

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Fair View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>42038</p> <p>Based on interview and record review the facility did not ensure that residents that are diabetic received routine diabetic foot checks in accordance with professional standards of practice for 1 of 1 resident (R10) reviewed for diabetic foot checks.</p> <p>R10 has no documentation of diabetic foot checks.</p> <p>This is evidenced by:</p> <p>Per ADA (American Diabetes Association), dated 2017, foot checks/screens should be conducted daily with a comprehensive exam conducted annually.</p> <p>Per AMDA (American Medical Director Association), dated 12/9/14, these foot checks/screens are vitally important for treatment of foot problems in patients with diabetes. Common foot problems in diabetic patients are broken down into three categories: at-risk foot, current mild foot/ankle or heel infection or ulcer, and limb-threatening foot/ankle/heel ulcer.</p> <p>It is important to note that the facility did not have a policy for diabetic foot checks.</p> <p>Example 1</p> <p>R10 has a diagnosis of type 2 diabetes mellitus.</p> <p>R10's medical record was reviewed for documentation of diabetic foot checks.</p> <p>R10's medical record does not include any documentation of the facility completing daily diabetic foot checks.</p> <p>On 12/5/24 at 1:44 PM, Surveyor interviewed RN D (Registered Nurse). Surveyor asked RN D what the process is for diabetic foot checks, RN D reported that skin checks were being completed weekly on shower days and that the diabetic foot checks were added to the staff worklist on 12/4/24.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Fair View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 2:16 PM, Surveyor interviewed ADON C (Assistant Director of Nursing). Surveyor asked ADON C where the documentation regarding diabetic foot checks could be found, ADON C reported that they would be on the worklist. Surveyor requested documentation of diabetic foot checks for R10. ADON C reported to Surveyor that the facility had not been completing daily diabetic foot checks but have been doing weekly skin checks on shower days. Surveyor asked ADON C what the standard of practice is for how often diabetic foot checks should be completed, ADON C stated they should be completed daily.</p> <p>On 12/5/24 at 3:35 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B what her expectations were for staff completing diabetic foot checks, DON B stated that they should be done daily.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Fair View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253</p> <p>Based on interview and record review, the facility did not ensure residents maintain acceptable parameters of nutritional status for 1 of 3 residents reviewed for nutritional status (R29).</p> <p>R29 experienced a significant weight loss, and the facility did not assess and notify the physician.</p> <p>Findings include.</p> <p>The facility's policy on weights states:</p> <p>*Each resident will be weighed on admission, day after admission and then weekly, unless stated by the physician. Weights will be taken by the certified nursing assistant (CNA) and reported to the team leader who will record them in the residence record.</p> <p>*If weight changes are identified to be significant, nursing will contact the physician for update and possible recommendations.</p> <p>The facilities policy titled Nutrition Risk Program, states:</p> <p>*The registered dietitian, speech pathologist, registered nurse, or other caregiver should identify the resident at nutritional risk during the initial assessment.</p> <p>* Any member of the healthcare team may alert the nutrition risk team to potential nutritional risk situations i. e., observation of poor intake, weight loss, etc.</p> <p>*The nutrition risk team will then determine if the resident meets the outline parameters for their nutrition risk program.</p> <p>*Residents on the nutrition risk program are identified in a few different ways, including a weight loss/gain of 5% or more in the past 30 days or weight loss/gain of 10% or more in the past 180 days. The *Nutrition risk updates will be sent to nursing staff, speech therapy, occupational therapy, physical therapy, and social services as appropriate. The physician will also receive notification that the resident was added to the program.