STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 07/21/2023, Surveyor completed a verification visit and 2 complaint surveys at Aria of West Allis. Thirteen deficiencies were identified. Three of 13 deficiencies were repeat deficiencies (See Statement of Deficiency (SOD) 6PHK12, dated 08/05/2022). One of 13 deficiencies is being cited for the third time (See SOD 25PG11, dated 04/01/2021 and 6PHK12, dated 08/05/2022). Two of 2 complaints were substantiated. Under statutory provisions of Wis. State. Ch 50, a $200 revisit fee is being assessed. Census: 28	{N 000}		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the community based residential facility (CBRF) and its operation complied with all laws governing the CBRF. This had the potential to affect 28 of 28 residents who resided at the facility. Findings include: The facility was licensed on 12/17/2020 to care for a maximum of 70 adults. The provider was licensed to provide services to client groups: terminally ill, advanced aged and irreversible	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 196	Continued From page 1 dementia/Alzheimer's. On 07/21/2023, Surveyor completed a verification visit and 2 complaint surveys. As a result of the survey 2 of 2 complaints were substantiated and 13 deficiencies were identified. Three of the 13 deficiencies are repeat deficiencies. One of 13 deficiencies is being cited for the third time. The deficiencies are as followed: 83.14(2)(a) Licensee Ensures Facility Complies with Laws 83.15(3)(a) Administrator Shall Supervise Daily Operation 83.22(1)-(4) Task Specific Training 83.32(3)(h) Rights of Residents: Receive Medication 83.35(3)(a) Comprehensive Individualized Service Plan - Repeat 83.36(1)(a) Adequate Staff To Meet Residents Needs - Repeat 83.37(2)(d) Documentation of Medication administration - Repeat 83.41(2)(b) Nutrition: Meals - Repeat 83.41(3)(b) Food Safety 83.43(1) Environment Safe, Clean and Comfortable 83.54(1)(b) Bedroom Walls and Doors 83.54(1)(c) Bedrooms: Open to Corridor and Living Area 83.55(4)(a) Bath and Toilet Area: Privacy On 02/14/2023, the provider was provided with a Notice and Order letter with Statement of Deficiency (SOD) 6PHK12, dated 02/14/2023. The Notice and Order letter included special orders that were not completed at the time of the verification visit. The special orders stated, " ...facility will develop (or review/revise) written procedures to ensure: staffing patterns will be	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 196	Continued From page 2 sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services, and to facilitate a safe evacuation of the building in the event of an emergency. When a resident or residents ...require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times ..." On 07/21/2023 at 11:39 a.m., Surveyor interviewed Licensee R. Licensee R stated Executive Director A and Administrator S were in the facility daily and were responsible for the "day to day" operations of the CBRF. Licensee R denied knowledge of the above deficiencies and inquired about the number of repeat deficiencies and the related SODs. Licensee R stated, "I will speak with my team and see what we can work on."	N 196		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected.	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the administrator did not supervise the daily operation of the community based residential facility (CBRF) including staffing, environmental concerns, medication administration and dietary concerns. Findings include: The facility was licensed on 12/17/2020 to care for a maximum of 70 adults. The provider was licensed to provide services to client groups: terminally ill, advanced aged and irreversible dementia/Alzheimer's. On 07/21/2023, Surveyor completed a verification visit and 2 complaint surveys. As a result of the survey 2 of 2 complaints were substantiated and 13 deficiencies were identified. Three of the 13 deficiencies were repeat deficiencies. One of 13 deficiencies is being cited for the third time. The deficiencies are as followed: 83.14(2)(a) Licensee Ensures Facility Complies with Laws 83.15(3)(a) Administrator Shall Supervise Daily Operation 83.22(1)-(4) Task Specific Training 83.32(3)(h) Rights of Residents: Receive Medication 83.35(3)(a) Comprehensive Individualized Service Plan - Repeat 83.36(1)(a) Adequate Staff To Meet Residents Needs - Repeat 83.37(2)(d) Documentation of Medication Administration - Repeat 83.41(2)(b) Nutrition: Meals - Repeat 83.41(3)(b) Food Safety	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 4 83.43(1) Environment Safe, Clean and Comfortable 83.54(1)(b) Bedroom Walls and Doors 83.54(1)(c) Bedrooms: Open to Corridor and Living Area 83.55(4)(a) Bath and Toilet Area: Privacy On 02/14/2023, the provider was provided with a Notice and Order letter with SOD 6PHK12, dated 02/14/2023. The Notice and Order letter included special orders that were not completed at the time of the verification visit. The special orders stated, " ...facility will develop (or review/revise) written procedures to ensure: staffing patterns will be