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 04/15/2024

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 04/04/2024 with information gathered through 04/15/2024, Surveyor conducted a verification survey and one complaint investigation. Three deficiencies were identified. Two of 3 were repeat deficiencies. One complaint was substantiated. Under statutory Provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 25	{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 25 of 25 residents who resided at the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) 6PHK13, dated 07/21/2023. 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.	{N 196}		

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

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{N 196}	Continued From page 1 On 04/04/2024, Surveyor completed a verification visit and 1 complaint investigation. As a result of the survey 1 of 1 complaint was substantiated and 3 deficiencies were identified. Three of 3 deficiencies were repeat deficiencies. The following deficiencies were identified: 83.14(2)(a) Licensee Ensures Facility Complies with Laws - Repeat 83.36(1)(a) Adequate Staff to Meet Resident's Needs- Repeat 83.54(1)(b) Bedroom Walls and Doors -Repeat On 10/17/2023, the provider was provided with a Notice and Order letter with Statement of Deficiency (SOD) 6PHK13, dated 07/21/2023. 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 04/15/2024 at 12:30 p.m., Surveyor interviewed Licensee C. Licensee C stated Executive Director A was in the facility daily and was responsible for the "day to day" operations of the CBRF. Surveyor interviewed and asked questions related to the actions the provider completed to ensure violations identified in SOD	{N 196}		

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{N 196}	Continued From page 2 6PHK13 were brought into compliance. Licensee C denied knowledge of the staff shortage on 10/27/2023 and stated, "I will speak with my team and see what happened. Regarding the pocket doors I thought we got a waiver for those doors. I will look into that as well." Licensee C confirmed they did not have a procedure for staffing patterns between the two units of the CBRF.	{N 196}		
{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 observation, interview, and record review, the provider did not ensure there was an adequate number of Resident Assistants working during the 3rd shift to meet the needs of 4 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 Statements of Deficiency (SOD) 25PG11, dated 04/01/2021 and 6PHK12, dated 08/05/2022. Findings include: The provider is licensed to care for advanced aged, terminally ill, and irreversible dementia/Alzheimer's residents. On 11/08/2023, the department received a complaint alleging there was no staff working on 10/27/2023 from 10:21 PM - 12:27 AM.	{N 396}		

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{N 396}	Continued From page 3 On 04/04/2024 at approximately 12:30 PM, 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 21. -Mansion unit was in a different part of the facility on the southeast corner of the campus separated from CBRF South but connected by a long hallway. Census at the time of the survey for the Mansion was 4. On 04/05/2024 at 12:30 PM Surveyor interviewed Emergency Medical Technician AC who stated they had arrived at the Mansion on 10/27/2023, at approximately 10:30 PM, to drop off a resident [Resident 20] but could not locate a caregiver in the building until 10/28/2023, at approximately 12:30 PM. On 04/04/2024 at 4:15 PM Surveyor interviewed Executive Director A who stated on 10/27/2023, they had received a phone call at approximately 10:30 PM from Resident Coordinator AA that a staff member had failed to show up. Resident Coordinator AA arranged for Resident Assistant AB to come in as soon as possible. Executive Director A stated the normal protocol was to have a resident assistant come over from the other unit when they were needed at the Mansion unit but on this night (10/27/2023), there was no one available. On 04/04/2024 at 3:15 PM Surveyor interviewed Resident Assistant AD who stated, "the facility has a hard time filling the schedule, so I often	{N 396}		

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{N 396}	Continued From page 4 work double shifts." On 04/05/2024, Surveyor reviewed staff schedules and employee time records for 10/27/2023-10/28/2023 and identified the following: -Resident Assistant X was scheduled for "CBRF South (Mansion)" indicating Resident Assistant X was scheduled to work in both locations from 2:00 PM - 10:00 PM. -Resident Assistant X clocked in to work on 10/27/2023 at 2:04 P.M. and out at 10:03 P.M. Resident Assistant X left before a replacement worker arrived. -Resident Assistant Q was scheduled for "CBRF South (Mansion)" indicating Resident Assistant Q was scheduled to work in both locations from 10:00 PM - 6:00 AM. A line was drawn through Resident Assistant Q's name and Resident Assistant Y's name was handwritten into the 10:00 PM slot. Resident Assistant Y's name also had a line drawn through it with the name of Resident Assistant Z handwritten on the schedule. -Resident Assistant Z was punched in but was unable to be located in Mansion unit when paramedics came to return a resident. -Resident Assistant AB, who was called in by Resident Coordinator AA when the paramedics called because they could not locate a caregiver (and was not on the schedule to work), clocked in to work at 12:38 AM on 10/28/2023.	{N 396}		

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{N 596}	Continued From page 5	{N 596}		
{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 and 12's shared bedroom had a pocket door. Resident 13's private room had a pocket door. This requirement is being cited for a 2nd time. See Statement of Deficiency (SOD) 6PHK13, dated 07/21/2023. Findings include: On 04/04/2024 at approximately 12:30 PM, 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 04/04/2024, Surveyor reviewed Department files and did not locate a waiver approving the use of pocket doors. On 04/04/2024 at 4:15 PM Surveyor interviewed Executive Director (ED) A. ED A reported the licensee was having a hard time finding a contractor to convert the pocket doors to regular doors. ED A inquired about the possibility of	{N 596}		

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{N 596}	Continued From page 6 getting a waiver to permit the doors.	{N 596}		