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 _____	R-C 06/06/2024

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

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{N 000}	Initial Comments On 05/30/2024 to 06/06/2024, Surveyor conducted a complaint investigation and verification visit at Frontida of Elkhorn. Two deficiencies were identified. One of 2 deficiencies was a repeat violation. See statement of deficiency (SOD) W48K12, dated 06/30/2022. All deficiencies from SOD NLJO11, dated 02/02/2024 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 31	{N 000}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 7 received prompt and adequate treatment that was appropriate to the resident's needs. Resident 7 sustained a change of condition related to a stroke and did not receive care timely. This is a repeat deficiency. See statement of	N 353		

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

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N 353	Continued From page 1 deficiency (SOD) W48K11, dated 12/08/2021. Findings include: On 04/03/2024, the Department received a complaint alleging care was not provided after a change in condition. On 05/30/2024, Surveyor reviewed resident records and identified the following: Resident 7 was admitted to the facility on 03/05/2021 with a diagnosis of dementia with behavioral disturbances. Resident 7 had an activated healthcare power of attorney. Resident 7's individual service plan (ISP) dated 03/05/2024 documented: "Staff will ensure resident transfers independently and safely. Staff will ensure resident safely repositions independently. Ambulation: Ambulatory. " No assisted devices were noted on Resident 7's ISP. Resident 7's progress notes documented: "03/31/2024: Upon waking up at 7:15 am resident was unable to bear weight and was lethargic. Resident's vitals were obtained at 7:30 am and BP was 150/108 with a temp of 96.7. ROM was performed with resident and [s/he] was able to squeeze writers hand and hold [his/her] arms up. Resident was placed in a wheelchair and taken to breakfast. Writer checked on resident at 8 am and resident was in good spirits laughing and playing with [his/her] hair. Writer checked on resident again at 9 am and resident was still playing with [his/her] hair and talking to writer. At 9:45 am writer noticed resident began to slump towards the right side in [his/her] chair. Writer called Nurse who directed writer to contact POA. POA agreed to send resident out vie 911.	N 353		

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Resident will be going to Aurora Lakeland. Emergency was called EMTs arrived at 10:30 am, EMTs did vital and ECG. EMTs left with resident at 10:44 am. Blood pressure [136/93] Pulse [94]. Resident had a stoke, resident has a brain bleed is being sent to Saint Lukes Hospital. Resident arrived to Saint Luke's Neuro ICU. Resident had MRI showed side right IPH. Hospital working on keeping residents blood pressure down.
04/01/2024: ...Stroke Consult Note: [Resident 7] ...originally presented to Lakeland ED on 03/31/2024 via EMS from NH for L side weakness ....On 03/31/2024 shortly prior to arrival in the ED (11am) staff were getting patient out of bed to [his/her] wheelchair when they noticed [s/he] was slumped to the L, and not talking as much. At baseline [s/he] is AOx1, only responds in one word answers that are usually incorrect. In field [s/he] was noted to be not moving on [his/her] L side but able to squeeze [his/her] R hand. In the ED a head CT was obtained revealing a large 95cc globular looking IPH with some SAH extension ....BP max 188/84 and was started on a Cardene gtt ....Neurosurgery discussed surgical options with [husband/wife] and ultimately decided to pursue medical management with plans for transition to comfort cares if [s/he] does not improve."

The provider's investigation dated 03/31/2024 concluded:
"In reviewing the investigation findings, staff statements, nurse and hospital evaluation notes, the facility concludes that no caregiver misconduct occurred. The staff responded to changes in the resident's medical condition in a reasonable amount of time and with appropriate escalation. The incident did present an opportunity to provide additional education and training. The nurse reviewed the change of

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condition guide with lead caregiver to define expectations for communicating and guidance for responses to resident acute changes in condition. Information reviewed included change of condition, interventions, when to notify Manager/ Manager On Call, emergency Care, Call 911, Possible Documentation. RN, team leader, MCO case manager, MD and family were aware. Facility actions: Education for lead caregiver. Follow up communication with family and MCO case manager."

A review of the provider's witness statements noted the following:
-Caregiver E: "I got there about 9:30. I saw that [Resident 7] was leaning which is not normal for [him/her]. [S/he] was also sitting in a wheelchair which is not normal for [him/her]."

Caregiver G: "I noticed that [Resident 7] was in a WC, I asked [Caregiver H] why, [Caregiver H] said [s/he] was dealing with it. Then [Resident 6] got very frustrated later and started yelling at people, you need to call 911. I told [him/her] we have protocols, and [Caregiver H] is dealing with it."

Caregiver I: "We were in morning huddle getting report. [Caregiver E] said that [Resident 7] was not bearing weight today and [Caregiver H] had told [him/her] to get a set of vitals. [Caregiver E] thought that [his/her] B/P was a little high.

[Caregiver H] said that the B/P is within [Resident 7's] normal range. [Resident 7] was sitting in [his/her] W/C in the dining room where we could see [him/her] leaning to [his/her] left."

