for review. Surveyor reviewed the employee records RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required effective communication training within the year based on hire date. RN-I - date of hire 2/21/24 RD-L - contract effective 1/24/23 CNA-M - date of hire 5/22/23 CNA-N - date of hire 4/6/23 CNA-O - date of hire 6/7/23 CNA-P - date of hire 5/20/22 CNA-Q - date of hire 9/20/23 On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having required effective communication training. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER: Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE: 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required trainings for employees DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. DES-R explained that DES-R is only responsible for coordinating topics for orientation of new employees. On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required effective communication training for direct care staff. DON-B stated there is no system in place for keeping track of of educational training for the employees. DON-B is aware that staff have not received the required educational training in the year identified. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee training documents that still need to be filed in employee files. DON-B informed Surveyor that DON-B was unaware that RD-L, as a contracted employee needed to received the required educational trainings provided by the facility. DON-B understands the concern that there is no documentation that RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required effective communication training. On 3/17/25, at 3:45 PM, NHA-A and DON-B were informed of the of the above findings. Additional information was requested, if available. At this time, no further information has been provided as to why RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required effective communication training. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed additional information provided and notes that documentation is evident the facility did not provide direct care staff with effective communication training.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 38829 Based on interview and record review, the facility did not ensure 8 of 8 facility staff chosen at random received either abuse prevention, activities that constitute abuse, procedures for reporting abuse and/or dementia management training. * Dietary Aide (DA)-J, Housekeeper (HK)-K, Registered Nurse (RN)-I, and Certified Nursing Assistants (CNA) CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not receive behavioral health training. In addition, contracted employee, Registered Dietitian (RD)-L did not receive abuse prevention, activities that constitute abuse, procedures for reporting abuse and dementia management training. *DA-J has no documentation that DA-J received abuse prevention, activities that constitute abuse, procedures for reporting abuse and dementia management training. *HK-K has no documentation that HK-K received abuse prevention, activities that constitute abuse, procedures for reporting abuse and dementia management training. *RN-I has no documentation that RN-I received abuse prevention, activities that constitute abuse, and procedures for reporting abuse. *RD-L has no documentation that RD-L received abuse prevention, activities that constitute abuse, procedures for reporting abuse and dementia management training. *CNA-M has no documentation that CNA-M received abuse prevention, activities that constitute abuse, procedures for reporting abuse and dementia management training. *CNA-N has no documentation that CNA-N received abuse prevention, activities that constitute abuse, procedures for reporting abuse and dementia management training. *CNA-O has no documentation that CNA-O received abuse prevention, activities that constitute abuse, procedures for reporting abuse and dementia management training. *CNA-P has no documentation that CNA-P received abuse prevention, activities that constitute abuse, and procedures for reporting abuse. *CNA-Q has no documentation that CNA-Q received abuse prevention, activities that constitute abuse, and procedures for reporting abuse. This practice had the potential to affect all 59 residents in the facility. Findings Include: The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation .1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the Resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. 6. Required training topics include the following: a. Effective communication with Residents and family(direct care staff) b. Resident rights and responsibilities c. Preventing abuse, neglect, exploitation or misappropriation of Resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of Resident property (2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of Resident property (3) Dementia management and Resident abuse prevention d. Elements and goals of the facility QAPI program e. The infection prevention and control standards, policies and procedures f. Behavioral health g. Compliance and Ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating 5 or more facilities) 8. Completed training is documented by staff development coordinator, or his or her designee and includes: a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. Hours of training completed . On 3/17/25, at 11:51 AM, Surveyor randomly selected 8 facility staff and 1 contracted employee for review. Surveyor reviewed the employee records of DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received either the required abuse prevention, activities that constitute abuse, procedures for reporting abuse and/or dementia management training within the year based on hire date. DA-J - date of hire 5/24/23 HK-K - date of hire 3/7/07 RN-I - date of hire 2/21/24 RD-L - contract effective 1/24/23 CNA-M - date of hire 5/22/23 CNA-N - date of hire 4/6/23 CNA-O - date of hire 6/7/23 CNA-P - date of hire 5/20/22 CNA-Q - date of hire 9/20/23 Surveyor noted the quiz 'Elder Abuse and Exploitation Team Quiz' documented for DA-J, DA-K, RN-I, CNA-M, CNA-N, CNA-M, CNA-O, CNA-P, and CNA-Q is for elder abuse in the community. There is no documentation that DA-J, DA-K, RN-I, CNA-M, CNA-N, CNA-M, CNA-O, CNA-P, and CNA-Q actually received training on abuse prevention, activities that constitute abuse, and procedures for reporting abuse. On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having required abuse prevention, activities that constitute abuse, procedures for reporting abuse and/or dementia management training. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them. On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required trainings for employees DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. DES-R explained that DES-R is only responsible for coordinating topics for orientation of new employees. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required abuse prevention, activities that constitute abuse, procedures for reporting abuse and/or dementia management training for all employees. DON-B stated there is no system in place for keeping track of educational training for the employees. DON-B is aware that staff have not received the required educational training in the year identified. