STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 10/12/2023, with additional information gathered through 10/16/2023, Surveyors conducted a complaint investigation and standard survey at Frontida Assisted Living of Kimberly I. One complaint was substantiated. Six deficiencies were identified. Two deficiencies were repeat violations, see Statement of Deficiency F31S11 (dated 09/08/2021). Census: 21	N 000		
N 230	83.19 Orientation Before an employee performs any job duties, the CBRF shall provide each employee with orientation training which shall include all of the following: (1) Job responsibilities; (2) Prevention and reporting of resident abuse, neglect and misappropriation of resident property; (3) Information regarding assessed needs and individual services for each resident for whom the employee is responsible; (4) Emergency and disaster plan and evacuation procedures under s. HFS 83.47(2); (5) CBRF policies and procedures; (6) Recognizing and responding to resident changes of condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 employees (Caregiver B) reviewed obtained all orientation training as required prior to performing any job duties. This is a repeat deficiency, see Statement of	N 230		

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
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 230	Continued From page 1 Deficiency F31S11, dated 09/08/2021. Findings include: The facility is licensed to provide services for up to 22 residents who may be physically disabled, advanced age, emotionally disturbed/mental illness and/or terminally ill. On 10/11/2023, Surveyors reviewed staff records for Caregiver B, who was hired on 10/27/2022. Executive Director (ED) A confirmed Caregiver B had been working in the facility. Caregiver B's employee file had no evidence Caregiver B had all required orientation upon hire and before performing any job duties. There was no evidence Caregiver B was orientated in assessed needs and individual services, job responsibilities and change in condition. On 10/11/2023 at approximately 2:45 PM, Surveyors interviewed ED A. ED A stated s/he talked to human resources and Caregiver B was assigned the incorrect orientation items. ED A stated, "What we have is what we have." The provider did not ensure 1 of 2 staff received all orientation training as required, prior to performing any job duties.	N 230		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 239	Continued From page 2 contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 1 of 2 employees obtained all department approved training as required. Caregiver B, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties. This is a repeat deficiency, see Statement of Deficiency F31S11, dated 09/08/2021. Findings include: On 10/12/2023, Surveyor requested training	N 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 239	Continued From page 3 records from Executive Director (ED) A for Caregiver B. Surveyors reviewed Caregiver B's employee record to verify compliance with department approved training requirements. Standard Precautions The record for Caregiver B, hired 10/27/2022, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 10/12/2023, at approximately 2:45 PM, Surveyor interviewed ED A. ED A confirmed Caregiver B actively performed job tasks that may expose the employee to blood or other bodily fluids. ED A confirmed the provider did not have evidence Caregiver B completed or met an exemption for standard precaution training prior to assuming these job duties. On 10/12/2023, Surveyor verified Caregiver B was not on the Community-Based Care and Treatment training registry for standard precautions. On 10/12/2023 at approximately 2:45 PM, Surveyor interviewed ED A. ED A stated, "What we have is what we have."	N 239		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following: (a) An accurate description of the basic services	N 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 310	Continued From page 4 provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 4 was given an admission agreement in writing and explained orally when s/he moved from one facility to another. Findings include: On 10/10/2023, the department received complaint information that alleged residents did	N 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 310	Continued From page 5 not receive or review admission agreements. On 10/12/2023, Surveyors reviewed Resident 4's record and noted s/he moved into this facility on 03/01/2023 at location 820 Schelfhout Ln. Surveyor reviewed the admission agreement provided from Executive Director A. Surveyor noted Resident 4's admission agreement was dated 08/16/2022 and listed the location address of 816 Schelfhout Ln Kimberly, which was provider's sister facility, Frontida Assisted Living of Kimberly II. Surveyors did not receive an admission agreement for Resident 1 for Frontida Assisted Living of Kimberly I. On 10/12/2023 at approximately 3:11 PM, Surveyors interviewed Executive Director A who verified Resident 4 moved from one provider facility to the other on 03/01/2023 and verified s/he did not review and sign a new admission agreement for this facility.	N 310		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the residents' living environment was clean and homelike. Findings include:	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 481	Continued From page 6 On 10/12/2023 at approximately 1:44 PM, Surveyors toured the facility. The facility was a square with resident rooms located along both hallways and outside walls. Surveyors observed approximately 5 areas throughout the hallway carpets with stains, approximately 2 areas with stains that appeared as liquid drips, and multiple areas with dark wear. On 10/12/2023 at approximately 2:38 PM, Surveyors interviewed Executive Director A who stated the carpet was last cleaned at the beginning of summer. Executive Director A verified there were multiple stains, areas of wear, and that the carpeting needed to be replaced.	N 481		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds, polishes, and toxic substances were stored in a secure area. Findings include: On 10/12/2023 at approximately 1:44 PM, Surveyors and Executive Director A toured the facility. Surveyors observed an unlocked laundry room located in one of the resident hallways. In the laundry room, Surveyors observed a cleaning cart which contained the following substances:	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 499	Continued From page 7 -spray bottle of ammoniated glass cleaner -bottle of toilet bowl cleaner -disinfectant room spray Surveyors observed two shelves spanning across the wall above the washing machines with the following unsecured substances: -17 bottles of multi-surface polish -7 bottles of carpet spotter -2 bottles of ammoniated glass cleaner -2 bottles of heavy duty degreaser -2 bottles of multi-surface polish -1 refill bottle of M-C 10 disinfectant sanitizer -1 refill bottle of AirWox concentrated odor remover At approximately 1:50 PM, Surveyors observed the unsecured hallway located in one of the resident hallways which led to the unlocked garage. Surveyors observed the following unsecured substances on shelves: -2 bottles of toilet bowl cleaner -1 spray bottle of Zep carpet & upholstery spot remover -1 bottle of multi-surface polish -1 bottle of rustoleum spray -1 jug of Raid bug cleaner spray -1 jug of floor polish -1 jug of industrial cleaner -1 jug of bleach -1 jug of Cid-A-L II disinfectant, fungicide, virucide Next to the garage door, Surveyor observed a maintenance closet with the following unsecured substances: -2 jugs of bleach -3 jugs of floor polish -1 jug of carpet cleaner On 10/12/2023 at approximately 2:38 PM,	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 499	Continued From page 8 Surveyors interviewed Executive Director A verified the laundry room with substances was unsecured and acknowledged the garage and maintenance closet with substances were unsecured.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted in 2 quarters in 2022 and 1 quarter in 2023. Findings include: On 10/12/2023, Surveyor reviewed provider's 2022 fire drill documentation and noted fire drills were conducted on 03/31/2022 and 09/23/2022.	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016997	A. BUILDING: _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA ASSISTED LIVING OF KIMBERLY I	820 SCHEFHOUT LANE KIMBERLY, WI 54136

(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 525	Continued From page 9 Surveyor reviewed provider's 2023 fire drill documentation and noted fire drills were conducted on 03/31/2023 and 06/14/2023. No documentation was found for other 2022 fire drills or quarter 3 of 2023 fire drills. On 10/12/2023 at approximately 1:00 PM, Surveyors interviewed Executive Director A who verified there was no other documentation of fire drills and fire drills were not conducted in quarter 2 and quarter 3 of 2022 and quarter 3 in 2023.	N 525		