| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235013 | A. Building<br>B. Wing | 07/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fairview Nursing and Rehabilitation Community | 441 E Main St<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on interview and record review, the facility failed to ensure residents received care in accordance with professional standards of nursing practice for 1 resident (Resident #6) of 5 residents reviewed for medications, resulting in the lack of physician notification of elevated blood sugar levels per physician's order, and the potential for worsening of the medical condition.Findings include: Resident #6Review of a Face Sheet revealed Resident #6 was a male, with pertinent diagnoses which included: Type 2 diabetes mellitus (a condition where the body is not able to properly use sugar from the blood) without complications. Review of an active Physician's Order for Resident #6 revealed, Check blood glucose (blood sugar) at HS (bedtime), Notify MD (medical doctor) of blood glucose less than 70 or greater than 300, At Bedtime 08:00 PM 08/02/2024Review of an active Physician's Order for Resident #6 revealed, Check blood sugar PRN (as needed) Special Instructions: PRN recheck blood sugar if over 350 at norm (normal) check Three Times A Day - PRN Morning, Mid-Day, Evening 10/02/24Review of Resident #6's Medication Administration Record (MAR) from 7/1/25 - 7/22/25 revealed blood sugar readings recorded by Registered Nurse (RN) P on 7/4/25 at 8:00 PM as 343 mg/dl (milligrams per deciliter) and by RN O on 7/19/25 at 8:00 PM as 340 mg/dl. There was no documentation that the physician had been notified of the blood glucose readings greater than 300. Review of Resident #6's progress notes for the period 7/1/25 - 7/24/25 revealed no documentation that the physician had been notified of the blood glucose readings greater than 300 on 7/4/25 and 7/19/25.In an interview on 7/23/2025 at 3:13 PM, regarding Resident #6's blood glucose level of 340 on 7/19/25, RN O reported she did not recall if she had notified Resident #6's physician of his elevated blood glucose level. RN O confirmed that the physician order for Resident #6 was for the physician to be notified of a blood glucose level over 300. RN O reported she would usually put in a progress note when the physician had been notified. In an interview on 7/24/25 at 7:20 AM, regarding Resident #6's blood glucose level of 343 on 7/4/25, RN P reported she had thought that the physician was to be notified of a blood glucose level over 350 like the prn blood sugar checks order. RN P reported she did not notify the physician of Resident #6's blood sugar level of 343 on 7/4/25 but that she should have according to the physician order.In an interview on 7/24/25 at 1:40 PM, Director of Nursing (DON) B reported it was the expectation that the nurses notify Resident #6's physician for blood glucose levels over 300 according to the physician order. DON B reported it was the expectation that a progress note is entered in the medical record to confirm the physician was notified. DON B reported if it was not documented, it was not done. |



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

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| | 235013 | A. Building<br>B. Wing | 07/24/2025 |

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| Fairview Nursing and Rehabilitation Community | 441 E Main St<br>Centreville, MI 49032 |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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| | 235013 | A. Building<br>B. Wing | 07/24/2025 |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #1323219. Based on interview and record review, the facility failed to ensure incontinence care was received timely, with the appropriate number of staff assistance, and that it was documented for 1 resident (Resident #10) of 3 residents reviewed for ADL (Activities of Daily Living) care resulting in dissatisfaction with care, potential for skin breakdown and injury to occur. Findings include: Resident #10 (R10)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R10's initial admission date to the facility was on 1/3/2023 with diagnoses including hemiplegia and hemiparesis on right dominant side (muscle weakness/partial paralysis on one side of the body that can affect the arms, legs and facial muscles), reduced mobility, depression and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R10 was cognitively intact (13 to 15 