sufficient to meet the personal care needs of residents, to ensure needed supervision, to provide needed services, and to facilitate a safe evacuation of the building in the event of an emergency. When a resident or residents ...require the assistance of two or more staff members to address care and service needs, to provide supervision, or to evacuate the building in an emergency, the licensee will ensure sufficient, qualified staff members are on duty, present and available to assist residents at all times ..." On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A and DON F reported DON F and Residential Care Coordinator (RCC) W assisted with filling in shifts when staff called in or did not show up for his/her scheduled time. ED A reported DON F and RCC W are salaried and would not show-up on the schedule and/or punches. ED A and DON F acknowledged the Notice and Order letter with SOD 6PHK12, dated 02/14/2023, stated, " ...Written staff schedules will be current and shall include each employee's full name, job assignment and time worked. Records will be	N 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 214	Continued From page 5 amended, as necessary to ensure an accurate and complete record of time worked by all facility employees, and/or employees of contract agencies providing routine services to facility residents ..." ED A and DON F reported he/she would ensure all future schedules will reflect the names of who worked, the job assignment and time worked.	N 214		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 247	Continued From page 6 transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 (Resident Assistant (RA) P and RA Q) of 3 employees obtained all task specific training. RA P and RA Q, who had responsibilities for providing assistance with activities of daily living, did not have training in the provision of personal care prior to assuming these duties. Findings include: On 07/14/2023, Surveyor conducted a review of 2 employees to verify compliance with task specific training requirements. Surveyor requested training records from Executive Director (ED) A for RA P and RA Q. Provision of Personal Care The record for RA P, hired on 01/09/2023, did not contain evidence of training or evidence of meeting an exemption for personal care training. The record for RA Q, hired on 02/16/2023, did not contain evidence of training or evidence of meeting an exemption for personal care training.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 247	Continued From page 7 On 07/14/2023 at 4:37 p.m., Surveyor interviewed RA Q. RA Q affirmed completing tasks related to personal cares. RA Q reported he/she was assigned trainings on Relias (online training system), however, did not complete any trainings on Relias since his/her date of hire. RA Q could not confirm if he/she was assigned a training related to provision of personal cares. On 07/21/2023, at approximately 10:00 a.m.., Surveyor provided Executive Director A the opportunity to submit additional evidence of training by the end of day on 07/21/2023. On 07/21/2023 at 12:14 p.m., through e-mail correspondence with Executive Director A, Executive Director A reported, "I did not see that [RA Q] and [RA P] completed Relias for ADLs (activities of daily living)."	N 247		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all prescribed medications were administered in the dosage and at intervals prescribed by a practitioner for 1 (Resident 17) of 1 resident reviewed. Resident 17 missed a total of 42 doses of prescribed medications in March 2023.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 8 Findings include: On 06/05/2023, the Department received a complaint alleging a resident did not receive his/her prescribed medication. On 07/12/2023, Surveyor reviewed Resident 17's record. Resident 17 was admitted on 02/16/2022 with diagnoses including Parkinson's disease, vitamin D deficiency, obesity, other disorders of mineral metabolism, other specified depressive episodes, sleep apnea, chronic kidney disease, stage 3, type 2 diabetes, and schizoaffective disorder. Surveyor reviewed Resident 17's March 2023 medication administration record (MAR). Surveyor did not observe staff initials on the following dates indicating the following medications were not administered to Resident 17. "AM" March 6, 2023 - Calcium citrate tablet 250 milligrams (mg), cholecalciferol tablet 200 units, citalopram hydrobromide tablet 40 mg, Flomax capsule 0.4 mg, fluticasone propionate nasal suspension 50 microgram (mcg), gabapentin tablet 300 mg, Humulin 70/30 kwik pen 100 unit/ml (milliliters), lisinopril tablet 5 mg, Myrbetriq tablet extended release 25 mg, nutritional supplement 8 oz (ounces), acetaminophen tablet 500 mg, and carbidopa-levodopa tablet 25-100 mg. March 26, 2023 - Calcium citrate tablet 250 mg (milligrams), cholecalciferol tablet 200 units, citalopram hydrobromide tablet 40 mg, Flomax capsule 0.4 mg, fluticasone propionate nasal suspension 50 mcg (microgram), gabapentin tablet 300 mg, Humulin 70/30 kwik pen 100	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 9	N 352		