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee training documents that still need to be filed in employee files. DON-B informed Surveyor that DON-B was unaware that RD-L, as a contracted employee needed to received the required educational trainings provided by the facility. DON-B understands the concern that there is no documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required abuse prevention, activities that constitute abuse, procedures for reporting abuse and/or dementia management training On 3/17/25, at 3:45 PM, NHA-A and DON-B were informed of the of the above findings. Additional information was requested, if available. At the time, no additional information has been provided as to why DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required abuse prevention, activities that constitute abuse, procedures for reporting abuse and/or dementia management training. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed additional information provided and notes that documentation is evident the facility did not provide 7 of 9 staff with abuse training which includes preventing, recognizing, and reporting abuse and/or dementia training.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 38829 Based on interview and record review, the facility did not ensure 8 of 8 facility staff chosen at random received QAPI training. Dietary Aide (DA)-J, Housekeeper (HK)-K, Registered Nurse (RN)-I, and Certified Nursing Assistants (CNA) CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not receive QAPI training. In addition, contracted employee, Registered Dietitian (RD)-L did not receive QAPI training. This practice had the potential to affect all 59 Residents in the facility. The facility did not provide staff with the required annual QAPI training which included the elements and goals of QAPI for 5 CNAs, CNA-M, CNA-N, CNA-O, CNA-P, CNA-Q, DA-J, HK-K, RN-I, and RD-L. Findings Include: The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement .All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation .1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the Resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. 6. Required training topics include the following: a. Effective communication with Residents and family(direct care staff) b. Resident rights and responsibilities c. Preventing abuse, neglect, exploitation or misappropriation of Resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of Resident property (2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of Resident property (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(3) Dementia management and Resident abuse prevention d. Elements and goals of the facility QAPI program e. The infection prevention and control standards, policies and procedures f. Behavioral health g. Compliance and Ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating 5 or more facilities) 8. Completed training is documented by staff development coordinator, or his or her designee and includes: a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment e. Hours of training completed . On 3/17/25, at 11:51 AM, Surveyor randomly selected 8 facility staff and 1 contracted employee for review. Surveyor reviewed the employee records RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required QAPI training within the year based on hire date. DA-J - date of hire 5/24/23 HK-K - date of hire 3/7/07 RN-I - date of hire 2/21/24 RD-L - contract effective 1/24/23 CNA-M - date of hire 5/22/23 CNA-N - date of hire 4/6/23 CNA-O - date of hire 6/7/23 CNA-P - date of hire 5/20/22 CNA-Q - date of hire 9/20/23 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER: Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE: 7500 W Dean Rd Milwaukee, WI 53223	

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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having required QAPI training. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them. On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required trainings for employees DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. DES-R explained that DES-R is only responsible for coordinating topics for orientation of new employees. On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required QAPI training for all staff. DON-B stated there is no system in place for keeping track of educational training for the employees. DON-B is aware that staff have not received the required educational training in the year identified. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee training documents that still need to be filed in employee files. DON-B informed Surveyor that DON-B was unaware that RD-L, as a contracted employee needed to received the required educational trainings provided by the facility. DON-B understands the concern that there is no documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required QAPI training. On 3/17/25, at 3:45 PM, NHA-A and DON-B were informed of the of the above findings. Additional information was requested, if available. At this time, no further information has been provided as to why DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required QAPI training. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed additional information provided and notes that documentation is evident the facility did not provide the above facility staff with QAPI training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 38829 Based on interview and record review, the facility did not ensure 8 of 8 facility staff chosen at random received infection control training. Dietary Aide (DA)-J, Housekeeper (HK)-K, Registered Nurse (RN)-I, and Certified Nursing Assistants (CNA) CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not receive infection control training. In addition, contracted employee, Registered Dietitian (RD)-L did not receive infection control training. The facility did not provide staff with the required annual infection control training which included standards, policies, and procedures of the facility's infection control program for 5 CNAs, CNA-M, CNA-N, CNA-O, CNA-P, CNA-Q, DA-J, HK-K, RN-I, and RD-L. This practice had the potential to affect all 59 residents in the facility. Findings Include: The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation .1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the Resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. 