</p> <p>R29 was admitted to the facility on [DATE] and has diagnosis that include dementia. Her most recent MDS (Minimum Data Set), dated 10/11/24, includes a BIMS score (Brief Interview for Mental Status) of 3, indicating R29 has severe cognitive impairment. R29's MNA (Mini Nutritional Assessment), conducted by the facility on 10/4/24, shows a score of 9, indicating R29 is at risk for malnutrition. R29's care plan states, Problem: Health maintenance .Needs: I report that my appetite is poor. Due to my dementia diagnoses, I am at risk for poor meal initiation .Outcome: Maintain nutritional status .I will maintain current body weight without significant weight change.</p> <p>The facility documented the following weights for R29:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Fair View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10/25/24: 178.5 lbs.</p> <p>10/29/24: 173 lbs.</p> <p>11/24/24: 168.6 lbs.</p> <p>11/26/24: 166.4 lbs.</p> <p>11/29/24: 168.6 lbs.</p> <p>12/4/24: 169.7 lbs.</p> <p>On 12/05/24 at 1:31 PM, Surveyor interviewed RD J (Registered Dietician) who stated that CNAs gather weights and the RNs (Registered Nurses) input them into the electronic system. RD J stated that she reviews weights weekly or every couple weeks, but sometimes monthly. RD J stated that if there is a significant change in the resident's weight, it depends on the physician as to who and when they are notified. RD J stated that she had reviewed weights on 11/4/24 and will be putting R29 on the facility's Nutrition at Risk alert for their next meeting on 12/12/24. RD J stated that she had conducted nutritional assessments for R29 on 10/4/24 and 10/18/24 but had not alerted the doctor to any recent weight changes.</p> <p>On 12/05/24, Surveyor interviewed RN G at 2:45 PM and RN H at 2:39 PM, both of whom stated that CNAs gather weights and report them to them (RN, charge nurse, etc.). Nurses then input the weights. RN G and RN H both stated that they look at the previous weight when documenting weights and if the previous weight is a 5-pound difference, they would request a reweight and if the reweight confirms the original weight, then they would conduct an assessment and notify the resident's physician of weight changes.</p> <p>It should be noted that no assessments were provided to Surveyors, nor was any evidence provided of correspondence to R29's physician regarding her weight loss. Additionally, no additional weights were gathered between 10/29/24 and 11/24/24 and no evidence was provided of interventions put into place.</p> <p>On 12/05/24 at 2:02 PM, Surveyor interviewed MD I (Medical Doctor) in person. MD I is also the facility's medical director. MD I stated that he could not recall being notified of R29's weight. While sitting at a computer, MD I searched for any recent contact or correspondence from either facility staff or the Nurse Practitioners (NP) that he oversees and could not see any recent weight notifications. MD I stated R29 was recently visited by an NP on 11/4/29, but there was no mention of weight changes. MD I stated, I did not know. We missed it. I should be much more aware of this and I'm not. MD I also stated that he expects to be notified of any significant weight changes.</p> <p>R29 experienced a significant weight loss of 6.78% in one month and the facility did not assess R29, notify R29's physician or put any additional nutritional interventions in place. The facility was aware that R29 had lost 5 lbs. between weights on 10/25/24 and 10/29/24 and no interventions or additional weights were gathered between then and 11/29/24.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Fair View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41788</p> <p>Based on interview and record review the facility did not ensure they followed their antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 2 of 2 supplemental residents (R11 and R186) reviewed for antibiotic stewardship.</p> <p>R11 was treated with an antibiotic for an UTI (urinary tract infection) without meeting criteria.</p> <p>R186 was treated with an antibiotic for an UTI and did not meet criteria.</p> <p>Evidenced by:</p> <p>The facility policy, entitled Antimicrobial Stewardship Program, 7/22/24, states, in part: .</p> <p>POLICY:</p> <p>A. (Facility Name) has established and will maintain an antimicrobial stewardship program (AMS). AMS programs promote appropriate antibiotic prescribing practices and play a critical role in reducing antibiotic resistance .</p> <p>C. The Antibiotic Stewardship Team will be responsible for, at a minimum: .</p> <p>b. Ensuring that (Facility Name) follows the Core Elements of Antibiotic Stewardship as recommended by the CDC (Centers for Disease Control) and required by CMS (Centers for Medicare & Medicaid Services) and the Joint Commission .