unit/ml (milliliters), lisinopril tablet 5 mg, Myrbetriq tablet extended release 25 mg, nutritional supplement 8 oz (ounces), acetaminophen tablet 500 mg, and carbidopa-levodopa tablet 25-100 mg.

"HS (bedtime) 1"
March 26, 2023 - divalproex sodium extended release (ER) tablet 250 mg, melatonin tablet 3 mg, risperidone tablet 1 mg, vitamin B+C complex tablet

March 28, 2023 - divalproex sodium ER tablet 250 mg, melatonin tablet 3 mg, risperidone tablet 1 mg, vitamin B+C complex tablet

"PM 1"
March 26, 2023 - nutritional supplement 8 oz (ounces), acetaminophen tablet 500 mg, carbidopa-levodopa tablet 25-100 mg

March 28, 2023 - nutritional supplement 8 oz (ounces), acetaminophen tablet 500 mg, carbidopa-levodopa tablet 25-100 mg

"MD"
March 6, 2023 - acetaminophen tablet 500 mg, carbidopa-levodopa tablet 25-100 mg

March 26, 2023 - acetaminophen tablet 500 mg, carbidopa-levodopa tablet 25-100 mg

On 07/12/2023 at approximately 10:17 a.m., Surveyor interviewed Resident 17. Resident 17 affirmed missing medication and having to ask staff for missed medication. Resident 17 reported, at times, he/she was informed by staff that the medication was not available. Resident 17 denied reasons were provided as to why the medication was not available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 352	Continued From page 10 On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A and DON F denied knowledge of Resident 17 missing the above medications or the reason why Resident 17 was not administered the above medication. DON F reported Licensed Practical Nurse (LPN) F was the nurse at the time Resident 17 was not administered the above medication. ED A and DON F stated LPN F was no longer employed at the community based residential facility (CBRF).	N 352		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individualized service plan (ISP) for 3 (Residents 13, 16, and 18) of 4 residents reviewed identified desired outcomes, specified methods for delivering needed care,	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 386}	Continued From page 11 who was responsible for delivering the care and the frequencies and approaches for the needed care. Resident 13's ISP did not address Resident 13's preference and who was responsible for delivering care for an identified focus of " ...memory loss/dementia r/t (related to) Alzheimer's disease" and the frequency of how often Resident 13 should have been checked on for the identified focus of, "The resident has had an actual fall without injury." Resident 16's ISP did not address Resident 16's goal, intervention, or frequencies and approaches for Resident 16's potential of being verbally aggressive. Resident 18's ISP did not state the frequency of how often Resident 18 should have been checked on. This is a repeat deficiency. See Statement of Deficiency 6PHK12, dated 08/05/2022. Findings include: On 07/13/2023, Surveyor reviewed resident records. The following was identified: Example 1: Resident 13 was admitted on 08/11/2021. Resident 13 was diagnosed with dementia. Surveyor reviewed Resident 13's ISP with a revision date of 06/02/2023. Resident 13 had a focus of "The resident has memory loss/dementia r (related) /t (to) Alzheimer's disease." The intervention identified stated, " ...Engage the resident in simple, structured meaningful and	{N 386}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 386}	Continued From page 12	{N 386}		

purposeful activities that focus on successful outcomes and avoid overly demanding tasks. The resident prefers (SPECIFY)." In addition, Resident 13 had an identified focus of, "The resident has had an actual fall without injury." The identified intervention was, "Check on resident at frequent intervals to see if any assistance is needed and to offer reassurance to resident." Resident 13's ISP did not address Resident 13's preference, who was responsible for delivering the care and the frequencies of how often Resident 13 should have been checked on.

Example 2:

Resident 16 was admitted on 12/28/2021. Resident 16 was diagnosed with sleep disorders, osteoarthritis, restless leg syndrome, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, hyperlipidemia, and embolism and thrombosis of unspecified vein. Surveyor reviewed Resident 16's ISP with a revision date of 02/28/2023. The ISP indicated Resident 16 had a focus of "The resident is/has potential to be verbally aggressive (using inappropriate language) r/t behavior." Resident 16's ISP did not address Resident 16's goal, intervention or frequencies and approaches for Resident 16's potential of being verbally aggressive.

Example 3:

Resident 18 was admitted on 01/27/2020. Resident 18 was diagnosed with difficulty in walking and atherosclerotic heart disease of native coronary artery without angina pectoris. Surveyor reviewed Resident 18's ISP with a revision date of 03/21/2023. The ISP indicated Resident 18 had a focus of "The resident has had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 386}	Continued From page 13 an actual fall without injury." The identified intervention was, "Check on resident at frequent intervals to see if any assistance is needed and to offer reassurance to resident ..." Resident 18's ISP did not state the frequency of how often Resident 18 should have been checked on. On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. DON F reported he/she was responsible for updating residents' care plans. DON F reported he/she would update the above ISPs. DON F did not provide a reason as to why the above ISPs did not meet state regulation.	{N 386}		
{N 396}	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure there was an adequate number of caregivers working during the "PM" and night of care (NOC) shift to meet the needs of 28 of 28 residents. This resulted in a lack of supervision to meet residents' needs and a delay in resident cares. This requirement is being cited for a third time. See Statement of deficiencies (SOD) 25PG11, dated 04/01/2021, and 6PHK12, dated 08/05/2022. Findings include:	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 14 The provider is licensed to care for advanced aged, terminally ill, and irreversible dementia/Alzheimer's residents. On 07/12/2023 at approximately 08:30 a.m., Surveyor toured the facility. The facility was observed to have 2 units, "CBRF [Community Based Residential Facility] South" unit and "Mansion" unit. CBRF South unit was located on the lower level of the facility and had a maximum capacity of 22 residents. Census at the time of the survey for CBRF South unit was 19. The Mansion unit was located in a different part of the facility. Census at the time of the survey for the Mansion unit was 9. On 07/12/2023 at approximately 8:30 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A and DON F reported the provider employed 3 shifts of caregivers. The 3 shifts consisted of "Day Shift (AM)", which was scheduled between 6 a.m. to 2 p.m., "Evening Shift (PM)", which was scheduled between 2 p.m. to 10 p.m., and "Night Shift (NOC)," which was scheduled between 10 p.m. to 6 a.m. ED A disclosed prior to May 2, 2023, the CBRF consisted of 3 floors, which was broken into two units, "CBRF [Community Based Residential Facility] South" and "CBRF West." CBRF South unit was located on the lower level of the facility and had a maximum capacity of 22 residents. CBRF West unit was located on the 2nd and 3rd floor. The 2nd floor had a maximum capacity of 9 residents. The 3rd floor had a maximum capacity of 7 residents. ED A reported 2 caregivers were scheduled for each shift on CBRF West, as the	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 15	{N 396}		

unit was broken into two floors. ED A stated 2 caregivers were scheduled to work on first and second shift and 1 caregiver was scheduled to work third shift on CBRF South.

