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	01/14/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure family was informed of a change in condition for one resident (Resident (R) 6) of 20 residents reviewed. The facility failed to inform family when R6 developed a stage 3 heel pressure ulcer (full thickness loss of skin). Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R6 was admitted to the facility on [DATE] and was discharged home on [DATE]. R6 had diagnoses that included cancer with metastasis to the bone, and a stroke.Review of the admission Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 10/24/25 revealed R6 had a Brief Interview of Mental Status (BIMS) score of 13 out of 15 which indicated R6 was cognitively intact.Review of a 10/28/25 Wound Care Note located in the Progress Notes tab of the EMR revealed, Stage 3 pressure ulcer on left heel, measures 5.0 x 5.0 x 0.2 cm [centimeters] had 100% Sanguineous drainage. Wound care physician to see. There was no documentation to show a family member was updated on the newly identified heel ulcer.Review of a 10/28/25 Order Summary located in the Orders tab of the EMR revealed, Cleanse left heel with normal saline, pat dry, apply Medi honey to wound bed and cover with ABD pad [a highly absorbent wound dressing] and kerlix [used to hold the wound dressing in place] daily and PRN [as needed].During an interview on 01/12/26 at 12:59 PM, Family Member (FM) 1 was asked if he was notified of R6's newly identified heel ulcer. FM1 stated, I was not notified of any wound.During an interview on 01/12/26 at 2:34 PM, Registered Nurse (RN) 1 was asked if she notified R6's family when the heel wound was identified. RN1 stated, R6 was his own person, and he did not specify who or if he wanted family notified of the wound. He had just three emergency contacts and no resident representative. RN1 was asked if she had documented in the EMR that R6 was asked and he declined to have family updated. RN1 acknowledged that the documentation was not in the EMR.Review of the facility policy titled, Notification of Change in Condition, dated 10/06/23 revealed, .Competent individuals .The facility must still contact the resident's physician and notify resident's representative, if known .A family that wishes to be informed would designate a member to receive calls .When a resident is mentally competent, such [sic] a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally .

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