STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525437	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair View Nursing and Rehabilitation Center	1050 Division St Mauston, WI 53948

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for 2 of 4 sampled residents (R1 and R2).R1 made an allegation of abuse against R2 to her daughter that was overheard by an RN (Registered Nurse). The RN did not report the allegation of abuse.CMS's indicates abuse is to be reported within 2 hours, as identified, in part, by 483.12(c)(1) as: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 2 hours if the events that cause the allegation do involve abuse and do not result in serious bodily injury, to the administrator of the facility and other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.This is evidenced by:The facility policy titled, Resident Safety and Abuse Prevention & (and) Reporting, undated, states in part .Policy: A. Reporting incidents:a. Any staff witnesses possible abuse, neglect, or misappropriation must:b. Report the incident to the Administrator or designee immediatelyH. Resident-to-Resident Abuse d. Reporting: i. Submit a completed Misconduct Incident Report (F-62447) within 24 hours of discovery. Note: According to the State Operations Manual any allegations involving abuse or resulting in serious bodily injury must be reported to the State Agency within 2 hours of discovery. The facility policy titled, Reporting Reasonable Suspicion of Crimes in Long Term Care Facilities, undated, states in part. Purpose: To ensure compliance with Federal and State Regulatory Agencies regarding the reporting of any reasonable suspicion of a crime committed against residents or individuals receiving care from the facility, promoting timely response to potential crimes, and protecting residents. Policy: D: If the events that cause suspicion result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion. If the events do not cause serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion. Note: According to the State Operations Manual any allegations involving abuse or resulting in serious bodily injury must be reported to the State Agency within 2 hours of discovery. R1was admitted to the facility on [DATE]. Diagnoses include in part . cerebral infarction, closed fracture of the distal end of left radius and dementia.R2 was admitted on [DATE]. R2's diagnoses include in part. history of stroke, and dementia.Surveyor reviewed the facility self-report submitted 9/15/25 which states, R1 was overheard on the phone stating that a man had held her hand and had been kissing up on her and that she wasn't here for that. R1 had been on the phone with her daughter and charge nurse spoke with daughter once their conversation had ended. Daughter relayed the same information. Charge nurse made sure that resident was safe, care plan was updated to reflect that the accused and R1 are not to be left alone together. DON (Director of Nursing)/Administrator notified, law enforcement was contacted, and full investigation began. AHCPOA's (Activated Health Care Power of Attorney) for both parties notified. Nurses Note in R1's chart from 9/13/25 at 21:53 (9:53 PM) states, this past week staff has noticed resident holding hands with 1 of our male Resident's. Resident did not seem to mind holding hands with the male. At times she was seen wheeling up to him and at others he wheeled up to her. Resident was not observed trying to pull her hand away, moving away or looking uncomfortable. Tonight, while on the phone talking to her daughter she was overheard telling daughter about a man that lived here who wouldn't leave her alone. Told daughter she really didn't want him touching her and especially kissing up on her. Staff has not observed any kisses being exchanged. After she was off the phone writer spoke with Resident about the male Resident and was assured if she didn't want him to touch her staff would keep them apart. Resident said she would like that as she really didn't want him to touch her. Resident was assured this was a safe place and we would keep her safe from unwanted advances. About an hour after speaking with Resident [name] her daughter called and spoke with writer about moms concerns about the male resident. Daughter assured that staff had already spoke with her mom and had reassured her that male Resident would be kept away from her. Daughter also voiced concern that Mom was afraid to go to sleep for fear the male Resident would enter her room. Reassured daughter that male Resident was wheelchair bound and had no idea what her moms name was or where her room is at. Reassured daughter

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview the facility did not develop and implement a Comprehensive Resident Centered Care Plan for 1 of 4 residents reviewed (R 2). R2's medical record indicated R1 had occasional sexual inappropriate behaviors. R2's comprehensive care plan does not include a care plan for sexual inappropriate behaviors.Evidenced by:The facility's Multidisciplinary Plan of Care Policy, undated, includes in part the following: D. The comprehensive plan of care is maintained in the electronic medical record (EMR) and is updated to reflect the resident's current status and goals. It will be reviewed at minimum quarterly and per resident need. R2 was admitted to the facility 9/12/24. R2's diagnosis include dementia, history of stroke, osteoarthritis and diabetes. R2's most recent MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 8/28/25, includes, in part, the following: R1 usually understands, is usually understood and has severe cognitive impairment. R1's Interdisciplinary Notes includes, in part, the following:9/11/25, 10:07 AM, Care Plan Conference, What staff attended meeting: Care Plan reviewed by each IDT (Interdisciplinary Team) prior to Care Conference attended by RN G (Registered Nurse), . Annual . FM H (Family Member) apologized for pt's (patient's) occasional sexual inappropriateness .On 9/24/25 at 2:10 PM Surveyor interviewed RN G. RN G stated she was responsible for updating care plans after Care Plan Conferences. Surveyor asked RN G if she had attended R2's Care Plan Conference on 9/11/25. RN G stated yes she did. Surveyor asked RN G if she had updated R2's Care Plan to include the concerns for sexual inappropriateness. RN G and surveyor reviewed R2's Care Plan. RN G stated no she had not updated R1's Care Plan to include concerns of sexual inappropriateness or interventions when R2 was sexually inappropriate. RN G stated she should have updated R2's Care Plan to include the concerns with sexual inappropriateness. RN G stated she would update R2's Care Plan right away.