On 07/14/2023 at approximately 2:00 p.m., Surveyor reviewed staff schedules for April 2023 and May 2023 and identified the following:

The following dates identified 1 caregiver was scheduled for CBRF South during the "AM" shift: 04/22/2023 and 04/23/2023.

The following dates identified 1 caregiver was scheduled for CBRF West during the "AM" shift: 04/22/2023, 04/23/2023, and 05/01/2023.

The following dates identified 1 caregiver was scheduled for CBRF South during the "PM" shift: 04/12/2023, 04/13/2023, 04/15/2023, and 04/22/2023.

The following dates identified 1 caregiver was scheduled for CBRF West during the "PM" shift: 04/21/2023 and 04/22/2023

The following dates identified 1 caregiver was scheduled for CBRF West during the "NOC" shift: 04/21/2023, 04/22/2023, 04/23/2023, and 05/01/2023.

On 07/12/2023 at approximately 08:30 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A stated, on May 2, 2023, CBRF West unit was moved to the "Mansion" unit. ED A reported the move was completed to ensure staffing requirements were being met, as the Mansion was one floor. ED A disclosed the current staffing pattern: 2 caregivers scheduled on "AM" and "PM" shift for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 16 CBRF South unit and 1 caregiver scheduled for the "AM" and "PM" shift for the Mansion unit. ED A reported 3 caregivers were scheduled during the "NOC" shift: 1 caregiver on the CBRF South unit, 1 caregiver on the Mansion unit and 1 caregiver floating between the two units. On 07/14/2023 at approximately 2:00 p.m., Surveyor reviewed staff schedules for May 2023, June 2023, and July 2023 and identified the following: The following dates revealed 1 caregiver was scheduled for CBRF South unit during the "AM" shift. 05/30/2023, 06/04/2023, 06/13/2023, 06/14/2023, 06/18/2023, 06/20/2023, and 07/11/2023. The following dates revealed 1 caregiver was scheduled for CBRF South unit during the "PM" shift: 05/16/2023, 05/20/2023, 05/28/2023, 06/03/2023, 06/07/2023, 06/08/2023, 06/18/2023, 06/19/2023, and 06/20/2023. The following dates revealed no floater was scheduled during the NOC shift: 05/15/2023, 05/21/2023, 05/22/2023, 05/26/2023, 05/27/2023, 05/28/2023, 06/02/2023, 06/03/2023, 06/04/2023, 06/05/2023, 06/06/2023, 06/07/2023, 06/08/2023, 0/09/2023, 06/10/2023, 06/11/2023, 06/13/2023, 06/14/2023, 06/15/2023, 06/17/2023, 06/18/2023, 06/20/2023, 06/21/2023, 06/22/2023, 06/23/2023, 06/24/2023, 06/25/2023, 06/26/2023, 06/27/2023, 06/28/2023, 06/29/2023, 06/30/2023, 07/01/2023, 07/02/2023, 07/03/2023, 07/04/2023, 07/06/2023, 07/08/2023, 07/09/2023, 07/10/2023,	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 17 07/11/2023, and 07/14/2023. On 07/12/2023 at approximately 9:15 a.m., Surveyor interviewed Resident 16. Surveyor observed Resident 16's bedroom located on the Mansion unit. Resident 16 stated, "there are so many call-ins, it's ridiculous." Resident 16 disclosed, "during the night and day, multiple days there have been no caregivers on the floor." Resident 16 stated, "on one occasion I would have liked a Tylenol, however, I had to wait until first shift came in before I can get a Tylenol." Resident 16 could not recall the amount of time he/she had to wait. On 07/12/2023 at 10:17 a.m., Surveyor interviewed Resident 17 in his/her bedroom located on the South unit. Resident 17 denied using the call lights. Resident 17 stated, "you are better off going to the front desk to ask for help." Resident 17 disclosed multiple days on the NOC shift where there was no staff on the unit or in the building. On 07/12/2023 at 11:04 a.m., Surveyor interviewed Resident 19. Resident 19 reported no staff was observed on the South unit during the NOC unit. Resident 19 reported having to go into the common area to ensure no one unknown entered the facility. On 07/12/2023 at approximately 8:30 a.m., Surveyor interviewed RA K. RA K reported working primarily on the Mansion during the AM shift. RA K affirmed he/she has come into the facility and no staff was in the Mansion unit. RA K affirmed coming into the facility with 1 caregiver working both units. RA K stated if 1 caregiver worked, he/she would need to get the residents up, which would delay medication passes and	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 18	{N 396}		

mealtimes. RA K disclosed the staff restroom was located on a separate floor, away from resident care areas. RA K reported when he/she had to use the restroom, the residents were left unsupervised. RA K denied DON F had assisted with resident cares when a shift was short staffed.

