STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008822	A. BUILDING: _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA RES ALTERNATIVES 52	1421 ROGERS DR PLOVER, WI 54467

(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
M 000	INITIAL COMMENTS On 05/13/2025, Surveyor conducted an abbreviated survey and investigation into one (1) complaint. As a result of the survey, 2 new deficiencies were identified, and the complaint was substantiated. Census: 4	M 000		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure Resident 3's prescription medications were securely stored and remained in the original container as received from the pharmacy. Findings include: Facility is licensed to serve up to 4 residents who are developmentally disabled. On 05/13/2025 at 9:25 AM, Surveyor observed approximately 16 bottles containing the following	M 458		

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

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M 458	Continued From page 1 medications, on top of a filing cabinet in an unlocked closet while on tour of the facility with Administrative Specialist (A.S.) B: -- Lamotrigine 100MG Tablets -- Clonidine 0.1MG Tablets -- Aripiprazole 2MG Tablets -- Sertraline 25MG Tablets -- Naltrexone 4MG Caps -- Aripiprazole 2MG tablets -- Vitamin C powder -- Fexofenadine HCl 180MG tablets -- Vitamin D3 2,000IU Tablets -- Calcium Plus Tablets -- Docusate Sodium 50MG Tablets -- Iron Plus Vitamin C Tablets -- B-6 100MG Tablets -- Alive Premium Gummy Multivitamin -- One pill bottle with a handwritten label taped on it which read, "Keppra." The bottle contained approximately 4.5 white pills. Surveyor confirmed all bottles contained medications. Surveyor also observed 2 blue weekly pill cases. One case contained an assortment of pills in the compartments labeled for Wednesday, Thursday, Friday, and Saturday. On 05/13/2025 at 9:26 AM, Surveyor interviewed A.S. B. S/he acknowledges Surveyors observation and said the medications were for Resident 3 who had recently been admitted to the facility. A.S B acknowledged that the medications were kept in an unsecured location and not in their original containers and stated that they would be moved.	M 458		

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M 548	Continued From page 2	M 548		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on observation, interviews, and records review, the provider did not ensure Resident 1 and Resident 2 were treated with courtesy, respect and full recognition of the resident's dignity and individuality. Resident 1 was observed in the common area wearing only a shirt and incontinence brief while other residents, staff, a visitor, and Surveyor were present. Resident 2 received incontinence care in the living room while Surveyor and Administrative Specialist (A.S.) B were present. Findings include: Facility is licensed to serve up to 4 residents who are developmentally disabled. Example 1 On 05/13/2025 at 8:19 AM, Surveyor observed Caregiver A transfer Resident 1 into the kitchen for breakfast. Resident 1 was wearing a t-shirt and an incontinence brief without pants. From 8:19 AM to 8:51 AM, Surveyor observed the following: -- 8:20 AM- A visiting family member of Resident	M 548		

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M 548	Continued From page 3	M 548		

3's in the kitchen within view of Resident 1.
-- Resident 3 and Resident 1 in the kitchen eating breakfast within view of Resident 1.
-- 8:35 AM: A.S. B walked into the kitchen area within view of Resident 1.
-- 8:51 AM- Resident 4 walked into the kitchen area within view of Resident 1.

On 05/13/2025 at 9:10 AM, Surveyor interviewed A.S. B and Caregiver C. Caregiver C said that Resident 1's briefs are soiled in the morning, and s/he will bring Resident 1 out "in [his/her] brief" to avoid applying a clean brief prior to his/her shower following breakfast. Surveyor expressed concern that incontinence care and dressing assistance were not provided out of staff convenience and that it was undignified for Resident 1 to be in the common area in view of others when s/he was not fully dressed. A.S. B acknowledged Surveyor's concerns.

On 05/13/2025 at 9:59 AM, Surveyor reviewed Resident 1's most current Individualized Service Plan (ISP) dated 03/12/2025. Resident 1 was admitted on 07/16/2012 with diagnoses that include Spastic Quadriplegia, Hydrocephalus, and Cerebral Palsy. The ISP identified the need for "total assistance" regarding dressing and toileting needs.

Example 2

On 05/13/2025 at 8:54 AM, Surveyor and A.S. B observed Caregiver A take Resident 2's incontinence briefs off while s/he was laying down in the living room and exposed Resident 2's private parts. A.S. B directed a comment towards Caregiver A and said Resident 2, "should be in [his/her] room for that." Caregiver A continued to change Resident 2 and expose his/her private

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M 548	Continued From page 4 parts to Surveyor and A.S. B. On 05/13/2025 at 10:34 AM, Surveyor reviewed Resident 2's most current Individualized Service Plan (ISP) dated 03/12/2025. Resident 2 was admitted on 07/17/2023 with diagnoses that include Athetoid cerebral palsy, Hypoxic ischemic encephalopathy, Dysphagia, and anxiety disorder. The ISP identified the need for "total assistance" regarding dressing and "help" with incontinence care. On 05/13/2025 at 11:25 AM, Surveyor interviewed A.S. B and Program Director (P.D.) C. A.S. B acknowledged Resident 2 was provided incontinence care which exposed his/her private parts while in a public space of the facility. P.D. C acknowledged that Resident 2 should have been provided privacy while receiving incontinence care, and if utilizing the living room, "the area needs to be cleared"	M 548		