cognitively intact).During an interview on 7/21/2025 at 3:35 PM, R10 stated that sometimes staff takes a while to come to her room and change her brief and asked this surveyor to come back another day to discuss details. During an interview on 7/22/2025 at 8:54 AM, Certified Nursing Assistant (CNA) BB stated that staff change R10's brief often and they check her every 1.5 to 2 hours and they document every time she was changed. CNA BB said that R10 complained about staff not changing her briefs when she was wet and soiled and especially had complaints about 2nd shift. CNA BB said that Director of Nursing (DON) B was aware of these concerns. During an interview on 7/22/2025 at 12:22 PM, CNA T stated that R10's brief was changed often usually every 2 hours, but every 1.5 hours was ideal. CNA T said that R10 doesn't refuse brief changes. CNA T stated that R10 drinks a lot of fluids and when she urinates, she urinates a lot. CNA T said R10 was a 2 person assist when changing her brief since she rolls around a lot. During an interview on 7/24/2025 at 8:23 AM, Registered Nurse (RN) S stated that R10 was a 2 person assist for bed mobility which includes changing briefs. During an interview on 7/24/2025 at 10:25 AM, CNA Z stated that R10 needs her brief changed every 2 hours since she was a heavy wetter. CNA Z said R10 was a 2 assist with brief changes but sometimes she wanted her brief changed right away and he was the only one to help her at the time so he would change her by himself. During another interview on 7/24/2025 at 12:33 PM, R10 stated that sometimes she sits in her brief for 8-10 hours depending on the CNA working that day. R10 said she worries because her bottom can get red when she lays in her wet and soiled brief for a long time. R10 said on 5/22 and 5/23 her brief wasn't changed on 1st shift, on 5/24, 5/29 and 5/30 her brief wasn't changed for 12 hours. R10 said that they need 2 staff to change her brief because she rolls too fast but sometimes only one staff member changes her. Review of R10's Resident Profile available in a book at the nurse's station for CNAs to review revealed ADLs functional status/rehabilitation potential. Start date 9/18/2023. Assist of 2 for bed mobility.Review of R10's Care Plan revealed Problem: Category: ADLs (activities of daily living) functional status//rehabilitation potential. (R10) has alteration in ADLs-self-care deficit r/t (related to) decreased mobility, right hemiparesis, and weakness. Goal: (R10) will be clean/well-groomed daily.Approach (intervention): Approach date: 9/18/2023 Assist of 2 for bed mobility. Review of R10's MDS section GG revealed Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. Was coded as a 02 which indicated R10 was a substantial/maximal assistance. Review of R10's MDS section H revealed that R10 was always incontinent of bowel and bladder. Review of R10's vitals spreadsheet of urine and bowel movement documentation of the dates in question that R10 mentioned to this surveyor revealed:On 5/22 a brief change was completed for a bowel movement at 4:48 AM and the next brief change was completed on 5/22 at 8:21 PM. On 5/23 a brief change was completed 5/23 at 11:09 AM and the next brief change was completed on 5/24 at 5:19 AM and then on 5/24 at 9:52 PM. On 5/29 a brief change was completed at 9:30 AM and the next brief change was on 5/30 at 5:31 AM. During an interview on 7/24/2025 at 1:07 PM, DON B stated that the expectation was that staff should document each time a brief was changed whether it's for bowel or bladder and agreed if it wasn't documented then it wasn't done. DON B reported that R10 needs 1 staff for a brief change since R10 can help with rolling at times and when this surveyor stated that the resident profile stated 2 assist with bed mobility, she agreed that R10 needs to always be a 2 assist when changing her brief. Review of the Activities of Daily Living (ADLs)/Maintain Abilities Policy with a review date of 1/2025 revealed Procedure. 3. The facility will provide care and services for the following activities of daily living.c. elimination toileting. 