STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017410	A. BUILDING: _____ B. WING _____	C 02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112W17500 MEQUON ROAD GERMANTOWN, WI 53022

(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 02/02/2024, Surveyor conducted a complaint investigation at Fairway Knoll. Complaint was substantiated. Two deficiencies were identified. Census 20	N 000		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on record review, observation, and interview the provider did not ensure all residents had the right to self-determination. The provider was locking resident doors to prevent Resident 1's behaviors. Findings include: On 02/02/2024 at approximately 10:26 AM, Surveyor interviewed Caregiver B. Caregiver B stated Resident 1 would go in and out of rooms. Caregiver B stated the other residents' doors on the unit were locked to prevent Resident 1 from going into their rooms. On 02/02/2024 at approximately 10:26 AM, Surveyor interviewed Caregiver C. Caregiver C	N 355		

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

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N 355	Continued From page 1	N 355		

stated Resident 1 wandered into other residents' rooms and that was typical behavior for him/her. Caregiver C stated the caregivers lock the other residents' doors to prevent Resident 1 from going into other rooms besides his/hers.

On 02/02/2024 at approximately 10:50 AM, Surveyor interviewed Administrator A. Administrator A stated staff were locking residents' doors to keep other residents from entering their rooms. Administrator A stated not all of the residents can use a key. Administrator A stated the residents that are not able to use a key need to wait for staff to help them enter their rooms.

On 02/02/2024 at approximately 11:10 AM, Surveyor reviewed Resident 1's facility file. Resident 1's individual service plan was dated 03/27/2023. Resident 1 was admitted to the facility on 07/01/2020. Resident 1's individual service plan stated Resident 1 had no behaviors that required intervention. Resident 1's individual service plan indicated Resident 1 wandered in common areas, but did not indicate Resident 1 wandered into other residents rooms frequently. Resident 1 did not have a behavioral support plan or any interventions in the individual service plan for wandering in to other residents' rooms.

On 02/02/2024 at approximately 12:00 PM, Surveyor observed residents in the dining room eating lunch. Surveyor observed multiple rooms were locked by staff while residents ate. Surveyor observed staff unlock rooms for residents using a key after dinner.

On 02/02/2024 at approximately 12:23 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 had behaviors they had to

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N 355	Continued From page 2 monitor. Caregiver D stated Resident 1 would go in and out of other residents' rooms, and staff had to keep the other residents' doors locked so Resident 1 didn't enter their rooms. Caregiver D confirmed there were residents on the unit that were not able to use a key to open their own door and would need to rely on staff to let them back into their room. Summary The provider locked resident doors to prevent Resident 1 from entering other residents' rooms. The provider indicated not all residents were able to use a key due to cognitive decline or dexterity concerns. The provider stated staff have to unlock the doors and let residents into their room if they are not able to use a key. There were no other interventions in place for wandering behaviors except for redirection and locking other residents' doors on the unit, which resulted in other residents not being able to enter their rooms independently. Cross Reference N 0389-83.35(3)(d) Service Plans Updated Annually or on Changes	N 355		
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	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 389	Continued From page 3	N 389		

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.

This Rule is not met as evidenced by:
Based on record review and interview the provider did not ensure Resident 1, Resident 2, or Resident 3's individual service plan was updated when there was a change in their needs. Resident 2 and Resident 3 had a fall history that was not addressed in the individual service plan. Resident 1 had behaviors that were not addressed in the individual service plan.

Findings include:

Example 1 Resident 1

On 02/02/2024 at approximately 10:50 AM, Surveyor interviewed Administrator A. Administrator A stated staff were locking residents' doors to keep residents from entering their rooms. Administrator A stated not all of the residents were able to use a key, and staff would have to help the ones that were not able to use a key to enter their room.

On 02/02/2024 at approximately 11:10 AM, Surveyor reviewed Resident 1's facility file. Resident 1's individual service plan was dated 03/27/2023. Resident 1 was admitted to the facility on 07/01/2020. Resident 1's individual service plan stated Resident 1 had no behaviors that required intervention. Resident 1's individual service plan indicated Resident 1 wandered in common areas, but did not indicate Resident 1

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N 389	Continued From page 4	N 389		

wandered into other residents' rooms frequently. Resident 1 did not have a behavioral support plan or any interventions in the individual service plan for wandering in to other residents' rooms.

