STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018192	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112 W17500 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
U 000	INITIAL COMMENTS On 02/11/2026, Surveyor conducted a standard survey and complaint investigation at Fairway Knoll, a Residential Care Apartment Complex (RCAC) in Germantown, WI. Three deficiencies identified. Complaint substantiated. Census: 43	U 000		
U 188	89.27(4) SERVICE AGREEMENT REVIEW AND UPDATE. The service agreement shall be reviewed when there is a change in the comprehensive assessment or at the request of the facility or at the request or on behalf of the tenant and shall be updated as mutually agreed to by all parties to the agreement. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Tenant 1's service agreement was reviewed when there was a change in the comprehensive assessment, and updated as mutually agreed to by all parties to the agreement. Tenant 1 had two hospital admissions, enrolled in hospice services and had an ambulation change without the service agreement and/or risk agreement updated. Findings include: On 01/11/2026, the Department received a complaint concerned about Tenant services. Tenant 1 has a diagnosis of TIA, Anxiety, CKD Stage 2, Degeneration of cervical, Edema,	U 188		

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
	0018192	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112 W17500 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
U 188	Continued From page 1	U 188		

Hyperlipidemia, Hypertension, Raynaud's Disease and Subdural Hematoma. Tenant 1 was admitted to the facility on 05/10/2021.

On 02/11/2026, Surveyor requested to review Tenant 1's record. Surveyor identified the following:
Tenant 1's most current functional assessment and service agreement/plan for Tenant 1 was dated 11/06/2025. Regarding Tenant 1's physical assistance, it states:
-"Independent: Ambulates without assistance or uses cane, walker or wheelchair independently."
-"Toileting Assist: Independent"

Tenant 1 was admitted to the hospital on 12/24/2025-12/29/2025 with diagnoses of Dehydration, C. Difficile diarrhea, Colitis and on 01/09/2026 with diagnoses of weakness, diarrhea.
Tenant 1's assessments stated the following:
-12/29/2025, Clinical Update Assessment, Reason: Hospice
-01/14/2026, Clinical Update Assessment, Reason: Update
-01/21/2026, Clinical Update Assessment, Reason: Clinical update, Resident admitted with UTI, slight positive on Occult Blood, Testing for C-Diff

Tenant 1's Resident Notes stated the following:
-"12/24/2025: Writer spoke with family-resident stool tested positive for C-diff. Family stated resident had 7 episodes of loose stool overnight. Prefer to have resident sent to hospital for further evaluation and tests. Writer called 911 for transport to ER.
-12/29/2025: Writer updated [Managed Care Organization] on return to facility and admission to hospice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018192	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112 W17500 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
U 188	Continued From page 2 -12/29/2025: Resident returned via ambulance with family present, alert, glasses on, hearing aids in, no c/o of pain/discomfort, up with w/w and 1 assist, hospice nurse came to admit to hospice services, hospital bed delivered. -01/09/2026: Family requested resident to be sent out via non-emergent ambulance to hospital to get reevaluated since having c.diff. -01/09/2026: Resident admitted with UTI. Slight positive on Occult Blood. Testing for C.Diff. -01/12/2026: Resident returned from hospital. -01/27/2026: RA called to report a fall, resident took self to bathroom and fell, skin tear noted on RT hand. -02/06/2026: Resident has redness on [his/her] buttock due to the loose stools, constant wiping, and depends. Encouraging resident to allow staff to put barrier cream on and to take [his/her] showers. -02/07/20266: Resident has weakness on left side arm and leg, very hard to transfer [his/her] leg is hurting and locked up and very swollen. Resident doesn't want to go in for a eval at this time, and wants to wait to contact family until AM, gave RA okay to use EZ stand at this time with a second staff member. 02/09/2026: Writer went in and assessed resident. Resident was able to stand up with 1 assist and declined any pain. Balance seemed at base line for resident. Resident's [child] was updated." On 02/11/2026 at approximately 12:30 PM, Surveyor interviewed Regional Director of Clinical Services A. Regional Director of Clinical Services A stated the most recent service agreement was the one dated for 11/06/2025. Regional Director of Clinical Services A stated it looked like s/he had been assessed for changes but they did not update the service agreement/plan.	U 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018192	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112 W17500 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
U 254	89.34(3) TENANT RIGHTS Rights of tenants. A tenant of a residential care apartment complex shall have all the rights listed in this section. These rights in no way limit or restrict any other rights of the individual under the U.S. Constitution, civil rights legislation or any other applicable statute, rule or regulation. Tenant rights are all of the following: (3) SELF-DIRECTION. To make reasonable decisions relating to activities, daily routines, use of personal space, how to spend one's time and other aspects of life in the residential care apartment complex. This Rule is not met as evidenced by: Based on observation and interview, the licensee did not ensure tenants were able to make reasonable decisions related to activities, daily routines, use of personal space, how to spend one's time and other aspects of life in the residential care apartment complex (RCAC). -Tenant 1 not allowed back to the RCAC on a weekend because the facility stated since they do not have a nurse on duty, Tenant 1 would have to wait until Monday when a nurse was in. Findings Include: On 01/11/2026, the Department received a complaint concerned about Tenant services. On 02/11/2026, at approximately 10:30 AM, Surveyor reviewed Tenant 1's record and	U 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018192	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112 W17500 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
U 254	Continued From page 4	U 254		

