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	07/24/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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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F 0585 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 observation, interviews, and record review the facility did not address and resolve grievances conveyed on behalf of 1 (R7) of 1 resident reviewed for grievances. * On 7/21/2025, Surveyor interviewed R7, regarding grievances that were reported to staff. R7 indicated reporting concerns with portion sizes of meals to R7's caring partner. R7's meal ticket didn't show double portions. R7 voiced concerns about getting double portions with every meal. Findings include:The facility's policy, titled Resident and Family Grievances, with implemented date of 3/4/2025 documents: Policy Explanation and Compliance Guidelines: .10. Procedure:a. This facility will not retaliate or discriminate against anyone who files a grievance or participates in the investigation of the grievance.b. Staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. c. Forward the grievance form to the grievance official as soon as practicable.R7 was admitted to the facility on [DATE] with diagnoses that include intertrochanteric fracture of left femur, chronic obstructive pulmonary disease, type II diabetes malleolus, chronic systolic congestive heart failure, hyperglycemia, presence of automatic cardiac defibrillator.R7's admission Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) of 15, indicating R7 is cognitively intact. The MDS documents R7's eating as, setup or clean-up assistance, Helper sets and cleans up, and then resident completes activity.R7's (nutritional) care plan, dated 5/7/2025, with a target date of 8/22/2025, under the intervention section it is documented as: Provide, serve diet as ordered. Surveyor could not locate any documentation of double portions in the care plan. On 7/21/2025, at 2:21 PM, Surveyor interviewed R7, who indicated that concerns were not being addressed and resolved with reporting. R7 stated giving complaints to R7's caring partner, this was Certified Nursing Assistant (CNA) Scheduler-J. A Caring Partner is a program at the facility that involves all residents to have an employee in management to report concerns to. R7 stated that the resolution was to have double portions with meals, R7 stated this doesn't happen with all meals. On 7/22/2025, at 8:32 AM, Surveyor observed R7's meal size and ticket. R7 stated that R7 will have to call down to kitchen to ask for a larger portion. Surveyor observed the meal ticket for breakfast and no size or preferences were documented on R7's meal ticket. Surveyor reviewed the grievance log from April 2025 to current. There were no documented grievances for R7.On 7/23/2025, at 9:52 AM, Surveyor interviewed CNA Scheduler-J, who stated that there was a concern from R7 related to portion size. CNA Scheduler-J stated there is a form to be filled out regarding concerns or grievances. CNA-Scheduler-J indicated that the form would be turned into the social worker upon completion. CNA Scheduler-J indicated that a form would only be fill out if the concern was something serious. CNA Scheduler-J stated that R7's meal size concern was addressed with Dietary Manager-C when reported a month ago. CNA Scheduler-C indicated that a form didn't need to be filled out for this concern as it was addressed verbally.On 7/23/2025, at 10:32 AM, Surveyor interviewed Dietary Manager (DM)-C, who stated DM-C remembers addressing the concern of portion size from R7 and that it was addressed with double portions. DM-C indicated that the concern was reported to him verbally and addressed verbally after, no documentation of R7's concern. DM-C stated the meal ticket should show R7's preferences on them, and that double portions was missed with R7's meal tickets, but that DM-C will be adding it to the tickets right away.On 7/23/2025, at 10:09 AM, Surveyor interviewed Social Services Director (SSD)-I, who stated that with any concern, a grievance form needs to be filled out. SSD-I stated that SSD-I wasn't aware of any concerns from R7. SSD-I stated that SSD-I will be following up with R7 today to address any concerns. On 7/24/2025, at 7:40 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated CNA Scheduler-J is a newer employee, to not only this company but also long-term care. DON-B indicated that CNA Scheduler-J, didn't know how to address the concern as a caring partner as CNA Scheduler-J is a newer employee. On 7/24/2025, at 8:24 AM, Surveyor informed Nursing Home Administrator (NHA)-A, of the concern with R7's grievances being addressed. Surveyor informed NHA-A that R7's caring partner didn't report grievances to social services or fill out a grievance form. NHA-A indicated that training would occur with CNA Scheduler-J on how to handle grievances. NHA-A indicated an understanding of the concern mentioned above.No additional information received as to why R7's grievance for double portions were not documented and addressed and or resolved.