STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019468	A. BUILDING: _____ B. WING _____	C 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIA COMMUNITY CARE LLC	2322 HARLEY DR MADISON, WI 53711

(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 03/17/2025, with information gathered through 03/31/2025, Surveyor conducted a complaint investigation at Alia Community Care LLC. Four deficiencies were identified. Complaint was substantiated. Census: 3	M 000		
M 230	88.04(2)(f) CONDITION WHICH REPRESENTS RISK OR HARM The licensee may not permit the existence or continuation of a condition in the home which places the health, safety or welfare of a resident at substantial risk of harm. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider permitted an existence of a condition in the home which placed the health, safety, and welfare for 1 of 1 resident at substantial risk of harm. Resident 2 became agitated, and Caregiver E was unable to communicate with the resident, due to a communication barrier. Caregiver E left the home to follow Resident 2 when s/he attempted to elope, leaving Resident 1 and Resident 3 unsupervised. Findings include: The provider is licensed to provide care for up to 3 residents in the client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, traumatic	M 230		

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

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brain injury, and/or developmentally disabled.

On 03/12/2025, the Department received a concern that a resident had eloped from the home.

On 03/16/2025, Surveyor reviewed the supporting documentation that was submitted with the concern filed with the department, which documented:
Adult Protective Services (APS) received a call from Officer F. "Per LE (law enforcement) they were told the following: 'the group home staff person, who was on duty when [Resident 2] eloped 2x (times) does not speak English very well and the caller is concerned that this may be impinging on their ability to effectively work with [Resident 2] and to call for help in a timely manner. Caller explained that they found out that the staff person on-duty had to call the [placement agency] Case Management office to speak to someone there who speaks their language, and that person had to then call 911 to report the elopement, which slowed down [LE] ability to respond.'"

On 03/16/2025, at approximately 10:40 AM, and was greeted by Caregiver E. Surveyor asked to review Resident 2's record and Caregiver E appeared to not understand what the Surveyor was asking. Surveyor continued to explain by describing different documents found in a resident record. Caregiver E appeared to not understand. Surveyor asked if the resident binders were in the medication closet. Surveyor pointed to the door of the medication closet and Caregiver E unlocked the door. Surveyor found the resident binders.

On 03/16/2025, at approximately 10:50 AM,

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M 230	Continued From page 2	M 230		

Caregiver B arrived at the home. Caregiver B stated s/he was running behind for his/her morning shift. Surveyor explained his/her concern that s/he was unable to communicate effectively with Caregiver E. Caregiver B explained that since Resident 2 had eloped from the home, staff members who do not communicate well with the English language were now scheduled for the third shift.

On 03/18/2025, at approximately 10:30 AM, Surveyor interviewed Licensee A. Licensee A explained that Caregiver E had been working independently on the day Resident 2 eloped. Caregiver E had followed Resident 2 but had not taken the house phone with him/her and had to walk back to the home to retrieve it as s/he was unable to redirect Resident 2. Caregiver E was going to go back to Resident 2, but then Resident 2 returned with his/her care manager. Surveyor asked if Caregiver E was able to communicate in Resident 2's language. Licensee A stated Caregiver E knew basic English words. Surveyor asked if Resident 1 and Resident 3 were able to be unsupervised while Caregiver E was following Resident 2. Licensee A stated Caregiver E was not away from the home for very long.

On 03/20/2025, Surveyor reviewed staff documentation regarding Resident 2's elopement incident on 03/10/2025, written by Caregiver E, provided by Caregiver B:
"For lunch [Resident 2] was suppose to go out with the [his/her] case manager and pick up time was 1:30. [S/He] out of room by 12 pm, waiting by window. [S/He] called the manager, and [s/he] tell [s/he] will be late. [S/He] become agitated, by 2:20 [Resident 2] go outside saying I will wait outside. Staff ask [him/her] come back and not safe, [s/he] refuse. explain to [him/her] for almost

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10 mins. Staff come back home to call the manager, manager say call 911, but [his/her] case manager come back with [him/her]. [Resident 2] very mad, and say [s/he] will go, case manager say no, coz u did something not safer and not listen to staff. Case Manager talk to [House Manager G], [House Manager G] tells [Resident 2] to not hit or yell at case manager or staff. [Resident 2] took the house phone and call 911, but case manager unblocked the phone and asked [Resident 2] to calm down, [s/he] say no, yell, scream, push and leave the house. [House Manager G] asked the case manager to go after [Resident 2] with a car and call 911. Police bring [Resident 2] back home. [S/He] took PRN (as needed medication) and [House Manager G] come to talk to [Resident 2] in the room. [Resident 2] ate food and watch TV the rest of the night."