6. Required training topics include the following: a. Effective communication with Residents and family(direct care staff) b. Resident rights and responsibilities c. Preventing abuse, neglect, exploitation or misappropriation of Resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of Resident property (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of Resident property (3) Dementia management and Resident abuse prevention d. Elements and goals of the facility QAPI program e. The infection prevention and control standards, policies and procedures f. Behavioral health g. Compliance and Ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating 5 or more facilities) 8. Completed training is documented by staff development coordinator, or his or her designee and includes: a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment e. Hours of training completed . On 3/17/25, at 11:51 AM, Surveyor randomly selected 8 facility staff and 1 contracted employee for review. Surveyor reviewed the employee records RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required infection control training within the year based on hire date. DA-J - date of hire 5/24/23 HK-K - date of hire 3/7/07 RN-I - date of hire 2/21/24 RD-L - contract effective 1/24/23 CNA-M - date of hire 5/22/23 CNA-N - date of hire 4/6/23 CNA-O - date of hire 6/7/23 CNA-P - date of hire 5/20/22 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CNA-Q - date of hire 9/20/23 On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having required infection control training. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them. On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required trainings for employees DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. DES-R explained that DES-R is only responsible for coordinating topics for orientation of new employees. On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required infection control training for all employees. DON-B stated there is no system in place for keeping track of educational training for the employees. DON-B is aware that staff have not received the required educational training in the year identified. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee training documents that still need to be filed in employee files. DON-B informed Surveyor that DON-B was unaware that RD-L, as a contracted employee needed to received the required educational trainings provided by the facility. DON-B understands the concern that there is no documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required infection control training. On 3/17/25, at 3:45 PM, NHA-A and DON-B were informed of the of the above findings. Additional information was requested, if available. At the time, no further information has been provided as to why DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required infection control training. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed additional information provided and notes that documentation is evident the facility did not provide direct care with consistent infection control training. The facility did not have a training that includes the written standards, policies, and procedures for the program for all of the above facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 38829 Based on interview and record review, the facility did not ensure 8 of 8 facility staff chosen at random received compliance and ethics training. Dietary Aide (DA)-J, Housekeeper (HK)-K, Registered Nurse (RN)-I, and Certified Nursing Assistants (CNA) CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not receive compliance and ethics training. In addition, contracted employee, Registered Dietitian (RD)-L did not receive compliance and ethics training. The facility did not provide staff with the required compliance and ethics training which included standards, policies, and procedures of the facility's compliance and ethics for 5 CNAs, CNA-M, CNA-N, CNA-O, CNA-P, CNA-Q, DA-J, HK-K, RN-I, and RD-L. This practice had the potential to affect all 59 residents in the facility. Findings Include: The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation .1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the Resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. 6. Required training topics include the following: a. Effective communication with Residents and family(direct care staff) b. Resident rights and responsibilities c. Preventing abuse, neglect, exploitation or misappropriation of Resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of Resident property (2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of Resident property (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(3) Dementia management and Resident abuse prevention d. Elements and goals of the facility QAPI program e. The infection prevention and control standards, policies and procedures f. Behavioral health g. Compliance and Ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating 5 or more facilities) 8. Completed training is documented by staff development coordinator, or his or her designee and includes: a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment e. Hours of training completed . On 3/17/25, at 11:51 AM, Surveyor randomly selected 8 facility staff and 1 contracted employee for review. Surveyor reviewed the employee records RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required compliance and ethics training within the year based on hire date. DA-J - date of hire 5/24/23 HK-K - date of hire 3/7/07 RN-I - date of hire 2/21/24 RD-L - contract effective 1/24/23 CNA-M - date of hire 5/22/23 CNA-N - date of hire 4/6/23 CNA-O - date of hire 6/7/23 CNA-P - date of hire 5/20/22 CNA-Q - date of hire 9/20/23 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having required compliance and ethics training due to the facility being a part of a company with 5 or more facilities. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them. On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required trainings for employees DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. DES-R explained that DES-R is only responsible for coordinating topics for orientation of new employees. On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required compliance and ethics training for all employees. DON-B stated there is no system in place for keeping track of educational training for the employees. DON-B is aware that staff have not received the required educational training in the year identified. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee training documents that still need to be filed in employee files. DON-B informed Surveyor that DON-B was unaware that RD-L, as a contracted employee needed to received the required educational trainings provided by the facility. DON-B understands the concern that there is no documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required compliance and ethics training. On 3/17/25, at 3:45 PM, NHA-A and DON-B were informed of the of the above findings. Additional information was requested, if available. At the time, no further information has been provided as to why DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required compliance and ethics training. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed additional information provided and notes that documentation is evident the facility did not provide all staff with Compliance and Ethics training. The facility provided what the staff should be educated on, but 9 of 9 staff reviewed did not acknowledge with signature and date of the ethics and compliance training.