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure admission and annual comprehensive Minimum Data Set (MDS) assessments were completed in the timeframe prescribed in the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual for 6 (R35, R10, R75, R79, R87, and R34) of 8 residents reviewed for late MDS assessments.*R35's admission MDS assessment dated [DATE] was completed after the specified timeframe.*R10's Annual MDS assessment dated [DATE] was in progress and had not been completed at the time of survey, 7/21/2025.*R75's admission MDS assessment dated [DATE] was in progress and had not been completed at the time of survey, 7/21/2025.*R79's admission MDS assessment dated [DATE] was in progress and had not been completed at the time of survey, 7/21/2025. *R87's admission MDS assessment dated [DATE] was completed after the specified timeframe.*R34's Annual MDS assessment dated [DATE] was in progress and had not been completed at the time of survey, 7/21/2025.Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2024 documents: The admission assessment is a comprehensive assessment for a new resident . that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (Assessment Reference Date) (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) (Care Area Assessment) completion date, but not later than. The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.1.)R35 was admitted to the facility on [DATE]. Per the RAI Manual, R35's admission MDS assessment must be completed by 6/27/2025. R35's admission MDS assessment was completed on 7/21/2025, 24 days after it was due to be completed.2.)R10's Annual MDS assessment dated [DATE], per the RAI Manual, must be completed by 7/4/2025. On 7/21/2025, R10's Annual MDS assessment was In Progress and not completed.3.)R75 was admitted to the facility on [DATE]. Per the RAI Manual, R75's admission MDS assessment must be completed by 7/4/2025. On 7/21/2025, R75's admission MDS assessment was In Progress and not completed.4.)R79 was admitted to the facility on [DATE]. Per the RAI Manual, R79's admission MDS assessment must be completed by 7/10/2025. On 7/21/2025, R79's admission MDS assessment was In Progress and not completed.5.)R87 was admitted to the facility on [DATE]. Per the RAI Manual, R87's admission MDS assessment and CAAs must be completed by 6/24/2025. R87's admission MDS assessment was completed on 7/11/2025, 17 days after it was due to be completed, and the CAAs were completed on 7/18, 24 days after it was due to be completed.6.)R34's Annual MDS assessment dated [DATE], per the RAI Manual, must be completed by 7/8/2025. On 7/21/2025, R10's Annual MDS assessment was In Progress and not completed.On 7/23/2025 at 8:24 AM, Surveyor asked Licensed Practical Nurse (LPN)-K how many MDS nurses were employed at the facility. LPN-K stated LPN-K works full time and another LPN works part time as MDS nurses. LPN-K stated LPN-K had been out of the facility on medical leave for three months and returned to work full time on 6/30/2025. Surveyor asked LPN-K if there was anyone covering LPN-K's workload while LPN-K was gone. LPN-K stated a couple MDS coordinators from sister facilities assisted with MDS assessments but was not sure of the extent of coverage. Surveyor shared with LPN-K the concerns R35, R10, R75, R79, R87, and R34 had late comprehensive assessments. LPN-K was aware of the late assessments and agreed they were behind schedule.On 7/23/2025 at 10:26 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concerns with resident comprehensive MDS assessments not being completed timely. NHA-A stated LPN-K made NHA-A aware of the concern and agreed staffing of the MDS coordinators was difficult for a period of time making assessments late.No additional information was provided.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure quarterly Minimum Data Set (MDS) assessments were completed in the timeframe prescribed in the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual for 1 (R69) of 8 residents reviewed for late MDS assessments.* R69's Quarterly MDS assessment dated [DATE] was completed after the specified timeframe.Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2024 documents: The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (Assessment Reference Date) (ARD + 14 calendar days).R69's Quarterly MDS assessment dated [DATE], per the RAI Manual, must be completed by 7/2/2025. R69's Quarterly MDS assessment was completed on 7/22/2025, 20 days after it was due to be completed.In an interview on 7/23/2025 at 8:24 AM, Surveyor asked Licensed Practical Nurse (LPN)-K how many MDS nurses were employed at the facility. LPN-K stated LPN-K works full time and another LPN works part time. LPN-K stated LPN-K had been out of the facility on medical leave for three months and returned to work full time on 6/30/2025. Surveyor asked LPN-K if there was anyone covering LPN-K's workload while LPN-K was gone. LPN-K stated a couple MDS coordinators from sister facilities assisted with MDS assessments but was not sure of the extent of coverage. Surveyor shared with LPN-K the concern R69 had a late quarterly assessment. LPN-K was aware of the late assessment and agreed it was behind schedule.On 7/23/2025 at 10:26 AM, Surveyor shared with Nursing Home Administrator (NHA)-A the concern R69's Quarterly MDS assessment was not completed timely. NHA-A stated LPN-K made NHA-A aware of the concern and agreed staffing of the MDS coordinators was difficult for a period of time making assessments late.No additional information was provided.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure admission, quarterly, and discharge Minimum Data Set (MDS) assessments were completed and transmitted in the timeframe prescribed in the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual for 5 (R102, R35, R79, R87, and R69) of 8 residents reviewed for late MDS assessments.*R102's Discharge Return Anticipated MDS assessment dated [DATE] was not completed or transmitted by the specified timeframe.*R35's admission MDS assessment dated [DATE] was not transmitted by the specified timeframe.*R79's Discharge Return Anticipated MDS assessment dated [DATE] and R79's Entry tracking record dated 7/11/2025 were not completed or transmitted by the specified timeframe.*R87's admission MDS assessment dated [DATE] was not transmitted by the specified timeframe.*R69's Quarterly MDS assessment dated [DATE] was not transmitted by the specified timeframe.Findings include:The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2024 documents: The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 . The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) (Care Area Assessments) completion date, but not later than. The CAA(s) completion date (item V0200B2) must be no later than day 14. The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days). Transmission Date No Later Than: Care Plan Completion Date + 14 calendar days. (The Quarterly assessment) MDS must be transmitted (submitted and accepted) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days). The Entry tracking record is the first item set completed for all residents. Must be completed within 7 days after the admission/reentry. Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days). OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated. Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).In an interview on 7/23/2025 at 8:24 AM, Surveyor asked Licensed Practical Nurse (LPN)-K how many MDS nurses were employed at the facility. LPN-K stated LPN-K works full time and another LPN works part time. LPN-K stated LPN-K had been out of the facility on medical leave for three months and returned to work full time on 6/30/2025. Surveyor asked LPN-K if there was anyone covering LPN-K's workload while LPN-K was gone. LPN-K stated a couple MDS coordinators from sister facilities assisted with MDS assessments but was not sure of the extent of coverage. Surveyor shared with LPN-K the concerns R102, R35, R79, R87, and R69 had entry tracking records, discharge assessments, quarterly assessments, and admission assessments that had not been transmitted in the timeframe allotted. LPN-K was aware of the late assessments and agreed they were behind schedule.1.) R102 was discharged from the facility on 5/23/2025. Per the RAI Manual, R102's Discharge Return Anticipated MDS assessment must be completed by 6/6/2025 and transmitted by 6/20/2025. R102's Discharge Return Anticipated MDS assessment was completed on 6/20/2025, 14 days late, and transmitted on 6/27/2025, 7 days late.2.) R35 was admitted to the facility on [DATE]. Per the RAI Manual, R35's admission MDS assessment must be transmitted by 7/18/2025. R35's admission MDS assessment had not been transmitted at the time of survey, 7/21/2025.3.) R79 was discharged from the facility on 7/8/2025. Per the RAI Manual, R79's Discharge Return Anticipated MDS assessment