

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/18/2026
NAME OF PROVIDER OR SUPPLIER FRONTIDA ASSISTED LIVING OF KIMBERLY I		STREET ADDRESS, CITY, STATE, ZIP CODE 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 06/12/2026, Surveyor conducted a standard survey and 1 complaint investigation at Frontida Assisted Living of Kimberly I. Additional information was gathered through 06/18/2026. The complaint was substantiated and resulted in the identification of 1 deficient practice. Census: 15	N 000		
N 327	83.31(4)(b) Allowable reasons for involuntary discharge. Discharge or transfer initiated by CBRF. Reasons for involuntary discharge. The CBRF may not involuntarily discharge a resident except for any of the following reasons: 1. Nonpayment of charges, following reasonable opportunity to pay. 2. Care is required that is beyond the CBRF 's license classification. 3. Care is required that is inconsistent with the CBRF 's program statement and beyond that which the CBRF is required to provide under the terms of the admission agreement and this chapter. 4. Medical care is required that the CBRF cannot provide. 5. There is imminent risk of serious harm to the health or safety of the resident, other residents or employees, as documented in the resident 's record. 6. As provided under s. 50.03 (5m), Stats. 7. As otherwise permitted by law. This Rule is not met as evidenced by: Based on record review and interview, the provider involuntarily discharged Resident 1 for reasons inconsistent with allowable reasons for discharge outlined in Chapter 83 codes. Resident	N 327		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/18/2026
NAME OF PROVIDER OR SUPPLIER FRONTIDA ASSISTED LIVING OF KIMBERLY I			STREET ADDRESS, CITY, STATE, ZIP CODE 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 327	Continued From page 1 1 was not allowed to return to the facility from the hospital after having a venous catheter placed for dialysis. The provider did not specify in the signed program statement that they could not provide care for the intervention, did not conduct a follow-up assessment of the resident at the hospital, and did not issue a 30-day involuntary discharge notice. Findings include: The provider is licensed to serve up to 22 residents who may have diagnoses including advanced age, physical disability, emotionally disturbed/mental illness and terminally ill. On 12/15/2025, the Department received a complaint alleging a resident was involuntarily discharged without notice. On 06/12/2026, Surveyor reviewed Resident 1's records. Resident 1 was admitted to the facility on 11/03/2023 and had an activated Power of Attorney for healthcare (POA F.) Resident 1 had diagnoses including Type 2 diabetes, dependence on renal dialysis, end stage heart failure, a cardiac pacemaker, and Chronic Obstructive Pulmonary Disease. Resident 1's dialysis needs, including care for his/her dialysis access port, was managed by the dialysis center medical professionals during 3 times weekly visits for dialysis. On 06/17/2026 at 2:00 PM, Surveyor interviewed POA F. POA F stated Resident 1 rarely urinated as s/he had dialysis 3 times a week and only on occasion would have an episode of incontinence. POA F stated on 12/10/2025 Resident 1 attended his/her regular dialysis treatment and discovered his/her access port was bleeding. Resident 1 was	N 327			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/18/2026
NAME OF PROVIDER OR SUPPLIER FRONTIDA ASSISTED LIVING OF KIMBERLY I			STREET ADDRESS, CITY, STATE, ZIP CODE 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 327	Continued From page 2 taken to the hospital and had a femoral catheter placed for dialysis access. POA F stated Resident 1 was stable and ready to go home after the procedure and the plan of care was for the dialysis center to continue to manage the care for the catheter 3 times weekly at the visits. POA F stated the only change in care the provider would need to make would be to provide bed baths instead of showers. POA F stated when s/he tried to make arrangements for Resident 1 to return to his/her home the provider refused to allow the resident to return. POA F stated no letter of 30-day notice of involuntary discharge was received, the provider did not come to the hospital to assess the resident, and that the provider (via phone conversation with Former Administrator A) stated the placement of the venous catheter was against their company policy and therefore Resident 1 was not allowed to return home. POA F stated s/he reviewed the admission agreement, program statement, and resident handbook and could not find anywhere that noted the placement of the catheter for dialysis was against their policy or would be cause to discharge the resident. POA F stated s/he reached out to Ombudsman H for assistance but was ultimately told by Former Administrator A, Regional Nurse C, and VP of Operations D that Resident 1 would not be allowed to return home. POA F stated Resident 1 had to move to another facility by 12/12/2025 and that the move was distressing for Resident 1. POA F stated Resident 1 was very sad to have to leave his/her home and all his/her friends at the facility. POA F stated the femoral port placement was temporary and Resident 1 had a permanent catheter port for dialysis placed in his/her chest within 1 week. On 06/12/2026 at 3:00 PM, Surveyor interviewed	N 327			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/18/2026
