STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525179	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Kenosha	3100 Washington Rd. Kenosha, WI 53144

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 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 interview and record review, the facility did not ensure each resident received adequate supervision and assistance to prevent accidents for 1 (R3) of 3 residents reviewed for falls.R3 has a history of falls and is assessed to be at a high risk for falls. R3 has an active care plan intervention for Dycem (a versatile, non-slip material used for various applications, including wheelchair use) to be in place in R3's wheelchair to prevent falling. On 8/30/25, R3 slid out of R1's wheelchair and fell on the floor. R3 did not have Dycem in R3's wheelchair at the time of the fall. Findings include:The facility policy dated 1/30/23 and titled, Accidents/Fall Prevention Program, documents, in part: The facility strives to promote safety, dignity, and overall quality of life for its residents by providing an environment that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents. An immediate/initial care plan for fall risk will be developed for any newly admitted residents whose assessment indicated the resident was at greater risk for falls/accidents. This plan of care is communicated to all appropriate staff. Each incident/accident or fall must be investigated and/or assessed using a root cause analysis process to determine the cause of the episode to prevent any further injury. A resident's individual care plan is to be updated with any changes or new interventions post fall, incident, and accident, communicated to appropriate staff and implemented.R3 was admitted to the facility on [DATE] with diagnoses that include Severe vascular dementia with mood disturbance, Type 2 Diabetes, and Generalized Osteoarthritis.R3's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents that R3 is severely cognitively impaired. R3 requires partial/moderate assist for hygiene and transfers. R3 has had 2 falls without injury since the last MDS assessment. R3's Annual Fall Care Area assessment dated [DATE] documents, in part: The resident has an [Activity of Daily Living (ADL)] self-care performance deficit [with] risk for falls. [related to] activity intolerance, musculoskeletal impairment [with] associated pain limiting mobility, respiratory failure, cognitive impairment, presence of intermittent incontinence of bladder.R3's fall risk assessment dated [DATE] documents a score of 15, indicating R3 has a high risk of falls.R3's fall risk care plan initiated 10/17/2024 documents the following pertinent interventions: Encourage the resident to use bell to call for assistance (initiated 1/29/25). Dycem in wheelchair (initiated 7/14/25), Grip strips on left side to left side of the bed (initiated 10/28/23). Pommel cushion added to [wheelchair] for pelvic alignment (initiated 6/23/23). Keep commonly used items within reach (initiated 1/5/25).R3's Certified Nursing Assistant (CNA) Kardex documents, in part: Dycem in wheelchair.R3's progress note entered by Licensed Practical Nurse (LPN)-H dated 8/30/25 at 5:30 PM, documents, in part: Writer notified [R3] had [unwitnessed fall] was found on bilateral buttocks. Fall appears to result from new [wheelchair] cushion which caused [R3] to slide out [wheelchair]. Neuro [checks] initiated. No presenting [signs/symptoms] impairment or changes to baseline [ADL] functions/mental status.On 9/3/25 at 1:04 PM, Surveyor attempted to reach LPN-H by telephone. Surveyor left a voicemail message but was unable to interview LPN-H.On 9/3/25 at 10:30 AM, Surveyor requested the facility's fall investigation into R3's fall on 8/30/25.R3's Interdisciplinary (IDT) note created on 9/3/25 at 10:51 AM and an effective date of 9/2/25 at 3:30 PM, documents, in part: IDT met to review unwitnessed fall that occurred on 8/30/2025 at approximately [5:30 PM]. Staff found resident on the floor seated on bilateral buttocks near [R3's] wheelchair. No injuries identified. [R3] has a history of self-transferring without asking for assistance [related to] impaired cognition and memory. Fall appears related to absence of Dycem in wheelchair at the time of incident, allowing resident to slide from the seat. Staff were re-educated on following Kardex interventions, specifically ensuring Dycem placement to reduce risk of slipping. Care plan reviewed and updated to reflect interventions for continued fall prevention. Surveyor noted that R3's IDT note was created on 9/3 at 10:51 AM, after Surveyor asked for R3's fall investigation.R3's facility fall investigation dated 8/30/25 documents, in part: R3 was wearing shoes at the time of the fall. R3 was assisted to the bathroom at 5 PM, 30 minutes before the fall. R3 was seen sitting in R3's wheelchair just prior to R3's fall. R3's fall risk care plan documents the following intervention with a creation date of 9/3/25 and an initiation date of 9/2/25: Educate staff on following Kardex and interventions. Included in the fall investigation is a CNA Education Note dated 9/3/25. Surveyor noted there is not a time documented on the CNA Education Note. The note documents, in part: Topic-Following resident care plans-fall prevention interventions. Date-9/3/25. Staff Educated- CNA-G. Education provided- Reviewed importance of following the individualized resident care plan at all times. Discussed the resident's risk of falls