

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020960	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/08/2026
NAME OF PROVIDER OR SUPPLIER ALLOUEZ SENIOR LIVING 1 BY FRONTIDA		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 LIBAL STREET GREEN BAY, WI 54301		
(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 07/06/2026 with additional information gathered through 07/08/2026, Surveyor conducted a complaint investigation at Allouez Senior Living 1 by Frontida. As a result, 1 of 1 complaint was substantiated and 1 deficiency was identified. Census: 35	N 000		
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 right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received all medications as prescribed. Resident 1 had scheduled dentist appointments on 04/13/2026 and 04/15/2026 and had orders for Amoxicillin to be administered 1 hour prior to dental appointments. Resident 1 did not receive his/her Amoxicillin as ordered. Findings include: On 04/16/2026, the Department received a complaint alleging concerns with medication administration. On 07/07/2026, Surveyor conducted a complaint investigation at the facility. A sample of resident	N 352		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 352	Continued From page 1 records was selected including the record of Resident 1. Surveyor reviewed Resident 1's record and noted the following: Resident 1 admitted to the facility on 06/14/2023 with diagnoses to include Type 2 diabetes, hypertension, hyperlipidemia, congestive heart failure, xenogeneic heart valve (valve replacement sourced from an animal) and visual impairment. Resident 1 was his/her own decision maker and has a managed care organization (MCO). Resident 1's "Annual - Resident Evaluation" completed by Registered Nurse (RN) A on 06/13/2026 included a section titled "Medication Administration" with the option to "choose - one or more" and there were 10 boxes and 1 of the boxes was checked next to "whole." There was an additional section titled "Self Control and Self Administer Meds" with the option to "choose - one" and 2 boxes with "No" or "Yes" and the "No" box was checked. (Surveyor note: Resident 1's Individual Service Plan (ISP) signed 06/13/2026 was silent to his/her needs related to medication administration.) Resident 1's April 2026 Medication Administration Record (MAR) reflected, "Give PRN Amoxicillin prior to dentist appointment," scheduled for 11:00 AM with a start and end date of 04/15/2026. There was a discontinue date of 04/16/2026 due to "end date for medication reached." Listed under the "Exception Reason" it reflected Resident 1's Amoxicillin was not administered due to "Other - Rescheduled." The MAR also reflected "Amoxicillin 500 mg [capsule]" and "added on 04/01/2026" with a start date of 04/15/2026. The instructions were to "take 4 capsules by mouth 1 hour prior to dentist	N 352		

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N 352	Continued From page 2 appointment." Resident 1's MAR reflected s/he was administered 4 capsules of Amoxicillin on 04/15/2026 at 8:17 AM for "Prep for dentist" with "[Appointment] rescheduled." On 04/29/2026, Resident 1 was administered 4 capsules of Amoxicillin at 10:00 AM "for dentist [appointment]" and "effective." Review of a physician order for Amoxicillin 500 mg capsules, dated 03/31/2026 with instructions to "take 4 [capsules] by mouth 1 hour prior to dental appointments. Refill [times] 5." Resident 1's observation notes from 03/31/2026 to 04/29/2026 noted the following: - 03/31/2026, 2:06 PM completed by Licensed Practical Nurse (LPN) B: "Request sent to provider for pre-dental work antibiotics." - 04/15/2026, 12:40 PM completed by RN A: " ... Regarding 4/13; Antibiotic was not scheduled in the MAR to give as it is listed as a PRN. Med Passer was not able to locate the Antibiotic, so it was not given. [Resident 1] asked med passer if [s/he] got [his/her] medication and med passer thought [s/he] meant [his/her] medications in the AM. Miscommunication resulted in missing dose of the Antibiotic which delayed [his/her] appointment. Dentist appointment rescheduled. Antibiotic scheduled for 1 hour prior to appointment." - 04/15/2026, 1:19 PM completed by RN A: " ... [Resident 1] received scheduled dose of Amoxicillin for dentist appointment at 8:30 AM as [Resident 1] asked med passer if [s/he] could have it for [his/her] dentist appointment. Amoxicillin cannot be given until 1 hour prior to appointment. Dentist office updated and	N 352		

