STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016336	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC (THE)	**795 TARRAGON DRIVE KAUKAUNA, WI 54130**

(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 01/30/2025, Surveyor conducted a complaint investigation at The Landings of Kaukauna MC. One deficiency was identified. Complaint was unsubstantiated. Census: 23	N 000		
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 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 observation, record review and interview, the provider did not ensure 1 of 1 Individual Service Plan (ISP) was reviewed when the resident experienced a change of condition. Resident 1's ISP was not updated to document his/her refusal to utilize his/her walker, which has resulted in falls. Findings include:	N 389		

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
	0016336	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC (THE)	795 TARRAGON DRIVE KAUKAUNA, WI 54130

(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 389	Continued From page 1 On 11/11/2024, the Department received a complaint alleging residents were not supervised when ambulating resulting in falls with injury. On 01/30/2025, at approximately 1:40 PM, Surveyor interviewed Resident 1 in his/her room. Resident 1's room contained a walker and a wheelchair. Resident 1, while smiling, explained to Surveyor that s/he has walkers that s/he can use but s/he doesn't use them. Resident 1 explained that his/her spouse told him/her that s/he needs to be careful as to not fall again because s/he needs to be available to the children. Surveyor determined that Resident 1 was not cognitively aware of the current timeframe. On 01/30/2025, Surveyor reviewed Resident 1's record. Resident 1 moved into the facility, 02/21/2024, with diagnoses including late onset Alzheimer's, history of falls, and age-related osteoporosis. Resident 1's "Progress Notes" documented: 09/20/2024 - Had a fall today, took him/herself to the bathroom, was leaving the bathroom and fell in the doorway. S/he was not using his/her walker. 10/30/2024 - Resident had an unwitnessed fall in his/her room. Resident was found on the floor lying flat on his/her back next to his/her recliner. Staff saw his/her walker was in the bathroom. Resident 1's ISP, dated 08/27/2024, documented: -Mobility/Ambulation/Escorts/Transfers: Will be able to ambulate safely with/without assistance from staff through next review. Independent with ambulation/mobility in room. -Fall Risk/HX (history) of Fall(s): Injuries will be	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016336	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC (THE)	795 TARRAGON DRIVE KAUKAUNA, WI 54130

(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 389	Continued From page 2	N 389		

minimized through next review. Encourage participation in activities that will increase strength and mobility. Encourage to stay in common areas to promote more supervision. Encourage to wear glasses and ensure that the glasses are clean and in good repair. Inform resident about safety reminders and to notify staff immediately if they have a fall or near fall.
-Had an actual fall:
03/11/2024 - fall by the bathroom with injury to right eye lid - Resident will be offered toileting before and after meals.
05/06/2024 - fall out of bed - legs tangled in blankets and didn't call for assistance. No injury. - Signage posted to call for assistance.
05/15/2024 - fall in bedroom self transferring. No injury. - Request PT/OT (physical therapy/occupational therapy) eval (evaluation) and treat (treatment).
07/21/2024 - Fall going into the bathroom and walker got away from [him/her] - no injury. - Resident will be rounded on right after shift change in the morning.
09/20/2024 - Fell coming from the bathroom w/out (without) using the walker, no injury. - Check at frequent intervals to see if any assistance is needed and to offer reassurance.
10/30/2024 - Unwitnessed fall in room w/out using walker. - Signage placed in resident's bathroom and room stating don't forget your walker.

Surveyor noted the ISP was not signed by the provider or Resident 1's power of attorney.

On 01/30/2025, at approximately 3:00 PM, Surveyor interviewed Administrator A. Administrator A explained that Resident 1 does not remember to use his/her walker, and s/he is independent when s/he is in his/her room which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016336	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF KAUKAUNA MC (THE)	**795 TARRAGON DRIVE KAUKAUNA, WI 54130**

(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 389	Continued From page 3 has resulted in his/her sustaining falls. Administrator A and Surveyor reviewed Resident 1's ISP. Administrator A stated that Resident 1's ISP did not document that Resident 1 displayed any behaviors regarding self-transferring. Administrator A explained that staff have 'care cards' that can be utilized on how to provide cares to residents, but Administrator A stated that the cards did not document that Resident 1 often did not utilize his/her call light and would self-transfer, just that s/he utilized a walker. Administrator A stated s/he did not realize the ISPs were to be signed by the resident or the resident representative.	N 389		