must be completed by 7/10/2025. On 7/21/2025, R79's Discharge Return Anticipated MDS assessment was In Progress and not completed.R79 was readmitted to the facility on [DATE]. Per the RAI Manual, R79's Entry Tracking Record must be completed by 7/18/2025. On 7/21/2025, R79's Entry Tracking Record was In Progress and not completed.4.) R87 was admitted to the facility on [DATE]. The facility combined R87's admission MDS assessment with R87's Discharge Return Anticipated MDS assessment. Per the RAI Manual, R87's admission MDS assessment and Discharge Return Anticipated MDS assessment must be transmitted by 7/15/2025. On 7/21/2025, R87's admission MDS assessment and Discharge Return Anticipated MDS assessment had not been transmitted at the time of survey.5.) R69's Quarterly MDS assessment dated [DATE], per the RAI Manual, must be transmitted by 7/16/2025. On 7/21/2025, R69's Quarterly MDS assessment had not been transmitted at the time of survey On 7/23/2025 at 10:26 AM, Surveyor shared with Nursing Home

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not revise care plans or complete a care conference for 2 (R61, R9) of 18 residents care plans that were reviewed. *R61 did not have hearing or depression focus areas added to R6's initial care plans. R61’s comprehensive care plan was not completed timely after admission to the facility. *R9 did not have a care conference after the MDS assessment 6/2025. Findings include: The facility's policy, titled Comprehensive Care Plans, with implemented date of 3/25/2025 documents: “Policy Explanation and Compliance Guidelines: …1. The care planning process will include an assessment of the resident’s strengths and needs and will incorporate the resident’s personal cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent in trauma-informed care as indicated.2. The Comprehensive Care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. …3. Comprehensive Care plan will describe, at a minimum, the following: a. The services that are to be furnished to obtain or maintain a resident’s highest practicable physical, mental, and psychosocial well-being.” 1.) R61 was admitted to the facility on [DATE] and has diagnoses that include pneumonia, acute respiratory failure, hypertension, dysphasia, depression and anxiety. R61's discharge Minimum Data Set (MDS), dated [DATE], documents a Brief Interview of Mental Status (BIMS) of 11, indicating R61 is cognitively intact. The MDS started on 6/13/2025, was not completed and surveyor could not locate a completed BIMS score, or comprehensive care plan. R61's PHQ9 (PHQ-9 (Patient Health Questionnaire-9 that objectifies and assesses degree of depression severity via questionnaire) documented a score of 10, indicating moderate depression. Surveyor noted that at the time of the assessment, a referral for psychiatric services for R61. Surveyor noted that despite the facility completing R61's PHQ9 assessment for depression, an initial care plan with a focus on depression was not developed or implemented for R61. R61's care plan initiated on 6/13/2025, did not have a focus area for hearing deficit or depression. The initial care plan was started, and no revisions were made for the comprehensive days until 40 days post admission. On 7/21/2025, at 10:39 AM, Surveyor observed a sign posted on R61’s back wall, in R61’s personal room. This sign documented to speak up, as resident is hard of hearing. R61 stated having 1 hearing aid, that is at home, and not at the facility. R61’s stated that family will be bringing it in, but currently R61’s family is in bad health, and can’t bring it to the facility. R61 indicated not being able to give a time frame of when family will be able to bring in the hearing aid. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/2025, at 10:25 AM, Surveyor interviewed Social Services Director (SSD)-I, who informed surveyor that the floor nurse would start the initial care plan for residents. SSD-I stated not knowing about the hearing deficit and will be following up on this with R61. SSD-I stated the admitting nurse would be expected to add the focus areas (hearing and depression) to the care plan. Surveyor asked about the depression care plan and if SSD-I would address the care plan for depression. SSD-I stated that SSD-I wouldn’t add information until after the initial psych visit. On 7/23/2025, at 10:37 AM, Surveyor interviewed SSD-I, who indicated that SSD-I will be adding all focus areas to the care plan and that the floor nurses should be addressing depression, hearing and refusals on the initial care plan. SSD-I stated that the MDS not being completed timely caused the initial care plan to also be