On 07/14/2023 at 4:26 p.m., Surveyor interviewed RA T. RA T reported working primarily during the NOC shift, however, picked-up PM shifts. RA T stated if the "floater" did not come in, the caregivers were not able to leave their units to assist one another, if needed. RA T stated both units had residents who wandered, which was difficult to supervise if there was only 1 caregiver working each shift. RA T affirmed the CBRF "does not have enough staff." RA T stated, "it is hard for 1 person to complete all tasks. It can be overwhelming." RA T disclosed when the CBRF is short staff, the facility did not get cleaned. RA T reported Resident Care Coordinator (RCC) W would come in to assist sometimes.

On 07/14/2023 at 4:35 p.m., Surveyor interviewed RA Q. RA Q disclosed working primarily on the AM shift for both units. RA Q acknowledged tasks were not completed when 1 caregiver worked on a unit during the AM shift. RA Q affirmed medication passes have been delayed, especially if only 1 caregiver worked both units during the NOC shift. RA Q affirmed coming into work after 1 caregiver worked a NOC shift. RA Q stated he/she would need to get the residents up, which was completed prior to medication pass. RA Q reported breakfast was then delayed, which occurred after the medication was passed. RA Q stated, if he/she was the only caregiver working on a unit, and he/she had to use the restroom, the residents were left unsupervised as the staff restroom was located on a different floor, away

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 19	{N 396}		

from resident care areas. RA Q denied DON F assisted him/her with resident cares when shifts were short staffed. RA Q reported RCC W would come in to assist sometimes.

On 07/18/2023 at 11:39 a.m., Surveyor interviewed RA U. RA U disclosed working primarily PM shift on the South unit. RA U affirmed working alone on the unit multiple times. RA U affirmed resident cares were delayed when he/she was the only caregiver working. RA U affirmed leaving his/her shift and only 1 caregiver was present working the NOC shift for both units multiple times. RA U acknowledged residents were left unsupervised due to "no staff." RA U denied DON F assisted him/her with resident cares when shifts were short staffed.

On 07/14/2023 at 4:13 p.m., Surveyor interviewed RA V. RA V reported working the NOC shift on South and Mansion. RA V affirmed working alone during the NOC shift for both units. RA V affirmed residents were left unsupervised when he/she was on the opposite unit. RA V denied DON F assisted him/her when a shift was short staffed. RA V reported RCC W would come in to assist sometimes.

On 07/21/2023 at 11:05 a.m., Surveyor interviewed RA X. RA X reported working primarily NOC shift on the South unit; however, had picked-up shifts working AM and PM shifts on the South unit. RA X affirmed coming into the CBRF on his/her AM shifts and no caregiver was onsite. RA X stated this had occurred twice since January 2023. RA X reported a resident reported he/she stayed up all night to ensure no one (who should not be there) entered the CBRF. RA X affirmed he/she had worked a PM and NOC shift alone. RA X acknowledged resident cares,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 20	{N 396}		

medication pass, and meals were delayed when he/she worked alone. RA X stated, "very seldom is there a floater during the NOC shift." RX A reported when he/she worked during the NOC shift alone, the opposite unit was left unsupervised. RA X disclosed when he/she worked alone during the NOC shift alone, he/she affirmed resident cares on the Mansion unit were not completed as he/she was too busy addressing resident cares on the South unit. RA X stated he/she has "found myself in tears. These are human beings who are not properly being cared for." RA X denied DON F assisted him/her when a shift was short staffed. RA X affirmed RCC W had picked-up additional shifts at times.

On 07/13/2023, Surveyor reviewed resident records. The following was identified:

Resident 13 was admitted on 08/11/2021. Resident 13 was diagnosed with dementia. Resident 13's individualized service plan (ISP), with a revision date of 06/02/2023, identified a focus of, "Resident is an elopement risk/wander ..." Resident 13's "Resident Evacuation Assessment," dated 08/13/2021, stated, "REQUIRES CONSIDERABLE ATTENTION OR MAY NOT RESPOND means the resident may fail to receive, understand or follow through with instructions and may require most of the attention of a staff member during the resident's evacuation..." In addition, Resident 13's assessment reported Resident 13 "does not react to the alarm until alerted by a staff member ...the resident is sometimes upset or confused and may seek out a staff member before evacuating ..."

