STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016370	A. BUILDING: _____ B. WING _____	C 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIDA OF MANITOWOC	2210 DUFEK DRIVE MANITOWOC, WI 54220

(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 08/19/2024, with information gathered through 09/04/2024, Surveyor conducted 3 complaint investigations at Frontida of Manitowoc. One (1) of 3 complaints were substantiated. As a result of the survey, 2 deficiencies were issued. Census: 21	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report within 3 working days after law enforcement personnel were called to the CBRF as a result of an incident that jeopardizes the health, safety or welfare of the residents or employees for 1 of 1 (Resident 2) residents reviewed. On 04/12/2024, Resident 2 exited the facility and walked toward the road, staff went out to assist and Resident 2 started fighting with staff. Resident 2 was almost hit by multiple cars and	N 164		

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

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almost fell. Police were notified and came to the facility. The provider did not send a written report to the department regarding the incident.

Findings Include:

On 05/13/2024, the department received a complaint regarding elopement activity.

On 08/19/2024, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the resident record of Resident 2.

Resident 2 was admitted to the facility on 03/08/2024 with diagnoses to include Alzheimer's Disease, dementia with other diseases classified elsewhere, unspecified severity with behavioral disturbance, and anxiety disorder. Resident 2's ISP (Individual Service Plan) dated 04/02/2024 indicated Resident 2 is ambulatory. The ISP also indicated Resident 2 attempts to get out of the building multiple times per day setting off the door alarms. Resident 2 has successfully gotten outside but has not gotten off the property.

A facility observation note for Resident 2 dated 04/13/2024 stated, "A resident [family member] was leaving, resident was trying to give [family member] a hug. [Resident 2] used [his/her] walker and almost knocked the resident over along with me. [S/he] made it out the doors and sat down I told [him/her] its cold out here let's put on a jacket. [S/he] started walking to the road where a coworker came out to assist, [s/he] started fighting us wouldn't stop, almost got hit by multiple cars and almost fell. On-call was notified as well as police. Police made it here talked to [him/her] and tried to keep [him/her] calm."

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N 164	Continued From page 2 Surveyor reviewed the department's facility folder and was not able to locate a facility self-report. On 08/19/2024 at 11:50 AM, Surveyor interviewed Executive Director A. Executive Director A indicated s/he started working at the facility in May 2024. Executive Director A stated s/he would look for any documentation of the incident being reported to the department and email Surveyor. At the time of writing, Surveyor had not received any documentation.	N 164		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide assistance in relocating the resident to ensure that a living arrangement suitable to meet the needs of the resident was available before discharging the resident when a 30 day involuntary discharge notice was given for 1 of 1 (Resident 1) resident reviewed.	N 326		

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N 326	Continued From page 3 Resident 1 was hospitalized on 04/21/2024. On 04/21/2024, the hospital said Resident 1 was ready to return to the facility. The provider refused to take Resident 1 back into the facility and discharged Resident 1 on 04/22/2024. Resident 1 passed away at the hospital on 04/29/2024. The provider did not ensure a suitable placement was found for Resident 1 before discharging Resident 1. Findings include: On 05/13/2024, the department received a complaint regarding involuntary discharges and suitable placement. On 08/19/2024, Surveyor reviewed Resident 1's resident record. Resident 1 was admitted to the facility on 03/22/2024 with diagnoses to include unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and major depressive disorder. On 04/21/2024, Resident 1 experienced behavioral changes including refusal of medications, increased agitation, potential injury to staff and staff unable to manage behaviors. Resident 1 did not respond to redirection, distraction, calming techniques, validation or offers of food or beverages. Police were called and Resident 1 was sent to the emergency room. An observation note dated 04/21/2022 at 11:31PM stated, "Manitowoc PD [police department] contacted writer to discuss best next steps and if 5150 is appropriate. Writer informed [officer] of history of aggressive behaviors at night, failure to respond to behavioral	N 326		

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interventions thus far and hope for review of medications. Stated resident fell asleep at hospital and now resting. Writer informed [officer] resident would be accepted back at community, however, staff would need to contact for assistance again if safety compromised. Requrested writer update [hospital] MD[medical doctor]. MD provided with verbal review of med list including recent change. Confirmed MAR[Medication Administration Record] faxed from community."

