STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015732	A. BUILDING: _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA OF ELKHORN	1550 COUNTRY CLUB PARKWAY ELKHORN, WI 53121

(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
N 000	Initial Comments On 02/01/2024, Surveyor conducted a standard survey at Frontida of Elkhorn. Four deficiencies were identified. Census: 32	N 000		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure complete background checks were conducted upon hire for 1 of 1 employees (Caregiver C) reviewed. The provider conducted a background check on Caregiver C and received the results on 05/18/2022. The results showed that Caregiver C was on the misconduct registry, but Caregiver C was allowed to work until the day of survey (01/30/2024). This presented a potential risk to the residents of the facility.	N 219		

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

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N 219	Continued From page 1 The complete background check is to include the background information disclosure form (BID), the criminal history search form from the department of justice (DOJ), and the information maintained by the department of safety and professional service regarding a person's credentials (IBIS). Findings include: The provider is able to serve up to 44 residents within the client groups of physically disabled, irreversible dementia/Alzheimer's, terminally ill, and advanced age. On 01/30/2024, Surveyor reviewed employee records and identified the following: The provider conducted a full caregiver background check when Caregiver C was hired on 05/18/2022. A review of the IBIS letter dated 05/18/2022 indicated Caregiver C had a finding of abuse dated 12/10/2021. Further review of the IBIS indicates Caregiver C had not completed a rehabilitation review process allowing him/her to work in a Department regulated facility. A review of the Wisconsin Caregiver Misconduct Registry confirms Caregiver C was placed on the registry due to substantiated finding of abuse. The registry indicates Caregiver C cannot work as a caregiver in any Department regulated facility in Wisconsin, except those specifically approved under the rehabilitation review process. A review of the summary of the substantiated findings of abuse documented:	N 219		

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N 219	Continued From page 2 "Caregiver Name: [Caregiver C] DQA report #190617 Incident: -Date Occurred: June 28th 2021 -Description: Caregiver yelled and sweared at a resident, including calling the resident names. -Decision: Abuse -Date Finding Placed On Registry: December 10, 2021." On 01/30/2024 at 1:15 PM, Surveyor interviewed Director of Operations (DOO) A, VP Clinical Services (VPCS) B, and Caregiver C. Caregiver C confirmed his/her identifying information on the IBIS letter belong to him/her. Caregiver C denied knowing about finding of abuse and being placed on the misconduct registry. Caregiver C asked if s/he had these findings, how did s/he get his/her current position in May 2022. Surveyor noted the provider did not complete a thorough review of Caregiver C's background check upon hire. DOO A and VPCS B stated the provider took over as the management company 06/01/2022 and was told their current employees were compliant with DHS Chpt 83. DOO A and VPCS B stated they were unaware of Caregiver C's finding of abuse and acknowledged s/he should of never been hired. DOO A and VPCS B stated they would suspend Caregiver C immediately following an investigation into his/her hire.	N 219		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the	N 352		

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N 352	Continued From page 3 right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 6 received prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 6 missed 14 doses of his/her Tramadol during January 2024. Findings include: On 01/30/2024, Surveyor reviewed resident records and identified the following: Resident 6 was admitted to the facility on 11/21/2021 with diagnosis including Parkinson's disease, Alcoholic fatty liver, and rheumatoid arthritis. Resident 6 was his/her own legal decision maker. Resident 6's physician orders included: "Tramadol 50 mg, take 1 tab every 12 hours (8am and 8pm) for chronic pain with a start date of 07/28/2023." Resident 6's January 2024 Medication Administration Record (MAR) documented 14 occurrences where his/her Tramadol was not available: " 01/04/2024-8am-Medication not available 01/06/2024-8am-Medication not available 01/06/2024-8pm-Medication not available 01/07/2024-8pm-Medication not available 01/09/2024-8am-Medication not available 01/10/2024-8pm-Medication not available 01/11/2024-8am-Medication not available 01/12/2024-8am-Medication not available	N 352		

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N 352	Continued From page 4 01/12/2024-8pm-Medication not available 01/14/2024-8am-Medication not available 01/15/2024-8am-Medication not available 01/20/2024-8am-Medication not available 01/20/2024-8pm-Medication not available 01/29/2024-8am-Medication not available." Resident 6's progress notes dated 01/02/2024 documented: "Some medications for residents are not accounted for due to zero refills the MD has been notified and will contact pharmacy for medication refills." The record did not include any other evidence to show the provider followed up with the pharmacy to see the status of Resident 6's Tramadol. On 02/01/2024 at 3:10 PM, Surveyor interviewed Director of Operations (DOO) A regarding Resident 6's Tramadol. DOO A acknowledged 14 missed administrations of Tramadol was a concern and stated s/he would follow up with the nurse and get back to the Surveyor. On 02/05/2024 at 7:24 PM, VP Clinical Services (VPCS) B sent the following email to the Surveyor: "Upon further audit of the January MAR, it appears the scheduled Tramadol was administered inconsistently. [Resident 6] is [his/her] own person and sees an outside provider. Education regarding the importance of strict adherence to medication compliance and following MD orders will be provided on 2/6/24 and documented as such. We will then redelegate med passers accordingly."	N 352		
N 441	83.39(3) Hand washing.	N 441		