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NAME OF PROVIDER OR SUPPLIER: Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE: 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 38829 Based on interview and record review, the facility did not ensure that 5 of 5 CNAs (Certified Nursing Assistants)(CNA) reviewed completed the required annual 12 hours of educational training hours. CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not receive annual 12 hours of educational training. This had the potential to affect all 59 residents who reside in the facility. Findings include: The facility's Facility Assessment last reviewed July 2024 documents: Staff training/education and competencies A competency approach is used to determine the knowledge and skills required among staff and contracted employees. .on-going monitoring of staff care and work conducted to ensure Residents are able to maintain or attain their highest practicable physical, functional, mental and psychosocial well-being and meet current professional standards of practice . .Competencies Obtained/Evaluated Education Provided for CNAs -Annual skills checks through staff development -As needed training from vendor, professional group or other for new/unique skill sets required for member care -Minimum of 12 credit hours per year . The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement .All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation .1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 8. Completed training is documented by staff development coordinator, or his or her designee and includes: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment e. Hours of training completed . On 3/17/25, at 11:51 AM, Surveyor randomly selected 5 CNAs for review. Surveyor reviewed the employee records of CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required the 12 hours of educational training within the year based on hire date. CNA-M - date of hire 5/22/23 CNA-N - date of hire 4/6/23 CNA-O - date of hire 6/7/23 CNA-P - date of hire 5/20/22 CNA-Q - date of hire 9/20/23 On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to the CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having documented 12 hours of required educational training. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them. On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required 12 hours of training for the CNAs. DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required 12 hours of CNA educational training. DON-B stated there is no system in place for keeping track of 12 hours of educational training for the CNAs. DON-B is aware that the CNAs have not received the required 12 hours of educational training in the year identified. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee documents that still need to be filed in employee files. DON-B understands the concern that there is no documented 12 hours of educational trainings completed for CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/17/25, at 3:45 PM, NHA-A and DON-B were informed of the of the above findings. Additional information was requested, if available. At this time, no further information has been provided as to why CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required 12 hours of educational training. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed additional information provided and notes that documentation is evident the 5 of 5 CNAs reviewed for 12 hours of required training was not met. All training certification forms were signed and dated after Surveyor exited the facility. Surveyor verified hours versus the trainings sent to Surveyor via email and found that 5 of 5 CNAs did not meet the minimum required 12 hours per year.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 38829 Based on interview and record review, the facility did not ensure 8 of 8 facility staff chosen at random received behavioral health training. Dietary Aide (DA)-J, Housekeeper (HK)-K, Registered Nurse (RN)-I, and Certified Nursing Assistants (CNA) CNA-M, CNA-N, CNA-O, CNA-P and CNA-Q did not receive behavioral health training. In addition, contracted employee, Registered Dietitian (RD)-L did not receive behavioral health training. The facility did not provide staff with the required behavioral health training for 5 CNAs, CNA-M, CNA-N, CNA-O, CNA-P, CNA-Q, DA-J, HK-K, RN-I, and RD-L This practice had the potential to affect all residents with a psychiatric diagnosis and/or that have the potential to experience behavioral health issues in the facility. Findings Include: The facility's In-Service Training, All Staff revised August 2022 documents: Policy Statement All staff must participate in initial orientation and annual in-service training. Policy Interpretation and Implementation .1. All staff are required to participate in regular in-service education. 2. For the purposes of this policy, staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. 3. The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the Resident's quality of life and quality of care and can demonstrate competency in the topic areas of training. 