</p> <p>f. Defining and tracking metrics specific to antibiotic stewardship.</p> <p>g. Monitor and report antimicrobial susceptibility trends and communicate these to Healthcare Providers.</p> <p>h. Reporting outcomes, protocol/practice compliance, and opportunities for improvement to providers, our administration, and staff. Monitoring of prescribing practices and adherence to policies and protocols and reporting trends back to the Team and to Healthcare Providers .</p> <p>Example 1</p> <p>R11 was admitted to the facility on [DATE] and has diagnoses that include Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids).</p> <p>R11 is listed on the September Infection Control Line List as having a UTI (Urinary Tract Infection). Symptoms are recorded as 9/14/24- right low back pain. Criteria box is marked with an x to show R11 met criteria. Bacteria: Actinotignum schaalii. Antibiotics: Amoxicillin 250 mg (milligrams) BID (twice a day). Start Date: 9/23/24. Stop Date: 9/30/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Fair View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R11's culture dated 9/18/24 shows organism is Actinotignum schaalii with no colony count. R11's culture report dated 9/15/24 shows Organism is gram positive cocci with colony count of 10,000-50,000 CFU (colony forming unit)/mL (Milliliters).</p> <p>Of note: to meet criteria, the colony count must be 100,000 or over.</p> <p>R11's Progress Note dated 9/19/24, states, in part: .</p> <p>Progress Note: A&P (Assessment and Plan) .</p> <p>(3) UTI: . The latest urine showed gram-positive cocci 10 - 50,000 that appears to be contaminant . Patient denies any dysuria. Is not running a fever and she does have a history of back pain much more likely this is related to musculoskeletal pain .</p> <p>R11's Physician order, dated 9/23/24, states, in part: . Amoxicillin 250 mg po (by mouth) BID. Total Doses: 14. Clinical Indication: UTI . Order: 9/23/24. Start: 9/23/24. Stop: 9/30/24. Complete: 9/30/24. Complete Reason: Reached Stop Date .</p> <p>R11's September's MAR (medication administration record) shows R11 received amoxicillin 250 mg x 1 on 9/23/24, bid on 9/24/24, 9/25/24, 9/26/24, 9/27/24, 9/28/24, 9/29/24 and x 1 on 9/30/24.</p> <p>Example 2</p> <p>R186 admitted to the facility on [DATE] and has diagnoses that include Chronic Kidney Disease Stage 3A (a stage of kidney disease where the kidneys are mildly to moderately damaged and are functioning at 45%-59% of what they should be) and Hypertension (defined as blood pressure above 140/90).</p> <p>R186 is listed on the October Infection Control Line List as having a UTI. Symptoms: strong urine. Type of Infection: UTI. Criteria Met box was left blank. Bacteria: Escherichia coli and Aerococcus species. Antibiotics: Cephalexin 500 mg po BID. Start Date: 10/7/24. Stop Date: 10/10/24.</p> <p>Of Note: Strong urine is not a symptom of McGeers Criteria.</p> <p>R186's culture report dated 10/7/24 shows Organism 1 as Escherichia coli with a colony count of >100,000 CFU/mL and Organism 2 as Aerococcus species with a colony count of >100,000 CFU/ML. Sensitivity show cephalixin is susceptible.</p> <p>R186's Physician Order, dated 10/7/24, states, in part: . Order: Cephalexin 500 mg po BID. Days: 3. Clinical Indication: UTI. Start:10/7/24. Stop: 10/10/24. Complete: 10/10/24. Complete Reason: Reached Stop Date .</p> <p>R186's MAR shows R186 received cephalixin 500 mg on 10/7/24 x 2, 10/8/24- refused, 10/9/24 R186 received x1 and refused x 1, and on 10/10/24 R186 received x 1.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Fair View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/05/24, at 10:17AM, Surveyor interviewed IP E (Infection Preventionist), RN F (Registered Nurse) and ADON C (Assistant Director of Nursing). Surveyor asked what standards of practice the facility uses for infection control and IP E indicated McGeers, CDC (Centers of Disease Control) and DHS (Dept. of Health Services). Surveyor asked if R11 met McGeers criteria to treat with an antibiotic for UTI with symptoms of low back pain and colony count of 10,000-50,000 and ADON C indicated no. Surveyor asked if strong urine is a symptom that meets McGeers Criteria and IP E indicated no. Surveyor asked if R186 met criteria to treat with an antibiotic for UTI with symptoms of strong urine and Escherichia coli with a colony count of >100,000 CFU/mL and Aerococcus species with a colony count of >100,000 CFU/ML. IP E indicated R186 had increased incontinence but was unable to provide supporting documentation. ADON C and IP E indicated R186 did not meet criteria to treat UTI with antibiotics.</p>