Resident 14 was admitted on 08/17/2022. Resident 14 was diagnosed with unspecified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 21 dementia, other abnormalities of gait and mobility, muscle weakness, cognitive communication deficit, and history of falling. Resident 14's ISP, with a revision date of 06/02/2023, identified a focus of, "the resident has bladder incontinence r/t (related to) functional incontinence." The identified intervention stated, "Full assist of two for toileting activity ...Staff to toilet resident upon arising, before and after each meal, before bed and during NOC ..." Resident 14's "Resident Evacuation Assessment," dated 02/17/2023, reported, " ...NEEDS FULL ASSISTANCE OR VERY SLOW ...may require physical assistance from a staff member during most of the evacuation or the total time required for staff assistance and for the resident to evacuate the facility, is greater than the required evacuation time for the facility ...NEEDS LIMITED ASSISTANCE from TWO STAFF means the resident requires some initial or brief assistance from two persons but will otherwise need help from no more than one person ..." On 07/21/2023 at 10:00 a.m., Surveyor interviewed ED A and DON F. ED A and DON F reported DON F and RCC W assist with filling in shifts when staff called-in or did not show up for his/her scheduled time. ED A reported DON F and RCC W were salaried and would not show-up on the schedule and/or punches. ED A and DON F acknowledged the Notice and Order letter with SOD 6PHK12, dated 02/14/2023, stated, " ...Written staff schedules will be current and shall include each employee's full name, job assignment and time worked. Records will be amended, as necessary to ensure an accurate and complete record of time worked by all facility employees, and/or employees of contract agencies providing routine services to facility residents ..."	{N 396}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 396}	Continued From page 22 ED A and DON F reported if a caregiver called-in, either the caregiver working on the same shift or the caregiver from the current shift will contact RCC W. RCC W will then contact DON F. RCC W and DON F will then "game plan" on who would come into the facility to pick the shift up. ED A and DON F acknowledged if a caregiver worked alone on the Mansion unit and needed to use the restroom, residents would be left unsupervised. ED A and DON F believed staff communicate effectively when shifts are short staffed. ED A and DON F reported he/she would look into the shifts that were not adequately staffed.	{N 396}		
{N 415}	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each residents' medication administration (MAR) was accurately maintained for 1 (Resident 17) of 4 residents	{N 415}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 415}	Continued From page 23	{N 415}		

reviewed. The provider did not accurately document when Resident 17's medication was administered.

This is a repeat deficiency. See Statement of Deficiency 6PHK12, dated 08/05/2022.

Findings include:

On 07/12/2023, Surveyor reviewed Resident 17's record. Resident 17 was admitted on 02/16/2022 with diagnoses including Parkinson's disease, vitamin D deficiency, obesity, other disorders of mineral metabolism, other specified depressive episodes, sleep apnea, chronic kidney disease, stage 3, type 2 diabetes, and schizoaffective disorder. Surveyor reviewed Resident 17's March 2023, June 2023, and July 2023 medication administration record (MAR).
Surveyor did not observe staff initials on the following dates indicating the following medications were administered to Resident 17.

"HS1 (At bedtime)"

June 6, 2023 - divalproex sodium extended release (ER) tablet 250 milligrams (mg)
July 5, 2023 - divalproex sodium ER tablet 250 mg, melatonin tablet 3 mg, risperidone tablet 1 mg, vitamin B+C complex tablet

On 07/21/2021 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A and DON F reported he/she audited the medication cart and found no extra medications located in the medication cart. ED A and DON F reported Resident 17 received all of his/her prescribed medication. ED A stated he/she believed the medication passer did not appropriately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 415}	Continued From page 24 document the medication administration. ED A reported ED A and DON F spoke with the clinical regional nurse to set-up a corrective action plan to ensure future medication documentation was accurate. ED A stated DON F pulled all MAR reports from the previous day to catch errors in "real time" versus waiting.	{N 415}		
{N 449}	83.41(2)(b) Nutrition: meals Meals. 1. The CBRF shall provide meals that are routinely served family or restaurant style, unless contraindicated in a resident ' s individual service plan or for short-term medical needs. 2. The CBRF shall provide at least 3 meals a day, unless otherwise arranged according to the program statement or the resident ' s individual service plan. A nutritious snack shall be offered in the evening or more often as consistent with the resident ' s dietary needs. 3. If a resident is away from the CBRF during the time a meal is served, the CBRF shall offer food to the resident on the resident ' s return. This Rule is not met as evidenced by: Based on record review and interviews, the provider did not offer nutritious snacks to meet the needs of 3 (Resident 16, Resident 17, and Resident 19) of 5 residents reviewed. This is a repeat deficiency. See Statement of Deficiency 6PHK12, dated 08/05/2022. Findings include: On 07/12/2023 at approximately 8:30 a.m.,	{N 449}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 449}	Continued From page 25	{N 449}		

Surveyor interviewed Resident 16. Resident 16 denied alternative meals were offered. Resident 16 stated if he/she does not like the food, he/she will "just not eat." Resident 16 denied snacks were offered on a daily basis. Resident 16 reported when snacks were offered, it was a peanut butter and jelly sandwich.

On 07/12/2023, Surveyor reviewed the provider's scheduled mealtimes. Breakfast was served between 8:00 a.m. - 8:30 a.m. Lunch was served between 12:00 p.m. - 12:30 p.m. Dinner was served between 5:00 p.m. - 5:30 p.m.

On 07/12/2023 at 10:17 a.m., Surveyor interviewed Resident 17. Resident 17 denied alternative meals were serviced. Resident 17 reported the meals are "terrible."

On 07/12/2023 at approximately 8:30 a.m., Surveyor interviewed Resident Assistant (RA) K. RA K denied alternative meals were offered to the residents. RA K disclosed residents often went hungry if he/she did not like the food that was served.

On 07/14/2023 at 4:13 p.m., Surveyor interviewed RA V. RA V denied snacks were available on daily basis. RA V denied alternative meals were offered to the residents. RA V disclosed residents often complained of the food being "nasty."

On 07/14/2023 at 4:26 p.m., Surveyor interviewed RA T. RA T reported the facility did not have enough food for the residents. RA T reported if a resident did not like what was being served, the resident had to wait for the next meal.