NAME OF PROVIDER OR SUPPLIER FRONTIDA ASSISTED LIVING OF KIMBERLY I		STREET ADDRESS, CITY, STATE, ZIP CODE 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 327	Continued From page 3 Regional Nurse C and Administrator B while reviewing records. Administrator B stated him/herself and Regional Nurse C were responsible for conducting resident admissions. Regional Nurse C stated s/he recalled the circumstances of Resident 1's discharge and reiterated the placement of the venous catheter was "against company policy." Regional Nurse C stated s/he did not recall if a letter of notice of involuntary discharge was given to the resident's legal representative (POA F) and stated s/he did not go to the hospital to assess the resident to return to the facility. Surveyor asked to review a copy of the policy that informed the resident and their legal representative of the dialysis catheter being against their policy and was given the admission agreement, program statement and resident handbook for review. Surveyor reviewed the records and noted the records did not contain an outline of specific medical interventions that the provider would not accept or would cause the need for an involuntary discharge. Regional Nurse C then provided Surveyor 2 color-coded lists titled "Move-In/Stay Criteria Grid" and "Move In Grid." The lists contained specific medical needs and interventions and guidance for the provider for admission and retention of residents. Regional Nurse C and Administrator B stated the lists were to guide the provider's process and were not given to the resident or their legal representative at the time of admission. Regional Nurse C stated s/he was aware the hospital discharge plan and dialysis center stated the care plan would include the catheter being maintained by the dialysis center three times a week and that the only change to the providers' level of care would be that the resident would require a sponge bath instead of a shower. Regional Nurse C stated s/he still reached out to	N 327		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/18/2026
NAME OF PROVIDER OR SUPPLIER FRONTIDA ASSISTED LIVING OF KIMBERLY I			STREET ADDRESS, CITY, STATE, ZIP CODE 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 327	Continued From page 4 a home health agency and stated the agency would not accept the resident on to their services as they stated care of the femoral catheter did not require skilled nursing care. Regional Nurse C stated again, despite acknowledging the catheter would not require skilled nursing care and would be maintained by the dialysis center, that this was against their company policy, but was unable to provide evidence of the policy. Regional Nurse C stated during a discussion on 12/12/2025 with POA F, Ombudsman H, VP of Operations D and Former Administrator A, VP of Operations D reiterated to POA F and Ombudsman H that the femoral catheter was against their company policy. Regional Nurse C acknowledged the provider did not have a policy and stated it was his/her discretion as an RN to determine what cares s/he was comfortable delegating and would accept responsibility for. It was reviewed that while Regional Nurse C is responsible for determining delegation under his/her license, Resident 1's femoral catheter was not under his/her management as it would be the dialysis center who managed the port, and catheter did not require delegation of skilled nursing care, as noted when it was determined s/he did not qualify for the use of an outside health care agency. Regional Nurse C then stated the reason the resident would not be accepted back to the community was due to the risk of infection. Regional Nurse C stated Resident 1 was incontinent and due to the placement of the femoral catheter it was at high risk for infection. Regional Nurse C provided Surveyor with Resident 1's observation notes: 12/10/2025, 12:57 PM- Former Administrator A noted, "Resident is having surgery for placing a perm [sic] dialysis catheter. Per our policy we	N 327			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/18/2026
NAME OF PROVIDER OR SUPPLIER FRONTIDA ASSISTED LIVING OF KIMBERLY I			STREET ADDRESS, CITY, STATE, ZIP CODE 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 327	Continued From page 5 can't accept return of resident after catheter is placed. Resident will be moving to a different community due to higher level of care." 12/12/2025, 2:58 PM- Regional Nurse C- "Spoke to Ombudsman regarding discharge of resident. Due to placement of permacath to femoral area community is not appropriate for residents return. Resident does have incontinence of loose stool frequently and does toilet self. Resident does go outside to smoke and has had falls due to this. Resident has a high risk of pulling out permacath or having infection develop to area. Community nurse is only at the community two times per week and cannot monitor the site as closely as needed. permacath is a skilled need at this time. Resident to be discharged to more appropriate community." On 06/12/2026 at 3:30 PM, Nurse C and Administrator B acknowledged the potential for risk for infection and risk of pulling out a catheter are not allowable reasons for involuntary discharge per Chapter 83. On 06/12/2026, Surveyor conducted an exit interview with Administrator D and Regional Nurse C present, and with Regional Nurse G, VP of Operations D, and VP of Clinicals E joining over the phone. The circumstances of the involuntary discharge were reviewed including the discharge not meeting Chapter 83 requirements to qualify for an involuntary discharge, and the provider not conducting an assessment or following the requirements to give a 30-day notice of the involuntary discharge. Surveyor gave the opportunity for the provider to submit documentation for review and ask any questions. On 06/18/2026 at 9:30 AM, Surveyor interviewed	N 327			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016997	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/18/2026
NAME OF PROVIDER OR SUPPLIER FRONTIDA ASSISTED LIVING OF KIMBERLY I			STREET ADDRESS, CITY, STATE, ZIP CODE 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 327	Continued From page 6 Regional Nurse C and reviewed the investigation would be resulting in a citation. Regional Nurse C had no further questions or documentation to provide.	N 327			