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 10/14/2024

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 10/14/2024, Surveyor conducted a complaint investigation and verification visit at Frontida of Elkhorn. One deficiency was identified. One of 1 deficiency was a repeat violation. See Statement of Deficiency (SOD) JG2W12, dated 02/27/2020. All deficiencies from SOD NLJO12, dated 06/06/2024 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200.00 revisit fee is being assessed. Census: 27	{N 000}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.	N 389		

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
	0015732	A. BUILDING: _____ B. WING _____	R-C 10/14/2024

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 389	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Individual Service Plans (ISPs) were updated to reflect the needs of Resident 9. Resident 9's ISP was not updated to include an updated fall management plan when s/he experienced 8 falls from 05/01/2024-07/25/2024. This is a repeat violation. See Statement of Deficiency (SOD) JG2W12, dated 02/27/2020. Findings include: On 10/14/2024, Surveyor reviewed Resident 9's record and identified the following: Resident 9 was admitted to the facility on 12/14/2023 with diagnosis including anxiety, type 2 diabetes, recurrent seizures, and cognitive communication deficit. Resident 9 had an activated healthcare power of attorney. Resident 1 discharged on 08/01/2024. Resident 9's ISP dated 07/25/2024 documented: "Extensive Fall Prevention Program-Mental Status: Eights falls from May 1 to present day. Face received bruising bilaterally, dissipating to minimal at this time. Repositioning Assistance: Requires assistance for proper positioning in bed. Able to help with bed mobility using legs/arms with staff present. Transferring Assistance: Staff to provide physical assistance for transfers, standing assistance with pivot transfers as needed." Resident 9's progress notes documented; "-07/17/2024: Therapy came up to writer and let them know resident was on the floor.	N 389		

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 10/14/2024

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 389	Continued From page 2 -07/04/2024: Resident bed alarm was put in [his/her] wheelchair. -07/01/2024: Resident will be returning by ambulance around 3pm. Hospital bed was delivered and set up in resident's room. -06/30/2024: Resident is currently at hospital, [s/he] has 2 broken bones in [his/her] nose and is very bruised up facially. Lakeland is keeping [him/her] until Monday afternoon, upon [his/her] return hopefully Gentiva hospice will be picking [him/her] up on their services ....Spoke with Gentiva nurse who also spoke to [son/daughter] and they are admitting [him/her] tomorrow if discharges as planned. Writer requested a hospital bed with scoop mattress and family is asking for a bed alarm which we need a waiver in order to use. -06/29/2024 at 1:14 AM: At 11:08 PM, Emergency department called to notify resident was on [his/her] way back to facility ...At 11:50pm, Resident arrived back at the facility. Resident was in bed and call light was placed on resident. Staff went to count med cart B. At 12:11pm (sic) staff went to update ALIS and another went to switch load of laundry and then went back to put eyes on resident. Resident lights were off, staff turned the small one on to put eyes on resident. Resident had made it all the way over by [his/her] dresser with the tv. Resident was bleeding from Right side of [his/her] head. Resident was found gargling on [his/her] own blood. 911 was called at 12:37AM. Resident sent back to Lakeland hospital. Lakeland called back that facility at 1:23AM stating facility is incompetent of taking care of residents.	N 389		

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 10/14/2024

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 389	Continued From page 3 -06/28/2024: Resident was found by another aid on the floor at 8:30PM. The Aid called for writer, upon writer walking into [his/her] wheelchair tipped over, residents legs were up in the air on [his/her] wheelchair. Residents pants were at [his/her] ankles. Writer noticed that there was blood from residents left side of head ...Notified: 911 was called. EMTS arrived at 8:49PM and transported resident to Aurora Lakeland Hospital ....Skin assessment: Residents eyes are red, nose appears swollen with a small cute, under residents left eye appears to have open area, above residents left eye brow there is an open area and a large bump about the size of half a baseball. 4:48PM: Resident was at the front desk playing with 4th of July decorations and went to walk away when [s/he] almost walked into a chair near the desk. [S/he] stumbled then tripped over [his/her] own feet and fell. -06/24/2024: Writer was going in to give resident 10 o'clock meds and resident was laying on [his/her] side on the floor next to [his/her] bed. -06/10/2024: Therapy: Please monitor room, ensure recliner unplugged and control placed behind chair as [s/he] requires supervision with using controls. -06/04/2024: Therapy: Placement of pool/noodle pillow when in bed for fall safety." -06/03/2024: Writer went to give resident [his/her] meds and found resident sitting on [his/her] bathroom floor. Resident was covered in blood, [his/her] nose swollen and a scrape on the bridge of [his/her] nose.	N 389		

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 10/14/2024

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 389	Continued From page 4 -05/26/2024: Another staff member came to get writer due to resident falling. When writer went into resident room, resident was on the found on [his/her] back in between bed and nightstand. -05/15/2024: Resident was paging on call button aide went see what resident needed and found resident on floor." The ISP was not updated to include new interventions such as hospice services, fall mat, hospital bed/ air mattress, pool noodle/pillow for positioning, and wheelchair alarm. Surveyor did not observe any signatures on Resident 9's ISP indicating that it was reviewed. Resident 9's change of condition assessment dated 05/13/2024 documented: "high risks for falls. Notes-Details of fall: Fall with nose fracture in [his/her] apartment. 4-16-24 fall-offer portable commode with handles over toilet." On 10/14/2024 at 10:30 AM, Surveyor interviewed Caregiver K regarding Resident 9's falls. Caregiver K reported Resident 9 liked to self-transfer during admission and confirmed s/he did have a lot of falls this summer. Caregiver K reported the provider used a fall mat, bed alarm, and frequent checks as approaches for Resident 9's fall risk. On 10/14/2024 at 11:52 AM, Surveyor interviewed Hospice Worker L regarding Resident 9's falls. Hospice Worker L stated s/he remembers Resident 9 because s/he was the man/women that kept falling at the facility. Hospice Worker L reported after Resident 9 started hospice services the following equipment was delivered on 07/01/2024: wheelchair alarm, fall mat, electric low bed, and alternating pressure mattress.	N 389		

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 10/14/2024

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 389	Continued From page 5 Hospice Worker L stated Resident 9 discharged from their services on 08/01/2024 and equipment picked up on 08/06/2024. On 10/14/2024 at 12:28 PM, Surveyor interviewed Executive Director D, Regional Nurse N, and Executive Director O. Surveyor asked about lack of fall interventions in Resident 9's ISP after 8 documented falls. Regional Nurse N reported Former Nurse M was responsible for updating resident care plans. Executive Director D and Regional Nurse N confirmed Resident 9 used the above interventions during his/her admission. Regional Nurse N reported within the provider's electronic record, staff can see another area under care plans that may contain more fall interventions. Regional Nurse N showed Surveyor Resident 9's "care plan" on a laptop that did not include the above interventions staff were using.	N 389		