6. Required training topics include the following: a. Effective communication with Residents and family(direct care staff) b. Resident rights and responsibilities c. Preventing abuse, neglect, exploitation or misappropriation of Resident property including: (1) Activities that constitute abuse, neglect, exploitation or misappropriation of Resident property (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) Procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of Resident property (3) Dementia management and Resident abuse prevention d. Elements and goals of the facility QAPI program e. The infection prevention and control standards, policies and procedures f. Behavioral health g. Compliance and Ethics program standards, policies and procedures. (Compliance and ethics training is conducted annually when this organization is operating 5 or more facilities) 8. Completed training is documented by staff development coordinator, or his or her designee and includes: a. Date and time of the training b. Topic of the training c. Method used for training d. A summary of the competency assessment e. Hours of training completed . The facility's assessment last reviewed July 2024 documents: .potential admissions with atypical diseases and/or conditions are reviewed and considered individually, as is set forth below: Psychiatric/Mood Disorders-Psychosis(Hallucinations, Delusions), Impaired Cognition, Mental Disorder, Depression, Bipolar, Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that needs intervention . The facility assessment also documents that there is 4-15 Residents with behavioral healthcare needs. The facility can provide service and care for mental health and behavior. .Manage the medical conditions and medication-related issues that may contribute to 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, truma/PTSD, other psychiatric diagnoses (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Waterfall Health of Brown Deer		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 W Dean Rd Milwaukee, WI 53223	

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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/25, at 11:51 AM, Surveyor randomly selected 8 facility staff and 1 contracted employee for review. Surveyor reviewed the employee records DA-J, HK-K,RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q. The facility was unable to provide documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required effective behavioral health training within the year based on hire date. DA-J - date of hire 5/24/23 HK-K - date of hire 3/7/07 RN-I - date of hire 2/21/24 RD-L - contract effective 1/24/23 CNA-M - date of hire 5/22/23 CNA-N - date of hire 4/6/23 CNA-O - date of hire 6/7/23 CNA-P - date of hire 5/20/22 CNA-Q - date of hire 9/20/23 On 3/17/25, at 1:45 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A in regards to DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q not having the required behavioral health training. NHA-A was understanding that trainings were completed after the last annual survey and will continue to try and locate them. On 3/17/25, at 1:56 PM, Surveyor interviewed Director of Employee Services (DES)-R. DES-R stated that the Director of Nursing (DON)-B and NHA-A is responsible for keeping track of the required trainings for employees DES-R is given the completed trainings and DES-R then files them in the employee files. DES-R confirmed that DES-R is responsible for maintaining employee files. DES-R explained that DES-R is only responsible for coordinating topics for orientation of new employees. On 3/17/25, at 2:36 PM, Surveyor interviewed DON-B in regards to the required behavioral health training for all employees. DON-B stated there is no system in place for keeping track of educational training for the employees. DON-B is aware that staff have not received the required educational training in the year identified. DON-B shared that it was decided that DES-R would develop a spreadsheet and keep track of the trainings being completed. Surveyor shared that DES-R had informed Surveyor that DES-R's only responsibility is to file the completed performance reviews. DON-B stated that DES-R knows DES-R is supposed to be keeping track. DON-B informed Surveyor that DES-R had informed DON-B there may be employee training documents that still need to be filed in employee files. DON-B informed Surveyor that DON-B was unaware that RD-L, as a contracted employee needed to received the required educational trainings provided by the facility. DON-B understands the concern that there is no documentation that DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q received the required behavioral health training. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterfall Health of Brown Deer	7500 W Dean Rd Milwaukee, WI 53223

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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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/25, at 3:45 PM, NHA-A and DON-B were informed of the of the above findings. Additional information was requested, if available. At the time, no further information has been provided as to why DA-J, HK-K, RN-I, RD-L, CNA-M, CNA-N, CNA-O, CNA-P, and CNA-Q did not receive the required behavioral health training. On 3/18/25, at 3:10 PM, Surveyor received additional information via email from the facility after exiting the facility. Surveyor reviewed the additional information provided and noted that documentation provided did document that the above staff received the required behavioral health training.