late. On 7/23/2025, at 1:24 PM, Surveyor interviewed Unit Manager (UM)-F, who stated that nurses on the floor can update and start the care plan, and then after that the Unit managers will go through the care plan and check for accuracy. UM-F indicated not being the unit manager that reviewed R61’s admission and believes UM-F was on vacation when R61 was admitted . UM-F indicated the whole nursing team knows how to enter focus areas into the care plan and they would all be aware of what areas should be in the care plan. The following focus area care plan was initiated on 7/23/2025: -Communication deficit related to hearing loss-R61 has a mood problem related to diagnosis of anxiety and depression. Surveyor noted that the focus areas were added to R61’s care plan after Surveyor informed the facility that R61 did not have these focus areas in the current care plan. On 7/24/2025, at 7:49 AM, Surveyor interviewed Director of Nursing (DON)-B, who stated that DON-B would expect the floor nurse to complete the initial care plan with all concerns, like hearing and depression. DON-B indicated that the unit managers would go through and clean up and add more information if needed to the care plan. Surveyor informed DON-B that Unit Manager-F indicated being on vacation at the time R61 was admitted and didn’t do this for R61. DON-B indicated that the nursing staff had monitoring for behaviors in place, and we were doing all the interventions as we should, it just didn't make it into the care plan. On 7/24/2025, at 8:24 AM, Surveyor informed Nursing Home Administrator (NHA)-A of concern with R61’s care plan, focus areas that did not include hearing and depression. Surveyor also informed NHA-A of comprehensive care plan being late. NHA-A indicated that this is a concern and NHA-A indicated that she will be talking with nursing staff to ensure that care plans are updated and accurate. No additional information was provided as to why R61's care plans were initiated and updated to include R61's depression and hearing deficit. 2.) R9 was admitted to the facility on [DATE] with diagnoses chronic obstructive pulmonary disease, asthma, morbid obesity, diabetes, congestive heart failure, bipolar disorder, anxiety, depression, panic disorder, and post-traumatic stress disorder. R9’s Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R9 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/2025 at 10:32 AM, Surveyor observed R9 in bed in R9’s room. Surveyor asked R9 if R9 participated in Care Plan meetings or Care Conferences. R9 was not sure what Care Conferences were. Surveyor shared with R9 meetings should be held every three months to discuss R9’s preferences and goals so a personalized Care Plan could be either developed or revised and the meetings usually consisted of nursing staff, social services, dietary, and any other disciplines pertinent to the resident’s care. R9 was not aware of any meetings and stated R9 would like to have a meeting. On 3/18/2025 at 3:01 PM in the progress notes, a social worker documented an annual Care Conference was held with R9, the social worker, the nursing unit manager, and R9’s Case Manager and Registered Nurse from the managed care service. No documentation of a care conference was found after 3/18/2025. In an interview on 7/23/2025 at 8:57 AM, Surveyor asked Social Services Director (SSD)-I how often care conferences are held for residents. SSD-I stated for long term care residents care conferences are offered quarterly. Surveyor asked SSD-I when was the last time R9 had a care conference. SSD-I stated R9 had been in and out of the hospital in June, 2025 so that last care conference was March, 2025. SSD-I stated SSD-I met with R9 at the beginning of July 2025 so needs to schedule a care conference. Surveyor asked when care conferences should be scheduled. SSD-I stated they follow the MDS assessment schedule. Surveyor noted R9 had a Quarterly MDS assessment completed 6/7/2025 and had been in the facility from 6/3/2025-6/23/2025 with no care conference scheduled. On 7/23/2025 at 9:04 AM in the progress notes, SSD-I documented SSD-I reached out to R9’s case management team to schedule a quarterly care conference. Surveyor noted this was done after Surveyor’s conversation with SSD-I. On 7/23/2025 at 3:03 PM, Surveyor shared with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B the concern R9 did not have a care conference since 3/18/2025 and R9 would like to attend a care conference meeting. Surveyor shared with NHA-A and DON-B the conversation with SSD-I and the progress notes in R9’s medical record that a care conference will be scheduled. No additional information was provided.

