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 09/30/2025

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 09/30/2025, Surveyor conducted 2 complaint investigations and a verification visit at Aria West Allis. One complaint was substantiated. One complaint unsubstantiated. Four deficiencies were identified. Two of 4 deficiencies was a repeat deficiency. See Statement of Deficiency (SOD) 6PHK12, dated 08/05/2022, and SOD 6PHK15, dated 11/07/2024.. Under statutory Provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 25	{N 000}		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 caregivers (Caregiver FF) reviewed received 15 hours annual training. Caregiver FF only received 11.5	N 277		

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

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N 277	Continued From page 1 hours of continuing education training in 2024. Findings include: On 09/30/2025, at approximately 11:00 AM, Surveyor reviewed Caregiver FF's record. Caregiver FF was hired on 12/01/2020. Caregiver FF's record indicated s/he had 11.5 hours of continuing education for 2024. On 09/30/2025, at 12:00 PM, Surveyor interviewed Executive Director (ED) A and Director of Nursing (DON) EE. ED A and DON EE confirmed the code requirement. ED A was unsure what happened that Caregiver FF did not receive 15 hours of continuing education. DON EE reported s/he would ensure staff received the required continuing education.	N 277		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.	{N 387}		

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{N 387}	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident and/or the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) and signed the plan acknowledging their involvement in, understanding of, and agreement with the plan for 1 of 3 resident records reviewed (Resident 22) This is a repeat deficiency. See Statement of Deficiency (SOD) 6PHK15, dated 11/07/2024. Findings include: On 09/30/2025 at 11:15 AM, Surveyor reviewed Resident 22's record. Resident 22 was admitted on 02/20/2025, with diagnoses including mild cognitive impairment, major depressive disorder, anxiety disorder and others. Resident 22 has an activated healthcare power of attorney (POA). Resident 22's ISP was signed on 03/24/2025, by Executive Director (ED) A, Director of Nursing EE and the resident. Resident 22's POA did not sign the ISP. On 09/30/2025 at 12:00 PM, Surveyor interviewed ED A. ED A confirmed the ISP was not signed by Resident 22's POA. They were unsure why Resident 22's POA did not sign the ISP. ED A stated they would work to have the ISP signed by the POA as soon as possible.	{N 387}		
N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep	N 419		

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N 419	Continued From page 3 medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure residents' medications were securely stored in the medication filing cabinet. Resident 23 had medications left unsupervised in his/her room. Findings include: On 09/30/2025 at 9:20 AM, Surveyor toured the facility, Surveyor entered Resident 23's room and observed 2 containers of nasal spray, a bottle of "fungi cure" anti-fungal liquid, and a bottle of "ultratussin" cough suppression liquid on the residents over bed table. On 09/30/2025 at approximately 11:30 AM, Surveyor reviewed Resident 23's records. Resident 23 was admitted on 10/13/2022, with diagnoses including dementia, major depressive disorder, anxiety disorder and other diagnoses. Resident 23's ISP states Resident 23 "is unable to self-administer any of his/her own medications ...medications will be administered by licensed or certified team members." On 09/30/2025 at approximately 12:30 PM, Surveyor interviewed Director of Nursing (DON) EE. DON EE confirmed Resident 23 requires staff to administer his/her medications and did not know why the medications were left in the room, and they would be removed at once.	N 419		
{N 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that	{N 499}		

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{N 499}	Continued From page 4 cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored. Cleaning compounds and toxic substances were not securely at the front desk. This deficiency is being cited for a 3rd time. See Statement of Deficiency (SOD) 6PHK12, dated 08/05/2022, and SOD 6PHK15, dated 11/07/2024. Findings include: The facility is licensed to serve 70 residents, in client groups of terminally ill, Irreversible dementia/Alzheimer's and advanced age. On 09/08/2025, the Department received a complaint alleging a resident consumed air freshener left in his/her room by staff. On 09/30/2025, Surveyor reviewed Department files and identified a self-report, dated 07/11/2025, received from the facility regarding a resident who went to the hospital after ingesting air freshener. As a result of the incident, the corrective action the provider reported on the self-report form was, "Conclusion - Continuing education with [resident assistants] on chemical storage and audit's [sic] of [facility] resident rooms." On 09/30/2025 at 9:00 AM, Surveyor toured the facility and observed the following:	{N 499}		

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{N 499}	Continued From page 5 A container of Sani-Cloth germicidal wipes on the front desk, with residents seated in the vicinity. On 09/30/2025 at 12:30 PM, Surveyor interviewed Director of Nursing (DON) EE, DON EE stated they were aware of the regulation regarding secure storage of toxic substances and would ensure they are stored appropriately.	{N 499}		