4. A resident who is an unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that an assistive transfer device (gait belt) was used during a transfer for 1 (Resident #53) of 3 residents reviewed for proper transfers resulting in the potential for a fall and/or an injury.Findings include:Resident #53Review of a Facesheet revealed Resident #35 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: myocardial infarction (heart attack), pneumonia, and congestive heart failure.On 7/21/25 at 1:35 pm, a gait belt (a safety device used to assist individuals with mobility issues, typically worn by a resident and allows for the caregiver to safely move or support a resident while walking or during transfers) was noted to be hanging over the top of the bathroom door in Resident #53's room. Resident #53 reported it was not his and the staff did not use it for him.On 7/22/25 at 12:34 pm, Registered Nurse (RN) S was observed assisting Resident #53 to transfer from his bed to this wheelchair. RN S was standing on Resident #53's left side, with the wheelchair positioned to Resident #53's right side while he was sitting on the side of the bed with his back facing the doorway of the room. RN S was observed holding Resident #53 under his left arm in the armpit area with her left hand and using her right hand to hold the back of Resident #53's pants for stability. Resident #53 was noted to hang on to the handles of the wheelchair and shuffle his feet to pivot and sit down in his wheelchair. RN S did not use a gait belt during the transfer. A gait belt was noted hanging over the bathroom door in the room.In an interview on 7/22/25 at 12:38 pm, RN S reported that Resident #53 was a one-person transfer. RN S reported that Resident #53 did not use a gait belt during transfers.Review of Care Plan for Resident #53 revealed problem/goal/approach ADLs (activities of daily living) functional ability and participation does vary and fluctuate. will participate in care to his fullest ability. TRANSFER STATUS. 1 person contact guard Assist with a GAIT BELT.On 7/23/25 at 12:45 pm, a gait belt was observed hanging over the bathroom door in Resident #53's room in the same position as the last two days.In an interview on 7/23/25 at 1:30 Certified Nurse Assistant (CNA) Y reported that a gait belt should be used for all one or two person transfers and the gait belts were kept in resident rooms.In an interview on 7/23/25 at 1:38 pm, CNA U reported all transfers not done with a mechanical lift needed a gait belt. CNA U reported there was a resident profile book that was communication between therapy and nursing staff and gave instructions on how a resident should be transferred. CNA U opened the book to Resident #53's profile page and the page was noted to reveal .TRANSFER STATUS. 1 person contact guard Assist with a GAIT BELT.In an interview on 7/23/25 at 1:34 pm CNA BB reported the resident's care plan was where transfer status was noted and that all transfers required the use of a gait belt.In an interview on 7/23/25 at 1:55 pm, Therapy Director (TD) M reported that Resident #53 was one person transfer with contact guard and a gait belt. TD M reported that gait belts should be used with all transfers unless the resident was independent or needed a mechanical lift. TD M reported that gait belts should be kept hanging on the back of the door in resident's room when not being used. In an interview on 7/24/25 at 10:39 am, Nursing Home Administrator (NHA) A reported there was no facility policy regarding transfer and the expectations were that everyone followed the recommendations for transfer status that was provided by the therapy department.In an interview on 7/24/25 at 10:40 am, Licensed Practical Nurse (LPN) N reported that gait belts were to be used for all transfers unless the resident was independent.In an interview on 7/24/25 at 1:07 pm, Director of Nursing (DON) B reported that using a gait belt with a transfer was a standard of care and the staff knew that. DON B reported that the therapy department would provide communication and direction regarding the use of a gait belt and transfer status of the residents. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 1). Maintain infection control practices, specifically the use of gloves during administration of insulin injections, 2). Sanitize or clean resident shared equipment specifically a glucometer (a portable device used to measure the concentration of glucose in the blood) for 6 (Resident #25, Resident #17, Resident #7, Resident #30, Resident #28, and Resident #22) of 6 residents reviewed for glucose monitoring during medication administration; and 3). Properly use personal protective equipment (PPE) for a resident in enhanced barrier precautions during a transfer for 1 (Resident #53) of 3 residents reviewed for transfers, resulting in the potential for the spread of infection, cross contamination, and