Wisconsin Department of Health Services

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N 352	Continued From page 3 appointment needed to be rescheduled. Appointment rescheduled to 4/29 at 11 AM. Antibiotic reordered and will be given by [Executive Director] or RN at 10 AM. Ride set up ..." - 04/29/2026, 1:34 PM completed by RN A: "Seen at [Dentist Office C] today. No new orders." On 07/07/2026 at 2:09 PM, Surveyor interviewed RN A who confirmed staff administer Resident 1's medication. RN A discussed Resident 1 had a dentist appointment scheduled for 04/01/2026, but they did not have the physician order for the antibiotic. RN A stated s/he was not aware of the appointment because s/he was off at the time and it was entered by House Manager (HM) H. S/he reported the order for the antibiotic was requested from Resident 1's physician on 03/31/2026 but the appointment on 04/01/2026 was rescheduled as they would not have received the antibiotic in time. RN A reported Resident 1's appointment was then rescheduled to 04/13/2026; however, s/he did not receive the antibiotic because "the prompt was not added to the MAR." S/he stated "[Resident 1] needs it 1 hour before the appointment and the prompt needs to be manually entered into the MAR. The antibiotic was in the medication cart, but staff did not know where it was located." RN A reported Resident 1's appointment was again rescheduled for 04/15/2026. S/he stated, "The prompt was added to [Resident 1's] MAR for 11:00 AM for [his/her] 12:00 PM dentist appointment, but it was administered too early. I called the dentist office and had to reschedule the appointment." RN A reported, "Finally on 4/29, I took it upon myself to administer the antibiotic to ensure [s/he] got it." RN A acknowledged Resident 1 did not receive his antibiotic as prescribed for his/her dental	N 352		

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N 352	Continued From page 4 appointments on 04/13/2026 and 04/15/2026 and stated it was a medication error. During an interview with Family G on 07/08/2026 at 3:39 PM, s/he reported Resident 1 is legally blind so s/he helps him/her with his/her appointments and notifies the facility who then sets up transportation. S/he stated after every appointment Resident 1 will bring paperwork back to the facility with any future appointments and gives it to the nurse. Family G stated Resident 1 was having tooth pain due to a cavity that was identified at a previous dental appointment. S/he reported "[Resident 1] has a pig's heart valve so [s/he] needs antibiotics 1 hour prior to any dental work. An infection could kill [him/her]." Family G confirmed Resident 1 had a dentist appointment on 04/13/2026 that was rescheduled from 04/01/2026 when the antibiotic was not available. S/he stated Resident 1 was sent to the dentist office on 04/13/2026 but returned to the facility after the dentist office called the facility to verify s/he received the antibiotic and when they were told s/he did not, they had to reschedule the appointment. Family G reported the appointment was rescheduled again for 04/15/2026 at 12:00 PM, but Resident 1 did not get the antibiotic 1 hour prior to his/her appointment. S/he stated Resident 1's appointment was rescheduled again for 04/29/2026. Family G reported, "[Resident 1] waited almost 1 month to get [his/her] tooth taken care of. [S/he] was eating soup because [s/he] could hardly eat and [s/he] is diabetic." S/he also stated, "This could have had a sad outcome. I just don't want this to happen to anyone else. They need a better system in place. This was a huge miss and is unacceptable." On 07/07/2026 at 1:00 PM, Surveyor interviewed RN A, Executive Director (ED) D, Vice President	N 352		

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N 352	Continued From page 5 of Clinical Operations (VP-CO) E and Senior Vice President (S-VP) F. S-VP F acknowledged Surveyor's concern Resident 1 did not receive [his/her] Amoxicillin as prescribed on 04/13/2026 and 04/15/2026.	N 352			