Resident 6: "Around 6:30 AM, [Resident 7] was slumped over on the side of [his/her] chair. I

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asked [Caregiver G] what's going with [him/her]. [S/he] was just out of it. [Caregiver G] was rather rude and told me [Caregiver H] is assessing the situation and is monitoring [him/her]. I said that's a line of crap, [s/he] needs to go to the hospital. When they got [him/her] out of bed, [his/her] blood pressure was elevated, [s/he] was not mobile or responsive and they just put [him/her] in a wheelchair. Some agency person says, put [him/her] back in bed so finally an hour later they decide they're going to send [him/her] to the hospital ....They should have acted a lot quicker. I expressed this to them."

Caregiver J: "I did a check and change at about 1 and 3 A.M. [Resident 7] was [his/her] normal self. I was getting [him/her] dressed for the day and noticed [s/he] had poor weight bearing on [his/her] left side. [Caregiver E] helped me put [him/her] back in bed. We told [Caregiver H] and [s/he] told us to get vitals."

Caregiver H: " ....Did [s/he] eat any of [his/her] breakfast or try to feed [him/herself] at all? Then what happened? [S/he] didn't eat breakfast or attempt to feed [him/herself] at all. [His/her] right UE was dangling around 9:45 / 9:50. Then we conducted huddle. I looked up and [s/he] was leaning a lot more."

On 05/30/2024 at 11:55 AM, Surveyor interviewed Resident 6. Resident 6 stated s/he came out to the dining room at approximately 6:30 am on 03/31/2024. Resident 6 stated s/he observed Resident 7 slouched in his/her wheelchair with his/her hand dangling on the floor. Resident 6 stated Resident 7 usually was walking around the facility, so seeing him/her in a wheelchair was strange. Resident 6 stated s/he reported Resident 7's change of condition to Caregiver G who noted

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N 353	Continued From page 5 Caregiver H was taking care of it. Resident 6 noted Resident 7 never moved, did not eat, and right at shift change at 10 am, staff finally got concerned and called 911. Resident 6 stated s/he urged staff to call 911 sooner but no one ever did. Resident 6 stated his/her tablemate (Resident 8) observed the incident as well. On 05/30/2024 at 12:55 PM, Surveyor interviewed Resident 8. Resident 8 stated on 03/31/2024, s/he came to the dining room at approximately 9 am. Resident 8 stated upon sitting down, s/he observed Resident 7 slouching to the left in his/her wheelchair. Resident 8 stated Resident 7 is usually up walking so to see him/her in a wheelchair was surprising. Resident 8 stated s/he could not recall if staff were engaging with Resident 7 while s/he was slouched over but do recall around shift change (10 am), 911 was called. On 05/30/2024 at 1:15 PM, Surveyor interviewed Executive Director D. Surveyor noted interviews reported Resident 7 was observed leaning in his/her wheelchair as early as 6:30 am and 9:00 am on 03/31/2024. Surveyor expressed concern staff documented as early as 7:15 am on 03/31/2024, Resident 7 could not bear weight, which would be a change in condition from him/her ambulating the day before and not needing a wheelchair. Surveyor continued to note Resident 7's blood pressure was elevated without additional checks completed until 911 was called. Surveyor stated the record did not indicate additional range of motion checks were completed or any other interventions to assess Resident 7's change in condition. Executive Director D stated the above incident occurred before s/he started but would report findings to his/her supervisor.	N 353		

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N 487	83.44(1)(b) Separate laundry storage areas or containers Storage and transport. The CBRF shall have separate clean and dirty laundry storage areas or containers. Storage containers shall be clean, leak-proof and have a tight fitting lid. The CBRF may not transport, wash or rinse soiled laundry in areas used for food preparation, serving or storage. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure separate storage areas or containers were provided for clean and soiled laundry. Findings include: On 05/30/2024 at 10:51 AM, Surveyor toured the facility. Outside the laundry room, Surveyor observed 5 resident laundry baskets filled to the top with soiled clothing and bedding. Surveyor observed dried brown substance consistent with fecal matter on soiled bedding exposed to the air. Three of 5 laundry baskets did not have lids and soiled items were observed piled to the top. Inside the laundry room, Surveyor observed 3 resident laundry baskets containing soiled clothing next to the washer. On top of the washer, observed 1 laundry basket full of hoyer slings that appeared dirty. Additionally, Surveyor noted a pile of dirty resident clothing on the floor and in the sink area. The room contained a strong urine-like odor. On 05/30/2024 at 11:15, Surveyor interviewed Caregiver K. Caregiver K stated the facility was without 1 of 2 washers for approximately 30 days	N 487		

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N 487	Continued From page 7 and just last week, a new 1 was installed. Caregiver K noted the provider was behind in laundry and staff are working to catch back up. On 05/30/2024 at 1:15 PM, Surveyor interviewed Executive Director D regarding the provider's laundry system. Executive Director D confirmed s/he observed the soiled resident laundry baskets sitting outside the laundry room upon arriving to the facility. Executive Director D stated the facility recently purchased a new washer, so staff were working to catch up. Executive Director D acknowledged an understanding of the concern and noted s/he will work with staff.	N 487		