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N 441	Continued From page 5 Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure employees followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards. Caregiver C did not wash or sanitize hands between each resident during medication administration. Findings include: In October 2002, the CDC published the "Guideline for Hand Hygiene in Healthcare Settings." This guideline sets the standard for caregivers regarding glove use and hand washing to prevent the spread of infections. The CDC has recommended that caregivers wash their hands before having direct contact with residents, after contact with a resident's intact skin, after contact with body fluids or excretions, if moving from a contaminated-body site to a clean-body site during cares, after contact with inanimate objects and after removing gloves. On 01/30/2024 at 11:04 AM to 11:15 AM, Surveyor observed Caregiver C administer medications. The medication cart was stationed in the dining room and Caregiver C unlocked the medication cart using a set of keys that s/he had on their person. Surveyor did not observe any hand sanitizer on the medication cart. At 11:04 AM, Caregiver C prepped Resident 1's medications then administered medication to Resident 1. Surveyor did not observe Caregiver C	N 441		

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N 441	Continued From page 6	N 441		

perform hand hygiene prior to prepping Resident 1's medication. Caregiver C returned to the medication cart and signed out Resident 1 's medication on the laptop.

At 11:08 AM, Caregiver C returned to the medication cart and prepped Resident 2's medications. Caregiver C followed Resident 2 inside a bathroom off the dining room to watch Resident 2 apply Bio freeze gel to their lower back. Surveyor asked Caregiver C if s/he performed hand hygiene while in the bathroom. Caregiver C stated "no." Caregiver C returned to the medication cart and signed out Resident 2's medication on the laptop.

At 11:11 AM, Caregiver C prepped Resident 3's medication, which included Diclofenac 1% gel. Caregiver C donned gloves, rubbed gel on Resident 3's fingers/hands, and doffed gloves. Caregiver C returned to the medication cart and signed out Resident 3's medication on the laptop.

At 11:13 AM, Caregiver C prepped Resident 4's medication and retrieved yogurt from top of the medication cart. Caregiver C donned a glove to his/her left hand to crush Resident 4's Buspirone, doffed the glove, then administered Resident 4's medication in yogurt. Caregiver C returned to the medication cart and signed out Resident 4's medication on the laptop.

At 11:15 AM, Caregiver C prepped Resident 5's medications, administered the medication to Resident 5 in his/'her room (touching Resident 5's doorknob twice), returned to the medication cart and signed out Resident 5's medication on the laptop.

Between 11:04 AM to 11:15 AM, Caregiver C was

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N 441	Continued From page 7 not observed to conduct hand hygiene. On 01/30/2024 at 1:15 PM, Surveyor interviewed Director of Operations (DOO) A and VP Clinical Services (VPCS) B regarding Caregiver C not conducting hand hygiene during medication administration. VPCS B acknowledged staff are trained on hand washing during orientation. DOO A and VPCS B stated staff have access to hand sanitizer through the facility at wall stations and in the backstock. DOO A and VPCS B stated they would re-educate staff.	N 441		
N 446	83.41(1)(b) Equipment. Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure all equipment and utensils were stored in a clean manner. Findings include: On 01/30/2024 at 9:43 AM, Surveyor toured the kitchen of the facility. Surveyor observed the following: -Inside the walk-in cooler, observed brown and red liquid spills that were stuck to the floor. The spills were visible upon entering the walk-in cooler.	N 446		

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N 446	Continued From page 8 -Inside the walk-in freezer, observed food crumbs spread across the floor. -The 3 compartmental sinks had old food covering the bottom of each sink basin. No staff were observed cleaning pot or pans. -The flat top grill was discolored and covered in grease stains. The wall to the right of the flat top grill was covered in brown grease stains. -The conventional oven's door had dried liquid stains running down the door in a dripping appearance. On the floor next to the conventional oven, observed food crumbs. -The conventional oven top was covered in food crumbs and dried liquid spills were stuck to the 6 burners. On 01/30/2024 at 1:15 PM, Surveyor interviewed Director of Operations (DOO) A and VP Clinical Services (VPCS) B. Surveyor reviewed photos taken during the tour of the provider's kitchen. DOO A acknowledged the kitchen needed to be cleaned better. DOO A stated s/he would address the above issues with the cook.	N 446		