disease transmission. Findings include: Resident #25Review of a Facesheet revealed Resident #25 was a female who originally admitted to the facility on [DATE] and had pertinent diagnosis which included: Type 2 diabetes mellitus with hyperglycemia (A condition in which the body cannot use insulin correctly and the sugar builds up in the blood causing high blood sugar.)Review of Physician Orders for Resident #25 revealed .insulin lispro insulin pen: sliding scale: if blood sugar less than 60 call MD (physician); if blood sugar is 140 to 199 give 6 units; if blood sugar is 200 to 249 give 9 units; if blood sugar is 250 to 299 give 12 units; if blood sugar is 300 to 349 give 15 units; if blood sugar is 350 to 399 give 18 units; if blood sugar is greater than 399 call MD; subcutaneous (into the layer of tissue just below the skin), before meals and at bedtime with a start date of 7/14/25. During an observation on 7/22/25 at 11:47 am, Registered Nurse (RN) S placed a glucometer into a plastic cup at the medication cart. RN S then gathered several lancets (a sharp pointed medical instrument used to puncture the skin) , alcohol prep pads, and a plastic container of glucometer test strips and placed all supplies into a second plastic cup. RN S then entered the room of Resident #25, placed the two plastic cups onto the over the bed table next to where Resident #25 was sitting in her room. RN S cleaned Resident #25's right index finger with an alcohol prep pad, used the lancet to stick the finger to obtain a blood sample, and applied the blood to the test strip in the glucometer. Once Resident #25's blood sugar reading was obtained, RN S returned to the medication cart, placed both plastic cups on top of the cart. RN S did not remove the glucometer or other supplies from the plastic cups and did not clean the glucometer. During an observation on 7/22/25 at 11:59 am, RN S prepared Resident #25's insulin lispro, 6 units (a unit is a basic measurement of the amount of insulin to administer), carried an alcohol prep pad and the insulin pen into Resident #25's room. Resident #25 lifted her shirt, exposed her abdomen, and RN S opened the alcohol prep pad, swabbed an area of Resident #25's abdomen and injected the insulin into Resident #25's abdomen. RN S did not wear any gloves during the insulin administration. Resident #17 Review of a Facesheet revealed Resident #17 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnosis which included: Type 2 diabetes mellitus with hyperglycemia.Review of Physician Orders for Resident #17 revealed . aspart insulin liquid 100 units/ml (milliliter) amt 20 units subcutaneous.hold for BS (blood sugar) < (less than) 100, before meals with a start date of 6/19/2025.During an observation on 7/22/25 at 11:53 am, RN S retrieved the two plastic cups from the top of the medication cart, one containing the glucometer and the other the lancets, alcohol pads, and container of glucose test strips, and entered the room of Resident #17. As RN S entered Resident #17's room she turned to this surveyor and stated, It's okay that I do this, because I keep the glucometer in a cup to take it to another resident, but I don't clean it until the very end when I'm done checking everyone's blood sugar. RN S was observed using a lancet to obtain a blood sample from Resident #17's fingerstick and applying the blood to the test strip inserted into the same glucometer in the same plastic cup and obtained Resident #17'a blood sugar reading. RN S then returned to the medication cart, placed both plastic cups on top of the cart. RN S did not remove the glucometer or exchange the other supplies from the plastic cups and did not clean the glucometer. During an observation on 7/22/25 at 12:03 pm, RN S prepared Resident #17's aspart insulin, 20 units, carried an alcohol prep pad and the insulin pen into Resident #17's room. Resident #17 lifted his shirt, exposed his abdomen, and RN S opened the alcohol prep pad, swabbed an area of Resident #17's abdomen and injected the insulin into Resident #17's abdomen. RN S did not wear any gloves during the insulin administration. Resident #7 Review of a Facesheet revealed Resident #7 was a male who originally admitted to the facility on [DATE] and had pertinent diagnosis which included: Type 2 diabetes mellitus without complications.Review of Physician Orders for Resident #7 revealed .Novolog flex pen U-100 insulin, per sliding scale, if blood sugar is less than 60 call MD, If blood sugar is 151 to 200 give 6 |