On 07/14/2023 at 4:37 p.m., Surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 449}	Continued From page 26	{N 449}		

RA Q. RA Q denied alternative meals were given. RA Q reported if a resident did not eat a meal, the resident would wait until the next meal was served. RA Q denied snacks were offered.

On 07/18/2023 at 11:39 a.m., Surveyor interviewed RA U. RA U reported the facility often ran out of food. RA U denied alternative meals were offered. RA U denied snacks were available daily. RA U reported if the resident did not like the food that was offered, the residents did not eat.

On 07/21/2023 at 11:05 a.m., Surveyor interviewed RA X. RA X denied alternative meals were consistently offered. RA X reported when he/she had contacted the kitchen for an alternative meal, the kitchen would not answer the phone, or the requested alternative meal was not provided. RA X denied snacks were offered to the residents. RA X reported other residents often offered personal snacks to other residents who stated they were hungry. RA X disclosed residents had purchased pizzas for all of the residents as residents complained of being hungry.

On 07/12/2023 at 11:04 a.m., Surveyor interviewed Resident 19. Resident 19 stated, "the food is terrible." Resident 19 denied alternative meals were offered. Resident 19 reported if he/she did not like the food, he/she was just going to be hungry. Resident 19 reported when snacks were offered, Resident 19 could only get a peanut butter jelly sandwich or canned fruit. Resident 19 denied snacks are available or offered daily.

On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 449}	Continued From page 27 Director of Nursing (DON) F. ED A disclosed the facility had a standing alternative meal. ED A reported he/she will need to re-educate the residents and staff. ED A reported he/she has observed dietary bring snacks to the units on several occasions. ED A disclosed he/she will have a conversation with the dietary staff to ensure snacks are being offered.	{N 449}		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the facility did not ensure food was stored to prevent food borne illness. The facility did not ensure open products were securely sealed, properly maintained labels, or dated on all opened food items in 1 of 1 miniature refrigerator located on the Mansion unit.	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 452	Continued From page 28 Findings include: On 07/12/2023 at approximately 8:30 a.m., Surveyor toured the Mansion unit. Surveyor observed 1 miniature refrigerator located in the nurses' station. Residents had free access to the refrigerator. Surveyor observed the following in the miniature refrigerator: -Food wrapped in aluminum foil without a label or date -Five clear plastic fruit cups without a date or label -Food wrapped in a plastic grocery bag without a date or label -One unsealed open 12 ounce can of Pepsi without a date -1 opened cup of raspberry yogurt sealed with a rubber glove and without an open date. On 07/21/2023 at approximately 1:00 p.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A reported he/she would check the miniature refrigerator and throw out all of the unlabeled, undated, and unsealed foods. ED A disclosed he/she would re-educate the resident aides to ensure food safety was being followed.	N 452		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 29	N 481		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure a safe, clean, comfortable, and homelike environment.

Flooring throughout the facility was observed to be dirty. Furniture was observed flipped over. Ceiling tiles were observed missing. Multiple fruit flies were observed flying in the facility. Shower rooms were observed having dirty laundry and soiled towels laying throughout the room.

Findings include:

Aria West Allis is a 70 bed, Class CNA (Nonambulatory) facility which serves residents who may be of advanced aged, irreversible dementia/Alzheimer's and terminally ill.

On 07/12/2023 at approximately 8:30 a.m., Surveyor conducted an onsite tour of the facility. During the tour, the following was observed:

South unit

-Three recliners located in the common area were flipped over. White debris was observed laying in the common area.

-The carpet located in the front of the entrance, approximately measuring 27 feet by 5 feet was discolored due to the multiple dark black stains. The corridor carpet located in front of the nurses' station and resident bedrooms 69-95, which measured approximately 70 feet by 5 feet was discolored due to the multiple dark black stains.

-Surveyor observed a black stain measuring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 30	N 481		

approximately 2 feet by 1 ½ feet and a white stain measuring approximately 2 feet by 1 foot located near the medication cart.

- Foyer: Before entering the unit, was observed to have 4 missing ceiling tiles.

Mansion unit

-Surveyor observed a clear sticky liquid on the dining room floor. Surveyor heard his/her shoe sticking to the dining room floor.

-Multiple fruit flies were observed flying in the dining room. Surveyor observed residents swatting the fruit flies from the front of their face. Surveyor swatted fruit flies from the front of his/her face.

-The shower room was observed to have 4 used towels laying in front of the shower. A wet towel was observed in the shower. A pair of jeans was observed laying on top of the cast iron radiator. Rust was observed under the cast iron radiator. A pair of sweatpants was observed hanging on the bath towel holder. Fruit flies were observed flying in the shower room and restroom.

On 07/12/2023 at approximately 8:30 a.m., Surveyor interviewed Resident 16. Resident 16 disclosed he/she was not happy with the lack of cleanliness of the facility. During Surveyor's interview with Resident 16, Resident 16 stated, "watch out for the fruit flies." Resident 16 denied the provider was addressing the fruit flies. Resident 16 stated, "best way I can describe this place is 'gross.'"

On 07/12/2023 at 10:50 a.m., Surveyor interviewed Resident 19. Resident 19 reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 31	N 481		

he/she was afraid to go out into the common area due to the carpet being heavily stained. Resident 19 reported he/she had a wound on his/her foot and was afraid his/her foot would get infected because of the heavily stained carpet.