identified the following:
-Tenant 1 was admitted to the facility on 05/10/2021 and was his/her own person.
-Tenant 1 admitted to the hospital on 01/09/2026 to 01/12/2026 due to weakness and diarrhea.

-Resident notes stated the following:

-"01/11/2026 at 2:00 PM: RA called writer stating that hospital nurse called facility stating resident was ready for discharge today and will be returning. Medication orders were sent to Radius. Writer called RN at hospital and informed RN we do not take admissions over the weekend due to no nurse being in the building to assess. Writer also informed nurse that Radius living will not be delivering medications today. Nurse was adamant that resident will be returning because [s/he] was medically cleared by the MD to return. Writer again informed nurse that resident resides in the RCAC and no nurse is in the building on weekends to readmit. Nurse asked writer if writer was refusing to take resident back as [s/he] resides at Fairway Knoll. Writer informed nurse that resident could return tomorrow when nursing is back in the building and medication can be delivered."

-"01/11/2026 at 2:25 PM: Writer received a phone call from hospital on call administrator stating Fairway Knoll had to accept resident back today because [s/he] lives at Fairway Knoll and is medically stable to be discharge. Writer informed Administrator that nursing is not in the building on the weekend to assess resident upon return. Writer also informed Administrator that medication orders sent to Radius would not be delivered today which would result in resident missing needed meds. Receptionist did receive a phone call after writer talked with Administrator stating resident would be returning to Fairway Knoll today and that the police were also called."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018192	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112 W17500 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
U 254	Continued From page 5 -"01/11/2026 at 11:00 PM: Resident did not return to facility." -01/12/2026 at 11:22 AM: Resident returned with [child] from hospital, alert, no c/o pain/discomfort, no SOB noted." -Tenant 1 had assessment completed 2 days after readmission on 01/14/2026. Assessment reason was update. On 02/11/2026 at approximately 12:00 PM, Surveyor reviewed above information with Regional Director of Clinical Services A. Regional Director of Clinical Services A stated Tenant 1 was back at baseline and that the facility does have a Resident Requirements and Limitations of Services that is part of the admission agreement but acknowledges that does not negate Tenant 1's tenant rights. Regional Director of Clinical Services A stated the situation could have been handled differently and allowed Tenant 1 to return home. Regional Director of Clinical Services A stated s/he had a meeting scheduled with the licensee later that day and would be reviewing their policy for Tenant's returning home from the hospital on weekends.	U 254		
Z 019	50.065(6)(am) Four Year Caregiver Background Requirement Every 4 years an entity shall require its caregivers and nonclient residents to complete a background information form that is provided to the entity by the Department.	Z 019		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018192	A. BUILDING: _____ B. WING _____	C 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY KNOLL	N112 W17500 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
Z 019	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a background check was completed every 4 years for 1 of 2 caregivers reviewed (Caregiver B). Findings include: On 02/11/2026, Surveyor requested to review Caregiver B's record. Caregiver B was hired on 11/29/2021. Caregiver B's record included the following background checks: - Background Information Disclosure date 11/09/2021. - Department of Justice Background Check dated 11/11/2021. - Department of Health Services Response to Caregiver Background Check dated 11/11/2021. On 02/11/2026 at approximately 12:00 PM, Surveyor interviewed Regional Director of Clinical Services A. Regional Director of Clinical Services A stated s/he just spoke with Human Resources and Caregiver B's 4 year background check was missed.	Z 019		