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	07/24/2025

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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility did not ensure that food was prepared to conserve nutritive value and flavor. This has the potential to effect 4 of 4 (R15, R49, R58, R106) residents residing at the facility whom receive a puree diet.*Cook-D was observed not following a recipe for preparing texture and modified consistency food for puree diets. Findings include:The facility's undated policy titled, Standardized Recipes documents under the Policy section: Standardized recipes will be used when preparing menu items.Under the Procedure section it documents: 1.) Standardized recipes (in appropriate portion sizes) for each set of cycle menus will be maintained in the facility.2.) The director of dining services or designee will be responsible for adjusting and recording the recipes for the needed yield.3.) Cooks/chefs are expected to use and follow the recipes provided.On 7/22/25 at 10:55 AM, Surveyor observed [NAME] -D prepare pureed cornbread for the lunch meal. Cook- D stated that there are currently 5 residents who receive puree meals (facility list provided had 4 residents listed). Surveyor observed Cook- D place several pieces of cooked cornbread into a commercial blender and then pour a small amount (not measured) of whole milk from a milk carton into the blender. Cook- C then closed the blender and activated the blender for approximately 10 seconds. The top of the blender was removed and then Cook- D poured thickening powder (unmeasured) into the blender. Surveyor asked if he was following a recipe or how Cook-D knew when the food is the correct puree consistency. Cook-D stated that he is looking for a certain consistency, but he was unable to indicate what that consistency would be like(i.e. pudding like). Cook-D showed Surveyor the contents of the blender and Surveyor noted that the puree food in the blender had a consistency that was thinner than pudding. Cook-D then emptied the pureed corn bread into a holding metal container, scrapped the sides of the blade for the remaining cornbread into the container and moved onto the next task.On 7/23/25 at 2:05 AM, Surveyor interviewed DM (Dietary Manager)- C regarding the process for pureeing foods. DM-C stated that there is a recipe for each food item that is to be pureed before the meal service. Surveyor shared the observation of Cook-D not following a recipe when pureeing the cornbread for the lunch meal on 7/22/25. DM-C stated that Cook-D should have followed the recipe to ensure that the right texture is achieved for puree.On 7/24/25, during the daily exit meeting, Surveyor informed Nursing Home Administrator (NHA)-A of the above findings. No additional information was provided as to why Cook- D did not follow the recipe for the lunch item on 7/22/25 to ensure the appropriate texture for pureed meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview the facility did not ensure that food was stored, prepared and served under sanitary conditions in 1 of 1 kitchens.* On 7/22/25 , Surveyor observed Cook-D not wearing a facial hair restraint that completely covered his hair from contacting exposed food while pureeing a lunch item.* On 7/22/25, Surveyor observed Dietary Aide- E handling exposed foods without all of his hair under the hair restraint. Cook- D did not have his facial hair restrained while handling exposed foods preparing the lunch meal trays.* On 7/22/25, Surveyor observed Cook- D not clean the thermometer probe between different foods as Cook-D took the temperature of several food items.These deficient practices have the potential to affect 90 of 90 residents who reside in the facility at the time of survey and who receive their meals from the main kitchen. All of the food for the facility is stored, prepared and served from the main kitchen.Findings include:The facility's policy with no date titled, Employ Sanitary Practices documents under the Policy section: All food and nutrition services employees will practice good personal hygiene and safe food handling procedures.Under the Procedures section it documents:1.) Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. 