On 07/14/2023 at 4:26 p.m., Surveyor interviewed Resident Assistant (RA) T. RA T reported when shifts were short staffed, the facility does not get cleaned.

On 07/18/2023 at 11:39 a.m., Surveyor interviewed RA U. RA U reported the cleanliness of the facility had deteriorated. RA U disclosed the carpet in the facility was "filthy." RA U had not observed the carpet being cleaned since the provider purchased the facility in 2021.

On 07/21/2023 at 11:05 a.m., Surveyor interviewed RA X. RA X reported "no one is available to clean resident bedrooms." RA X stated, "carpets are filthy." RA X reported seeing the carpets being cleaned once since the provider purchased the facility in 2021.

On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A stated the recliners were flipped over as bed bugs were found on the recliners. ED A reported the recliners were flipped over so that the residents did not sit on the recliners. ED A disclosed a pest company came and sprayed the recliners and follow-up inspection was scheduled.

ED A reported the carpet was cleaned once a quarter. ED A acknowledged cleaning the carpet once a quarter may not be sufficient. ED A reported maintenance was responsible to ensure the carpet was cleaned. ED A disclosed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 32 carpet cleaner was shared with 3 other facilities within the company. ED A reported he/she may need to contact a carpet cleaning company given the current condition of the carpet. ED A disclosed he/she had found great results when using a carpet cleaning company. ED A could not recall the last time the carpet was cleaned. ED A reported he/she would address the environmental concerns.	N 481		
N 596	83.54(1)(b) Bedroom walls and doors. Floor to ceiling walls with rigid construction swing-type doors that are of the side-hinged or pivoted swinging shall enclose resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 2 of 7 resident bedroom doors were swing-type doors that were side-hinged or pivoted swinging. Resident 11's and 12's shared bedroom and had a pocket door. Resident 13's private room had a pocket door. Findings include: On 07/12/2023 at approximately 8:30 a.m., Surveyor toured the facility and observed 3 residents' bedrooms contained pocket doors. Pocket doors are sliding doors that disappear into a compartment in the adjacent wall when opened. On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and	N 596		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 596	Continued From page 33 Director of Nursing (DON) F. ED A reported he/she would address the pocket doors. ED A was not aware of state regulations regarding the need for swing-type doors.	N 596		
N 597	83.54(1)(c) Bedrooms: open to corridor or living area. Bedrooms shall open directly into a corridor, the resident ' s private living area or common living space. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 7 resident bedroom doors opened directly into a corridor, the resident's private living area or common living space. Resident 14's and 15's shared bedroom opened into the nursing station. Findings include: On 07/12/2023 at approximately 8:30 a.m., Surveyor toured the facility and observed 2 residents' shared bedroom located inside of the nursing station. Surveyor had to walk into the nursing station to get to Resident 14's and 15's bedroom. On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A reported he/she would address Resident 14's and 15's bedroom. ED A was not aware of state regulations regarding resident bedrooms needing to open directly into a corridor, private living area, or common living space.	N 597		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 613	83.55(4)(a) Bath and toilet areas: privacy. Bath and toilet rooms shall have door locks to ensure privacy, except where the toilet, bath or shower room is accessed only from a resident room that is occupied by one person. All door locks shall be operable from both sides. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 shower stall and 2 of 2 toilet stalls were equipped with an operable lock. Surveyor observed 1 of 1 resident shower stall was without an operable lock. Surveyor observed 2 toilet stalls were without an operable lock. Findings include: On 07/12/2023 at approximately 8:30 a.m., Surveyor toured the facility and observed a co-ed bathroom containing 2 operable toilet stalls and 1 shower stall. Two of 2 operable toilet stalls and 1 of 1 shower stall was equipped with a shower curtain that was used as a door. Surveyor did not observe an operable lock on 2 of 2 operable toilet stalls and 1 of 1 shower stall. On 07/12/2023, Surveyor reviewed Resident 13's record. Resident 13 was admitted on 08/11/2021. Resident 13 was diagnosed with dementia. Resident 13's individualized service plan (ISP), with a revision date of 06/02/2023 identified a focus of, "Resident is an elopement risk/wander as evidenced by ...significantly intrudes on the privacy of others or activities ..." On 07/12/2023 at approximately 9:00 a.m., Surveyor interviewed Resident 16. Resident 16 acknowleged sharing the bathroom with male and	N 613		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018335	A. BUILDING: _____ B. WING _____	R-C 07/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARIA WEST ALLIS	5301 W LINCOLN AVE WEST ALLIS, WI 53219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 613	Continued From page 35 female residents. Resident 16 informed Surveyor that a resident of the opposite sex had opened the shower curtain while he/she was showering. Resident 16 reported being uncomfortable with having to sharing a bathroom with residents of the opposite sex. On 07/12/2023 at approximately 9:00 a.m., Surveyor interviewed Resident Assistant (RA) K. RA K affirmed male and female residents shared the bathroom. On 07/21/2023 at 10:00 a.m., Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) F. ED A acknowledged male and female residents shared the restroom. ED A affirmed residents were not able to lock each stall as each stall was equipped with a shower curtain and not a lockable door. ED A reported he/she would address having lockable doors in the shared restroom.	N 613		