On 03/22/2025, Surveyor reviewed Resident 2's mental health support services documentation provided by his/her Case Manager (CM) H, which documented:
"03/10/2025 - I just wanted to make you aware of a situation that happened today with [Resident 2]. I planned to pick [Resident 2] up to take [him/her] to [fast food name] today at 1:30 pm. However, my meeting before had run late, and I called [him/her] to inform [him/her] I would be late. I called again around 2 pm to let [him/her] know I was on the way, but there was no answer. Around 2:30 pm I am turning onto Harley Dr from Raymond Rd (approximately .3 miles from home) and see [Resident 2] standing on the corner of Harley Dr by the stop sign by [him/herself]. I turned and had [Resident 2] get in the car and asked what [s/he] was doing. [S/he] said [s/he] couldn't see from the window of the house because the van in the neighbor's driveway was

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blocking [his/her] view. [Resident 2] knows [s/he] is not allowed to leave the house without staff at any times. [S/he] said [s/he] knew that but did it anyway. I told [him/her] that I would not be taking [him/her] to [fast food name] due to not following the rules and I drove [him/her] back to the AFH (adult family home). The door was locked to the house, but we knocked and spoke with the staff member at the house. [Resident 2] became very dysregulated for obvious reasons and I tried to calm [him/her] down. [Resident 2] was very adamant [s/he] needed to go so [s/he] went back outside and attempted to get into my car. [S/he] tried to move my hand a few times from the handle and lock. [S/he] finally went back inside after multiple pleads for [him/her] to go back inside. [S/he] said [s/he] wanted to call [name] and asked that I come inside with [him/her]. I did and the staff member was on the phone with [House Manager G]. [S/he] wanted to talk to [Resident 2] to calm [him/her] down. [S/he] began to lunge at the staff member to grab the phone out of [his/her] hand. [S/he] did get the phone and nothing was really working to calm [him/her] down and [s/he] was very adamant we would still be going. [S/he] became increasingly angry and was yelling at the staff and at one point I had the phone in my hand talking to [House Manager G] when [s/he] did the same thing and lunged at me too. It happened a third time with the staff member and eventually [Resident 2] said [s/he] was going to walk to [fast food name]. [S/he] left the house and [House Manager G] said [s/he] was trying to find a [fe/male] staff to come and to wait. The staff member and I watched [Resident 2] walk down Harley Dr and we spoke with [Licensee A] and it was decided I would drive to see where [s/he] was. I drove and found [him/her] crossing the crosswalk at Raymond Rd and Verona Rd (approximately .5 miles from

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home) going towards the beltline. I called [Licensee A] back and [s/he] advised me to call 911. I did and gave all information. 1 got a call back from an officer saying they found [him/her] and [s/he] is back at the house, but that [s/he] was walking into traffic. The officer said that they would be trying to remove [Resident 2] from the AFH if staff could not care for [him/her] properly. I provided information regarding [his/her] diagnoses and answered their questions."
"03/11/2025 - (Email received from Licensee A) - Today, the staff went after [him/her] and tried to convince [him/her] to come back and wait for you inside the house. [S/he] refused and screamed at [him/her]. [S/he] stayed with [him/her] for a little bit but ended up going back to check on the other resident and to get [him/her] phone to call the police and myself at 2:23 pm. Unfortunately, I didn't answer and by the time the other managers told [him/her] to call 911 [CM H] you were able to return [Resident 2] back home. We re educated the staff and plan on signing [him/her] up again for more caregiver education classes. The staff should have called 911 and reported missing person first which our policy also states. However; [s/he] thought maybe I could have convinced [him/her] to come back inside giving the relatlonship [sic: relationship] I have with [Resident 2]. This is the reason why the police officers became upset with [him/her], and belleved [sic: believed] that neglect has occurred."

