STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	590137	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA RES ALTERNATIVES SPOONER 082	525 BLACK BEAR CT SPOONER, WI 54801

(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 01/27/2026, Surveyor began a complaint investigation and abbreviated licensure survey at Aurora Res Alternatives Spooner 082. Data was collected through 01/29/2026. The complaint was substantiated. One violation was identified. Census: 4.	M 000		
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that residents received all prescribed medications as required when resident medications were not administered 6 times in 2025. Findings include: On 12/26/2025, the Department received a complaint regarding medication administration. On 01/27/2026, at approximately 11:00 AM,	M 582		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	590137	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA RES ALTERNATIVES SPOONER 082	525 BLACK BEAR CT SPOONER, WI 54801

(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 582	Continued From page 1 Surveyor interviewed Program Manager (PM) B, who stated the staffing pattern at the home was currently: - 1 staff usually on during the AM shift (6:00 AM to 2:00 PM) - 2 staff on during the PM shift (2:00 PM to 10:00 PM) - 1 awake-staff on during the overnight shift. PM B stated it was ideal to have 2 staff on during the AM shift, and that there had been during the summer. PM B stated the second AM-shift staff had gone to college, and now it was usually just 1 staff working during the AM shift. At approximately 11:40 AM, Surveyor interviewed Caregiver A. Caregiver A stated medication errors happened often at the facility. Caregiver A described an incident on 11/11/2025 where staff had reported a 5 milligram (mg) half-pill stuck inside an opened bubble pack spot of Resident 3's escitalopram. Caregiver A stated staff were incorrect, and that s/he had seen the bubble-pack empty that day. At approximately 12:45 PM, Surveyor requested 2025 medication error documentation from PM B. According to the provider's electronic record system, there were 6 medication errors in 2025. The medication errors indicated the following: - On 03/13/2025, Resident 1 missed his/her 12:00 PM dose of naproxen 500 mg. This was discovered when evening staff found the 12:00 PM dose still in its spot in the bubble pack. - On 03/23/2025, Resident 2 missed his/her 8:00 AM dose of red docusate sodium. This was discovered when evening staff found the gel capsule stuck to Resident 2's medication cup when preparing his/her 2:00 PM dose. - On 03/27/2025, Resident 1 missed his/her 8:00	M 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	590137	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA RES ALTERNATIVES SPOONER 082	525 BLACK BEAR CT SPOONER, WI 54801

(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 582	Continued From page 2	M 582		

AM dose of an unspecified medication. This was discovered by morning staff on 03/26/2025 when s/he found the medication.
- On 11/18/2025, Resident 1 missed an unspecified medication during the 6 AM to 2 PM shift.
- On 12/14/2025, Resident 1 missed his/her 12 PM dose of naproxen. This was discovered when evening staff found the 12:00 PM dose still in its spot in the bubble pack.

There was no record of the incident mentioned by Caregiver A on 11/11/2025.

Surveyor reviewed Resident 3's November 2025 medication administration regimen (MAR) which indicated Resident 3 was to take 1 and 1/2 tablets of escitalopram daily.

At approximately 4:15 PM, Surveyor interviewed PM B. PM B stated s/he remembered a medication error in November 2025 which resulted in a meeting between him/herself, Caregiver A, Caregiver D, and the provider's human resources (HR) staff. PM B stated both him/herself and Caregiver D had seen the half tablet of Resident 3's medication left in its bubble-pack, in the same incident described by Caregiver A. PM B stated s/he was verbally told to take photographs of medication packs by Program Director (PD) C.

On 01/28/2026, at approximately 10:29 AM, Surveyor interviewed Caregiver D, who described the alleged medication error on 11/11/2025. Caregiver D stated s/he and PM B observed Resident 3's half tablet of medication left in its bubble-pack. Caregiver D stated s/he had been instructed by PD C to take photographs of resident medication packs. Caregiver D stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	590137	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA RES ALTERNATIVES SPOONER 082	525 BLACK BEAR CT SPOONER, WI 54801

(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 582	Continued From page 3	M 582		

s/he took a photograph of the bubble-pack which showed the non-administered half tablet and sent it to PD C.

At approximately 4:18 PM, Surveyor received an email from PD C, which outlined the medication error described by Caregiver A, PM B, and Caregiver D. The email read, in part:
"11/11 3:09p -Staff [Caregiver D] reported a med [medication] error to me. They reported when checking medication that [Resident 3's] Escitalopram 15mg at 7am. It appeared that a half of a pill was lodged behind the foil in the bubble pack so [s/he] only received 10mg. A picture of the bubble pack was sent to me for verification. Staff were instructed to destroy the pill and create an incident report.

11/12 7:59am [Caregiver A] reached out to me and stated that [s/he] saw a medication error was filed for [Resident 3] on 11/11 at 7am. [S/he] stated [s/he] had proof that this was inaccurate. [S/he] sent me a picture stamped the day of 11/11 stamped at 6:43am indicating the bubble pack was empty.

On 11/13 Our HR department was informed of the situation [sic] and it was decided to bring staff in and discuss the discrepancy...."

The email went on to describe that there had been 2 meetings between the staff involved, PD C, and HR, but it could not be determined if a medication error occurred.

On 01/29/2026, at approximately 2:04 PM, Surveyor interviewed PD C. PD C stated s/he was not sure what had occurred during the alleged medication error on 11/11/2025, but that Caregiver A was responsible for multiple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	590137	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA RES ALTERNATIVES SPOONER 082	525 BLACK BEAR CT SPOONER, WI 54801

(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 582	Continued From page 4 medication errors. PD C stated s/he had instructed staff to take photographs after finding a medication error as verification, due to Caregiver A having had a "stretch of med errors" and would state s/he did not remember when asked about the medication errors. PD C stated s/he knew instructing staff to take photographs was a wrong decision, and that staff were no longer doing so per HR guidance. PD C stated procedure for educating staff after medication errors involved meeting with the staff, going over the provider's medication policy, and re-training staff on the 10-step medication pass process. PD C stated that in October 2025, s/he had met with Caregiver A to discuss late documentation and missed medications. PD C stated s/he believed the reason for the repeated medication errors was that Caregiver A needed a second person to work with during the AM shift, and that the provider had recently hired another AM shift staff. The provider did not ensure all residents had the right to receive all medications as prescribed.	M 582		