2.) Wash hands before handling food, using posted hand-washing procedures.On 7/22/25 at 10:55 AM, Surveyor observed [NAME] -D prepare puree cornbread for the lunch meal. Cook- D was observed to have a surgical mask that sat below on his chin, leaving his mustache hair exposed and not restrained. Cook-D's mustache was exposed for the entire observation while Cook-D made purred cornbread. On 7/22/25 at 11:25 AM, Surveyor observed Cook-D take temperatures of the prepared food for the lunch meal. Cook-D remained with his mustache hair exposed to the foods and not restrained. Cook-D was also observed to not clean the thermometer probe between each different type of food on the steam table. On 7/22/25 at 11:28 AM, Surveyor observed Dietary Aide- E assisting with plating ready to eat foods on lunch meal trays that were being served to residents. Surveyor observed Dietary Aide-E to have hair that rested just above his shoulders. Dietary Aide- E was observed to not have all of his hair underneath the hair restraint while plating ready to eat foods. Surveyor noted that Cook- D was also assisting to plate ready to eat foods while Cook-D had his mustache hair exposed. During this observation, Dietary Manager- C asked Surveyor how the observation was going. Surveyor stated that both Dietary Aide- E and Cook- D did not have their hair properly restrained while working with exposed foods. Dietary Manager- C stated that he also observed that but did not want to call the staff out in front of the Surveyor.On 7/23/25 at 2:05 PM, Surveyor interviewed Dietary Manger-C regarding sanitary practices in the kitchen. Dietary Manager- C stated that all hair must be tucked underneath the hair restraints and that beard nets are also to be used to restrain all facial hair, including mustache hair. On 7/24/25, during the daily exit meeting, Surveyor informed NHA (Nursing Home Administrator)-A of the above findings. Surveyor requested any additional information. No additional information was provided as to why dietary staff did not always prepare and serve food under sanitary conditions.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review, the facility did not ensure the mandatory staffing data, submitted for the second quarter of 2025 (January 1- March 31) was accurate, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (Centers for Medicare and Medicaid Services). During review of the payroll-based-journal (PBJ) staffing data for the facility, the facility was triggered for excessively low weekend staffing. This had the potential to affect all 90 residents. Findings include: The facility's assessment dated [DATE] was reviewed, including staffing hours and acuity levels of care being provided. The facility's assessment documented staffing needs in the facility and triggered for low weekend staffing for the second quarter of 2025 Surveyor reviewed nursing schedules, along with the nurse staff posting hours and noted that there were no documented trends or gaps in weekend staff coverage. On 7/23/2025, at 9:09 AM, Surveyor interviewed Scheduler-J, and reviewed the nurse schedules, during this interview. Scheduler-J stated they have been in this role for about 7 months and that the facility does not use agency staff and have a lot of log-term staff to fill any absences. Scheduler-J stated they over staff on weekends for call-ins and that the facility had no staffing concerns as the facility has a consistent number of staff nurses working at the facility. On 7/23/2025, at 10:37 AM, Surveyor interviewed Director of Recruitment (DOR)-H via phone. DOR-H submits the PBJ staffing reports to CMS for the facility. DOR-H stated they pull from the timecards from the period and they input staff time into the computer system. DOR-H stated that the system will alert you for staffing concerns and if there is, an alerts will come up, and that DOR-G will notify the Nursing Home Administrator (NHA)-A of the alert. DOR-H informed Surveyor that there was an alert that came up from the software that you're at the bottom 20th percentile for staffing and that this alert came up for all of the company's facilities. DOR-H informed Surveyor that DOR-H did not investigate further what caused the alert for all of the company's facilities. DOR-H stated that the facility hasn't changed staffing patterns and did not understand why this was triggered. On 7/23/2025, at 1:16 PM, Surveyor interviewed NHA-A regarding any PBJ alerts. NHA-A informed Surveyor that NHA-A was not aware of any staffing alerts and was not aware of having low staffing on the weekends. No additional information was provided as to why the facility did not ensure that mandatory staffing data, submitted for the second quarter of 2025 (January 1-March 31) was accurate, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.