On 03/31/2025, Surveyor reviewed Resident 2's police records provided by local law enforcement which documented:
On 03/10/25 at approximately 2:52 pm, there was a 911 disconnect call from [address of home]. While en route, another call came in 18 minutes later from a [case manager], advising that

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M 230	Continued From page 6 [Resident 2] eloped from [his/her] family group home and was walking in traffic on Verona Rd. I located [Resident 2] shortly after that call came in and noted [s/he] was approximately 1.1 miles from the group home. [Resident 2] was walking dangerously close to traffic. [Resident 2] then crossed a lane of travel with no regard to vehicles traveling at a high rate of speed and approached my squad. ... I then returned [Resident 2] to [home] and learned that this was the second time [s/he] had eloped from the address today. I was advised that the first time [Resident 2] eloped was around 2 pm when [s/he] was located by [his/her] [case manager] while [s/he] was en route to meet with [him/her]. At that time, [Resident 2] was across the street of Raymond Rd, another equally busy street. ... At the home, I made contact with a staff member who was unable to speak English, did not verbalize why [s/he] didn't call 911, or go after [Resident 2]. I then spoke with [Licensee A] who stated that [s/he] runs ALIA Community Care. [Licensee A] advised that after [Resident 2] fled, [his/her] employee called [him/her] and [s/he] contacted the [case worker] and had [him/her] call 911, resulting in the delay. Cross Reference: M0414 DHS 88.06(3)(d)2. Level of Supervision	M 230		
M 384	88.06(2)(b) SERVICE AGREEMENT EXCEPT RESPITE An adult family home shall have a service agreement with each person to be admitted to the home except a person being admitted for respite care. The service agreement shall be completed prior to admission and revised at least 30 days prior to any	M 384		

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M 384	Continued From page 7 change. The service agreement shall be dated and signed by the licensee and the person being admitted or the persons guardian or designated representative. Copies shall be provided to all parties and to the placing agency, if any. This Rule is not met as evidenced by: Based on record review and interview, the provider did not have a service agreement for 1 of 1 resident (Resident 1) prior to admission. The provider did not have a signed service agreement that was dated and signed by the person being admitted or the guardian or designated representative, or the licensee. Findings include: On 03/17/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the home on 09/23/2024 and is his/her own person. Resident 1's service agreement did not contain his/her signature. The licensee typed a date of 01/28/2024 on their designated signature line, with no signature. On 03/18/2025, at approximately 10:30 AM, Surveyor interviewed Licensee A. Licensee A stated s/he would review Resident 1's record and determine what documentation was not completed.	M 384		
M 406	88.06(3)(b) PERSONS INVOLVED WITH ISP & ASSESSMENT The individual service plan and written assessment shall be developed	M 406		

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by the placing agency, if any, the service coordinator, if any, the licensee, the resident and the resident's guardian, if any and designated representative, if any, with the resident participating in a manner appropriate for the resident's level of understanding and method of communication.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure the Individual Service Plan (ISP) for 2 of 2 resident (Resident 1 and Resident 2) were developed together with the resident or the resident representative, the placing agency and the provider.

Findings include:

The provider is licensed to provide care for up to 3 residents in the client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, traumatic brain injury, and/or developmentally disabled.

Example 1: Resident 1

On 03/17/2025, at approximately 11:15 AM, Surveyor observed Resident 1 sitting at the kitchen table and had an unkempt appearance. Surveyor requested Resident 1's record.

Resident 1 moved into the home, 09/23/2024, with diagnoses including attention deficit disorder due to hyperactivity (ADHD), anxiety disorder, and cognitive impairment due to a cerebrovascular accident (stroke). Resident 1

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M 406	Continued From page 9 was his/her own person and was represented by managed care organization (MCO) Care Manager (CM) D, the placing agency. Resident 1's "Behavior Support Plan," which was being utilized as his/her current ISP, was dated 09/27/2024 and updated 02/25/2025, was not signed by Resident 1, CM D or the provider. Example 2: Resident 2 On 03/12/2025, the department received a concern that a resident had eloped from the home. On 03/17/2025, Surveyor reviewed Resident 2's record. Resident 2 moved into the home, 05/2024, with diagnoses including aggression and mental illness and was represented by Guardian C. Resident 2's "Individual Service Plan," dated 11/14/2024, was not signed by the provider or Guardian C. Resident 2's "Safety Plan," dated 11/14/2024, was not signed by the provider or Guardian C. On 03/18/2025, at approximately 10:30 AM, Surveyor interviewed Licensee A. Licensee A stated s/he would review Resident 1's and Resident 2's record and determine what documentation was not completed.	M 406		
M 414	88.06(3)(d)2 LEVEL OF SUPERVISION Identification of the level of supervision required in the home and	M 414		

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community.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure 3 of 3 (Resident 1, Resident 2, and Resident 3) individual service plans (ISP) reviewed contained the level of supervision required in the home and community. Census 3.

