STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235013	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Nursing and Rehabilitation Community	441 E Main St Centreville, MI 49032

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of nursing practice related to monitoring laboratory results for one resident (R101) of 3 residents reviewed for professional standards and quality of care, resulting in a delay of treatment for a bacterial infection, the potential for a diminished medical outcome, and the resident not maintaining or achieving their highest practical physical well-being. Findings include:Review of R101's Progress Note, dated 9/15/25 6:02 AM, indicated the Nurse Practitioner (NP) noted the resident continued to complain of low back pain the evening before and was exhibiting confusion. The confusion was said to be worse than usual. A urine sample was obtained and found to be dark and cloudy with sediment. Order was given to send a UA (urine analysis) due to the worsening mental status and low back pain. Spinal x-ray was negative for injury from fall on 9/13/25. Review of R101's Face Sheet, revealed the resident was admitted to the facility on [DATE] with diagnoses that included primary congestive heart failure and urinary tract infection (UTI). Review of R101's Care Plan revealed there was not a comprehensive focus regarding UTI with a goal or interventions to prevent or treat the resident upon admission. According to R101's Observation Detail List Report, dated 9/16/25, the resident scored 13/15 (cognitively intact) on her BIMS (Brief Interview Mental Status). Review of R101's Progress Note, dated 9/13/25 4:52 PM, indicated the resident had a fall from her bed. She complained of increasing back pain to right lower back down into her sacral area (lower back and buttocks at base of spine) with a pain score of 6 out of 10. New orders for x-rays.Review of R101's Order Summary dated 9/15/25, revealed a UA with C&S (culture and sensitivity lab test to find out what antibiotic will effectively treat the infection) was ordered to rule out a UTI.Review of R101's UA laboratory results were sent to the facility on 9/15/25 with a positive UTI infection. The C&S was completed on 9/20/25 with a sensitivity to ciprofloxacin, an antibiotic.Review of R101's Infection Tracker with McGeer's Criteria (a standardized set of definitions for identifying infections in long-term care facilities, primarily used for surveillance), dated 9/23/25 and completed by Infection Control Preventionist (IPC) I, revealed 9/19/25 was the infection onset date with new/marked increase in incontinence, urgency, and frequency. Indicating the criteria was met to start antibiotics upon the onset of symptoms, 9/15/25. The UA was positive for infection with at least 100,000 cfu/ml of no more than 2 species of microorganisms in a voided urine sample dated 9/15/25. The result of the Infection Tracker was to begin surveillance with the use of the antibiotic.Review of R101's Progress Note 9/24/25 10:35 PM revealed the IDT (interdisciplinary team) reviewed the resident's antibiotic therapy for her UTI. The resident was noted to have recent change in condition with UTI and antibiotic therapy. Resident continues with cloudy and foul odorous urine and including pain upon urination.During an interview and record review on 10/7/25 at 2:35 PM, IPC I stated while reading R101's medical chart, I am responsible for the infection control and wound care programs. There is a new form, McGeer's, in the facility's electronic medical charting for infection surveillance that the facility uses. It's a form to make sure the resident meets McGeer's criteria before starting an antibiotic. I did (R101's) McGeer's on 9/23/25 at 7:57 AM, the score indicated she met the criteria to receive an antibiotic. I do not know why I put the 9/19/25 on (R101's) McGeer's form. I do not work (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekends. I do wound rounds with the wound doctor on Mondays so I cannot look for lab results until Tuesday. I try to look online at the laboratory's website for results almost everyday Tuesday through Friday. Typically, the facility tries to have labs done on weekends because I am not here to look for results online. (R101's) antibiotic was ordered on 9/23/25 after I initiated McGeer's for her. (R101's) urine sample was sent out on 9/15/25 and the facility was notified via the laboratory's online system the same day. The C&S result was completed on 9/20/25 and put in the lab's online portal the same day. It was noted the facility failed to follow up on R101's lab results until 9/23/25. According to R101's McGeer's criteria, the resident met 3 criteria and could have began antibiotic treatment when UA results showed positive on 9/15/25. During an interview on 10/7/25 at 2:57 AM, Director of Nursing (DON) B stated, (R101's) family expressed concern about her increased confusion before 9/15/25. Staff discussed the confusion with therapy and tested her for dementia. There was no documentation for increased monitoring for her increased confusion. (R101's) confusion increased enough to where a UA was ordered. Typically, I will check over the weekend online for lab results or the other on-call manager will check for lab results online while in the facility on weekends. The lab results are also faxed to the facility from the lab. The facility has had no problem with the results coming over on the fax. On Mondays, I or another manager will look for the lab results either online or on the fax because (IPC I) works with the wound doctor on that day. (R101) started symptoms of confusion about the same time her UTI was developing.During interview and record review on 10/8/25 at 1:00 PM, DON B reviewed R101 medical chart, stating, Labs are sent to the fax machine in the pantry at the nurse's station. On the weekend of September 20th, me and (ICP I) were working in the facility on the floor. Both of us should have been looking at the lab website and the fax machine for results, especially with a pending UA. DON B then reviewed the lab's portal on their website, stating, Looking on the labs website, there are UA results for (R101) posted 9/15/25 and 9/20/25. September 15 was a Monday, (IPC I) does not look at lab results on Mondays as she is doing wound rounds. It is up to me to look for lab results on Monday, especially with a pending UA. For the week of September 16-19, the ICP (I) should have been looking at both the lab's website portal and the fax machine for (R101's) UA results. It is the expectation of (ICP I) to look for pending lab results daily and when she does not, then, me or the ADON (assistant director of nursing) would look for the results even on the weekend. I see on (R101's) McGeer's criteria sheet, (ICP I) documented the onset of the UTI was 9/19/25. The facility had no proof of that because the portal was not reviewed, and the fax results were not reviewed until 9/23/25. I do not know why 9/19 was documented as the onset of infection. (R101's) lab results were first available on 9/15/25 and no one checked for them on the portal or fax until 9/23/25.