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 09/15/2025

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 09/08/2025, with information gathered through 09/15/2025, Surveyor conducted a complaint investigation at Alia Community Care LLC. One deficiency was identified. Complaint was unsubstantiated. Census: 2	M 000		
M 438	88.07(2)(b) SERVICES DIRECTED TO GOALS Services shall be directed to the goal of assisting, teaching and supporting the resident to promote his or her health, well-being, self-esteem, independence and quality of life. The services shall include but are not limited to: This Rule is not met as evidenced by: Based on interview and record review, the Licensee did not ensure 1 of 1 resident were provided with services that assisted, taught, and supported the resident to promote his/her health, well-being, self-esteem, independence, and quality of life. Resident 1 required step-by-step communication during bathing/showering, which was not provided, which resulted in him/her feeling traumatized. Findings include: On 09/08/2025, at approximately 8:05 AM, Surveyor interviewed Assistant Manager B. Surveyor asked if any residents had expressed concerns that they had been abused by a staff	M 438		

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

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M 438	Continued From page 1	M 438		

member. Assistant Manager B stated Resident 1 had expressed concerns and staff were required to retake resident rights training and abuse and neglect training.

On 09/08/2025, at approximately 8:30 AM, Surveyor interviewed Caregiver C. Surveyor asked if any residents had expressed concerns that they had been abused by a staff member. Caregiver C stated Resident 1 had expressed concerns that a staff member harmed him/her during peri care. Caregiver C explained that when cares are provided to Resident 1, the staff member must explain each step and ensure Resident 1 has recognized what the next step is and that s/he is ready for the next step to be completed.

On 09/10/2025, Surveyor reviewed Resident 1's record.

Resident 1 moved into the home 02/12/2025.

Resident 1's daily notes documented:
07/31/2025 - Later in the day, staff assisted [Resident 1] with a shower, and they took their medications. During this time, [Resident 1] shared concerns about a previous shower experience. They expressed feeling sad and depressed because their last shower, which took place three days ago, did not go well. Staff apologized and reassured them that they can talk to us anytime, and that we are here to support them.
08\01\2025 - [Resident 1] went to bed early, but they came out when I got there. angry and they expressed how mad they were at the [fe/male] staff that helped them with the shower weeks ago. They said [s/he] was helping them in the shower, they said [s/he] was in such a rush to

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clean their genitals that they started to bleed ever since. ... They (Resident 1) talked about it with their social worker who told them that it was an assault and that they should think about filing a police report. I encouraged them to let the management know and that actions should be taken. They (Resident 1) did, and [Manager B] is coming over today to talk about.

Resident 1's incident report, dated 07/31/2025, written by Manager A, documented:
"[Resident 1] reported that [Caregiver D] gave them a shower, possibly on July 11th. On July 30th, [Resident 1] stated that [Caregiver D] did not follow the instructions for giving them a shower, such as being gentle when cleaning their body and talking through the steps. [Resident 1] reported that the staff scrubbed their body hard and wiped their private area from front to back firmly with a washcloth. Since then, [Resident 1] reported experiencing ... pain. ... [Resident 1] also told the house manager that their case manager had said this incident "seems like an assault."

Resident 1's individual service plan, dated 06/10/2025, documented:
"The direct caregivers have completed training about recognizing, preventing, managing, and responding to challenging behaviors and monitoring changes in the member status."
"Presenting Challenge from the Individual's Perspective: Member is struggling to seek or allow help from AFH (adult family home) staff. Member does not feel comfortable with [fe/male] staff. Member suffers from anxiety and touches be fe/male staff during showers can be triggering."
"Triggers: Feeling like staff is touching them without their permission/Staff not saying loud

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what they are doing during showers/feeling like being touched without their permission/Staff not saying loud what they are doing during showers. Interventions: Staff will ask permission before initiating any physical contact during personal care. Staff must clearly and audibly announce each step during the shower process. Use calm/respectful tones and give [Resident 1] time to respond before proceeding with each step."

On 09/10/2025, Surveyor reviewed Resident 1's managed care organization (MCO) documentation which was provided by his/her MCO provider, which documented: 08/20/2025: Shower incident: New staff member allegedly failed to follow bathing protocol, did not verbally explain actions thoroughly, and was physically rough, resulting in bleeding due to the member's surgical history and skin sensitivity. Member described this as sexual assault. Staff member [Caregiver D] reportedly stated they acted based on assumptions about the member's body size; the Staff member is a larger [fe/male] and felt [s/he] was only trying to make sure the member was clean, as [s/he] is also a larger female. The member feels this explanation was unacceptable. Member does not feel safe in home, reports triggers when passing bathroom where incident occurred, and describes negative impact on mental health, socialization, and overall quality of life.

On 09/15/2025, at approximately 1:40 PM, Surveyor communicated with Licensee E regarding the concern that had been called into the Department. Licensee E stated that Caregiver D was a new staff member, and s/he did not understand that care requirements for Resident 1. Caregiver D was retrained. Manager B had spoken with Resident 1 who informed

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M 438	Continued From page 4 him/her that s/he didn't think Caregiver D had intentionally tried to harm him/her but it was a traumatizing moment.	M 438		