| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 0009007 | A. BUILDING: _____ B. WING _____ | R-C 04/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AURORA RES ALTERNATIVES INC 083 | 7736 NINE MILE CREEK ROAD EAU CLAIRE, WI 54701 |

| (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<br><br>On 04/09/2025, Surveyor conducted a verification visit at Aurora Res Alternatives Inc 083.<br><br>One of 2 deficiencies identified in Statement of Deficiency (SOD) FL0M14, dated 10/24/2024 was corrected.<br><br>Three deficiencies were identified.<br><br>One of 3 deficiencies was a repeat deficiency. See SOD FL0M14, dated 10/24/2024.<br><br>Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 3 | {M 000} | | |
| M 436 | 88.07(2)(a) SERVICES<br><br>The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure medication assistance services were provided as specified in Resident 1's individual service plan (ISP).<br><br>Findings include:<br><br>On 04/09/2025, Surveyor reviewed medication assistance procedures with Program Manager | M 436 | | |

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

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| M 436 | Continued From page 1<br><br>(PM) A. PM A informed Surveyor Resident 1 administered his/her own medications but medications were stored by the provider. PM A stated Resident 1 would retrieve the keys from the bulletin board, access the medication cabinet where 2 other residents had medications stored, and administer his/her medications throughout the day. PM A stated Resident 1 had been administering his/her own medications for the past 10 years.<br><br>On 04/09/2025, Program Director (PD) B stated Resident 1 should not be doing his/her own medications. Surveyor requested Resident 1's ISP which read, in part: "Needs help taking meds. Note: [Resident 1] has medication times of 9am and 8pm daily. Resistant to taking medication-[Resident 1] has a history of medication refusal if agitated. Needs full med (medication) set up - needs medication doses prepared in advance. Note: Medications are setup and delivered to the home by [pharmacy name]. Med self-administration is not applicable." The ISP was updated with a last revision date and signature of 02/27/2025.<br><br>The provider did not provide medication assistance to Resident 1 as specified in the ISP. | M 436 | | |
| {M 462} | 88.07(3)(c) MEDICATION ASSISTANCE<br><br>If the licensee or service provider assists a resident with prescription medication, the licensee or service provider shall help the resident securely store the medication, take the correct dosage at the correct time and communicate effectively with his or her physician. | {M 462} | | |

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| {M 462} | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure prescription medications were securely stored when the medication keys were hanging on the bulletin board next to the medication filing cabinet.<br><br>This is a repeat deficiency. See Statement of Deficiency (SOD) FL0M14, dated 10/24/2024.<br><br>Findings include:<br><br>On 04/09/2025 at approximately 11:00 AM, Surveyor asked Program Manager (PM) A to open the medication storage area. PM A retrieved a set of keys from the bulletin board hanging in the dining room and opened the filing cabinet directly to the left of where the keys were hanging. PM A stated the keys were always maintained on the bulletin board in the dining room, which was accessible to anyone in the home.<br><br>On 04/09/2025 at 11:05 AM, Surveyor discussed the above observation with Program Director (PD) B. PD B stated the keys should not be hanging and would purchase a lanyard for staff to maintain possession of the keys while working. | {M 462} | | |
| M 482 | 88.09(1)(a) RESIDENT RECORDS<br><br>The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure | M 482 | | |

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| M 482 | Continued From page 3<br>location within the home to prevent unauthorized access.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not ensure resident records were maintained in a secure location to prevent unauthorized access. Records were stored in a filing cabinet in the dining room and the keys were stored on the bulletin board next to the cabinet.<br><br>Findings include:<br><br>On 04/09/2025 at approximately 11:00 AM, Surveyor observed PM A retrieve a set of keys from the bulletin board hanging in the dining room and opened the filing cabinet directly to the left of where the keys were hanging. PM A stated the keys were always maintained on the bulletin board in the dining room, which was accessible to anyone in the home.<br><br>Three of 3 resident records were stored in a filing cabinet.<br><br>On 04/09/2025 at 11:05 AM, Surveyor discussed the above observation with Program Director (PD) B. PD B stated the keys should not be hanging on the bulletin board and would purchase a lanyard for staff to maintain possession of the keys while working. | M 482 | | |