Findings include:

The provider is licensed to provide care for up to 3 residents in the client groups: emotionally disturbed/mental illness, irreversible dementia/Alzheimer's, advanced aged, traumatic brain injury, and/or developmentally disabled.

On 03/12/2025, the department received a concern that a resident was able to elope from the home twice in one day.

On 03/16/2025, at approximately 11:30 AM, Surveyor observed Resident 1 walk out the front door of the home. Caregiver B asked Resident 1 where s/he was going. Resident 1 stated s/he was going out to smoke.

On 03/16/2025, at approximately 12:00 PM, Surveyor interviewed Caregiver B. Surveyor asked if there were residents in the home that were elopement risks. Caregiver B explained that Resident 1 had been known to leave the home and Resident 2 had eloped from the home a few days earlier.

On 03/16/2025, Surveyor reviewed Resident 1's, Resident 2's, and Resident 3's record.

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M 414	Continued From page 11 Example 1: Resident 1 Resident 1 moved into the home, 09/23/2024, with diagnoses including attention deficit disorder due to hyperactivity (ADHD), anxiety disorder, and cognitive impairment due to a cerebrovascular accident (stroke). Resident 1's "Behavior Support Plan," being utilized as his/her current ISP, dated 09/27/2024 and updated 02/25/2025, documented: "Elopement: [Resident 1] has been observed leaving the residence area. Elopement: [Resident 1] had left the facility and relocated after missing several days. The AFH (adult family home) staff dropped off [Resident 1] at [location] and [Resident 1] left with friends. Members will ask the pedestrian or anyone [s/he] sees for cigarettes, cocaine, tobacco or items. Members will ask the pedestrian if [s/he] can go home with them. Member refuses guidelines or directions from the staff." "Missing Person Response Plan: Missing person is defined as any instance when [Resident 1] physically wanders away and is out of sight (leaves [his/her] residence or a community setting) for any length of time contrary to his care plan." Resident 1's record did not contain a care plan that identified his/her supervision levels or an acceptable length of time away from the home. On 03/22/2025, Surveyor reviewed Resident 1's managed care organization (MCO) documentation provided by his/her MCO provider, which documented: "10/28/2024 - Reviewed email noting member had eloped over the weekend while going outside	M 414		

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to smoke a cigarette. Staff contacted police who found the member sleeping in a neighbors back yard. Per [Licensee A], member continually is attempting to elope from the AFH in order to obtain cigarettes or drugs. ... Behavioral Health Progress Note: BHS (behavioral health services) received a request from member's CM (care manager) to assist with member's elopement concerns. Member's AFH has developed a BSP for member."
"10/29/2024 - AFH has documented several instances where member wanders from AFH without staff's knowledge. BHS asked CM to inquire about capacity for intensive staffing as well as behavioral tracking in order to put together a pattern for behavior."

Example 2: Resident 2

Resident 2 moved into the home, 05/2024, with diagnoses including aggression and mental illness.

Resident 2's "Individual Service Plan," dated 11/14/2024, documented:
"Due to [Resident 2's] high level of symptom interference and impairment in [his/her] judgment and insight, [Resident 2] has limited community living skills."

Resident 2's "Safety Plan," dated 11/14/2024, documented:
"Definition of Medication Compliance ..."
"Definition of Violation of Phone Boundaries or Expectations ..."
"Enforcement of Phone Boundaries ..."
"Definition of Aggression ..."
"Making Environment Safe ..."

Resident 2's ISP and Safety Plan did not discuss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019468	A. BUILDING: _____ B. WING _____	C 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIA COMMUNITY CARE LLC	2322 HARLEY DR MADISON, WI 53711

(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 414	Continued From page 13 that Resident 2 was an elopement risk and what supervision levels s/he required. Example 3: Resident 3 Resident 3 moved into the home 02/12/2025. Resident 3 did not have an ISP that identified supervision levels. On 03/18/2025, at approximately 10:30 AM, Surveyor interviewed Licensee A. Licensee A stated s/he would review Resident 1's and Resident 2's record and determine what documentation was not completed.	M 414		