An observation note dated 04/22/2024 at 1:32AM stated, "Starting around 7:30PM [Resident 1] got upset after [his/her] family left. [S/he] was upset wondering where [family member] was. Staff members reassured [Resident 1] that [s/he] just ran to the store and would be back. Shortly after that [s/he] became more upset, and staff tried to give [him/her] some ice cream and something to drink to take [his/her] mind off it. [S/he] refused the food and drink and became more aggravated with staff. They tried to sit with [him/her] and talk about trucks/cars, where [s/he] was from, tried to keep [him/her] preoccupied by asking for help moving some tables and doing laundry. Multiple staff tried to take [him/her] for a walk somewhere quiet, but [s/he] wasn't interested in any of it. We finally offered to call [family member] or [spouse] but nobody answered. [S/he] started becoming very aggressive with staff. [S/he] was yelling at everyone to get off [his/her] property, and to stop stealing from [him/her]. Staff reassured [him/her] that they would never steal from [him/her] and that they would let [him/her] be and leave shortly. [S/he] was following different staff members around trying to punch, kick, hit, slap and throw furniture at them. [S/he] put [his/her] hands around one staff's neck to choke them. [Resident 1] went up to a resident who was sitting in a chair

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and tried to whip them out of it. [S/he] went up to another staff and ripped their glasses off of their face. Two staff members escorted [Resident 1] down to [his/her] room hoping some quiet and alone time would help. While staff was in [his/her] room with [him/her], [s/he] continued to hit, punch, and try to bite staff. [S/he] came out of [his/her] room as soon as staff left. Other staff member was walking someone to their room and [Resident 1] went up to them screaming and tried to hit them. Two other staff members had to try and redirect [him/her] to safetly get that staff member and resident away from [him/her]. [S/he] tried to take a mop and hit staff with it. [S/he] started pushing on all the doors setting the alarms off. Finally, [s/he] got out the back door and staff went outside with [him/her]. [S/he] started coming after staff that was outside with [him/her] and another staff member had to come outside to make sure nobody got injured. [Resident 1] once again tried to [his/her] then choke staff. Eventually we got [him/her] inside and had to call the police to help deescalate the situation. They arrived around 10:00PM and [Resident 1] was taken to the hospital."

An observation note dated 04/22/2024 at 9:35AM stated, "Upon further investigation into recent altercations. It has been determined that [Resident 1] requires a level of care beyond what Frontida can provide. Writer called [hospital], spoke to RN [registered nurse] and notified [him/her] that in order to ensure the safety and well being of [Resident 1], as well as our other residents and staff, [Resident 1] will need to find alternate placement upon discharge and cannot return to Frontida. RN stated [s/he] will speak to [social worker] and MD and get back to me to determine best plan to notify family. RN stated [Resident 1's family member] has been in

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N 326	Continued From page 6 [his/her] room this morning, hoping to get [him/her] transferred back ASAP [as soon as possible] for fear this would be the case." On 09/04/2024 at 12:10PM, Surveyor interviewed Family Member B. Family Member B verified s/he was the Health Care Power of Attorney for Resident 1. Family Member B stated originally the facility said Resident 1 could come back to the facility and then called back and said no they can't take him/her back. Family Member B stated hospital staff stated Resident 1 was very traumatized by everything and Family Member B needed to make a decision to try to get Resident 1 back to baseline or to "let [him/her] go." Family Member B became weepy and stated, "I chose to let [him/her] go." Family Member B stated s/he sat with Resident 1 for the next week until Resident 1 passed away on 04/29/2024 at the hospital. On 08/19/2024 at 11:50AM, Surveyor interviewed Executive Director A. Executive Director A stated s/he was not involved in the decision as s/he did not start working at the facility until May 2024. Executive Director A stated the previous Executive Director is no longer employed with the company. The provider did not allow Resident 1 to return after a brief hospitalization and assist Resident 1 to find suitable placement to meet the needs of Resident 1.	N 326		