STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010596	A. BUILDING: _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA RESIDENTIAL ALT INC 85	1500 S EDGEWATER DR 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 On 11/13/2024, Surveyor conducted an abbreviated survey and complaint investigation. Data collection continued through 11/26/2024. The complaint was unsubstantiated. Three deficiencies were identified. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a report was submitted within 24 hours when Resident 2 went missing from the home. Findings include: On 11/13/2024 at approximately 11:10 AM, Surveyor interviewed Residential Administrative Specialist (RAS) C and asked if there had been any incidents within the last 6 months. RAS C stated Resident 2 had eloped twice in the	M 134		

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

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M 134	Continued From page 1 summer. Surveyor reviewed the following incident reports: -07/11/2024: Resident 2 was having behaviors at Walmart while grocery shopping and attempted to put a Reese's peanut butter cup down his/her pants. Staff retrieved it and Resident 2 got increasingly upset and hit staff and other customers and continued grab merchandise. Resident 2's behaviors escalated at home as s/he struck out at staff. Resident 2 snuck out of the home while staff was completing a report and went to the neighbor's garage and walked down the road. Resident 2 was returned to the home by staff and was offered a PRN (as needed) medication. Resident 2 continued to hit staff and attempted to leave the home multiple times before going to bed. -09/29/2024: Resident 2 became agitated after staff redirected him/her from eating the other resident's breakfast. Resident 2 left the home on multiple occasions during the morning but never actually left the property. Resident 2 was occupied and settled down. Resident 2 was agitated with shift change and left the home around 3:40 PM. One staff was working so law enforcement was called to locate Resident 2. At approximately 4:10 PM, law enforcement brought Resident 2 back to the house. Resident 2 took a PRN medication and calmed down. On 11/13/2024 at approximately 11:20 AM, Surveyor interviewed Program Director (PD) B and asked if the above elopements were reported to the Department. PD B stated s/he was unsure if the above incidents were reported to the licensing agency but would let Surveyor know. PD B further stated Resident 2's guardian and case manager were notified of the incidents and	M 134		

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M 134	Continued From page 2 medication adjustments were made after the elopements. As of 11/26/2024, no additional information was received to show the above incidents were reported.	M 134		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the home was safe and well-maintained. Findings include: On 11/13/2024 at approximately 11:00 AM, Surveyor toured the home with Caregiver A and observed the following items: - The main floor bathroom vanity was missing a door. - The main floor bathroom vanity was missing a drawer. - The main floor bathroom vanity doors were ajar and did not remain closed. - The main floor bathroom vanity contained two sinks. Both sinks had several cracked and chipped areas with a dark black substance/staining.	M 276		

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M 276	Continued From page 3 - The downstairs bathroom vanity used by Resident 1 had two missing drawers. - The downstairs bathroom vanity was missing two drawers. - The downstairs bathroom door trim was loose, exposing nails. - The downstairs bathroom vent was not covered. - The downstairs bathroom fan was hanging from the ceiling and not properly adhered. Caregiver A stated the above items were not new and had been in the above noted condition for a while. Caregiver A further stated that most of the items that needed to be fixed were a result of resident behaviors. On 11/13/2024 at approximately 12:00 PM, Surveyor discussed the above observations with Program Director (PD) B. PD B informed Surveyor some of the items had already been submitted to maintenance but had not been fixed yet. PD B took note of the above items and stated s/he would put in a maintenance request.	M 276		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident records were maintained in a secure location within the home to prevent	M 482		

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M 482	Continued From page 4 unauthorized access. Findings include: On 11/13/2024 at approximately 11:00 AM, Surveyor toured the home with Caregiver A and observed the staff office. The office contained a desk and file cabinets and was in an area of the home between the kitchen and living room. The staff office area did not contain doors and was accessible from the living room and kitchen. The office contained two, 2-drawer metal file cabinets and the key for each cabinet was left in the lock in the "unlocked" position. Surveyor opened all 4 drawers, which contained confidential resident information including medication lists, appointments, and care plans for all 4 residents. On 11/13/2024 at approximately 12:00 PM, Surveyor discussed the above observation with Program Director (PD) B. PD B stated s/he had retrieved the keys from the file cabinet and would discuss putting the keys on a lanyard or keychain with the house manager.	M 482		