On 02/02/2024 at approximately 12:23 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 had behaviors they had to monitor. Caregiver D stated Resident 1 would go in and out of other residents' rooms, and staff had to keep the other residents' doors locked so Resident 1 didn't enter their rooms. Caregiver D confirmed there were residents on the unit that were not able to use a key to open their own door. Caregiver D stated when the behaviors would start, staff had to redirect Resident 1. Caregiver D stated s/he was working one day Resident 1 went into Resident 2's room and caused Resident 2 to fall. Caregiver D stated when Resident 1 entered a room s/he tends to swing the door hard because s/he has a walker and it allows him/her to enter the room. Caregiver D stated s/he was walking down the hallway and witnessed Resident 1 attempt to enter Resident 2's room. Caregiver D stated s/he attempted to redirect Resident 1, but heard a loud noise. Caregiver D stated s/he went to the room to find Resident 2 on the floor complaining of pain. Caregiver D stated Resident 2 was located on the floor by the closet at the entrance of the room, with his/her walker located in the closet. Caregiver D stated Resident 2 complained of hip pain, and neck pain but was moving his/her neck. Caregiver D stated EMS was called and Resident 2 did not return to the facility after this incident.

Example 2 Resident 2

On 02/02/2024 at approximately 11:10 AM, Surveyor reviewed Resident 2's facility file.

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N 389	Continued From page 5 Resident 2 was admitted to the facility on 12/13/2022. Resident 2's facility file had a document named "Resident Occurrence Report" dated 08/11/2023. The report indicates on 08/11/2023, Resident 2 had suffered a fall because s/he was assisting Resident 3. The report indicated there was no injury but Resident 2 should call for staff when Resident 3 needed assistance. Resident 2's facility file had a document named "Resident occurrence report". The report indicated on 08/29/2023, Resident 2 had a fall resulting in 2 vertebrae in his/her neck being fractured, and his/her femur being fractured. The report indicates Resident 2 was standing behind his/her door in his/her room, when someone opened it resulting in Resident 2 falling. Resident 2 was ultimately sent to the hospital for his/her injuries. Resident 2 passed away at the hospital from his/her injuries. Resident 2's individual service plan dated 06/29/2023, did not indicate Resident 2 had a fall history. Resident 2's individual service plan did not include any interventions to minimize fall risk. Resident 2's individual service plan indicated Resident 2 was a high risk for falls due to balance concerns and used a walker for ambulation. On 02/02/2024 at approximately 12:23 PM, Surveyor interviewed Caregiver D. Caregiver D stated Resident 1 had behaviors they had to monitor. Caregiver D stated Resident 1 would go in and out of other residents' rooms, and staff had to keep the other residents' doors locked so Resident 1 didn't enter their room. Caregiver D confirmed there were residents on the unit that were not able to use a key to open their own door. Caregiver D stated when the behaviors start staff have to redirect Resident 1. Caregiver D stated s/he worked the day Resident 1 went into Resident 2's room and caused Resident 2 to fall.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 389	Continued From page 6	N 389		

Caregiver D stated when Resident 1 enters a room s/he swings the door hard because s/he has a walker and it allows him/her to enter the room. Caregiver D stated s/he was walking down the hallway and witnessed Resident 1 attempt to enter Resident 2's room. Caregiver D stated s/he attempted to redirect Resident 1, but heard a loud noise. Caregiver D stated s/he went to the room to find Resident 2 on the floor complaining of pain. Caregiver D stated Resident 2 was located on the floor by the closet at the entrance of the room, with his/her walker located in the closet. Caregiver D stated Resident 2 complained of hip pain, and neck pain but was moving his/her neck. Caregiver D stated EMS was called and Resident 2 did not return to the facility after this incident.

On 02/02/2024 at approximately 3:30 PM, Surveyor interviewed Administrator A. Administrator A stated this was the most recent individual service plan, and it was not updated after the fall on 08/11/2023.

Example 3 Resident 3

On 02/02/2024 at approximately 11:10 AM, Surveyor reviewed Resident 3's facility file. Resident 3's facility file included a report named "Resident Occurrence Report" dated 10/08/2023. The report indicated Resident 3 was found on the floor with the pendant by his/her bed and wheelchair. The report indicated when Resident 3 was asked what happened s/he stated s/he was trying to pick up a blanket on the floor and ended up falling over on to the floor. Resident 3 was not injured.

Resident 3's individual service plan dated 03/21/2023, indicated Resident 3 was a two person transfer with a stand assist lift. Resident

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	0017410	A. BUILDING: _____ B. WING _____	C 02/02/2024

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N 389	Continued From page 7 3's individual service plan indicated Resident 3 had balance problems while standing and walking and was at risk for falling. Resident 3's individual service plan did not indicate a fall history and did not include new interventions for fall prevention after the fall on 10/08/2023. On 02/02/2024 at approximately 3:30 PM, Surveyor interviewed Administrator A. Administrator A stated this was the most recent individual service plan. Cross Reference N 0355-83.32(3)(k) Rights of Residents: Self-Determination	N 389		