STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525270	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Fond Du Lac	115 E Arndt St Fond Du Lac, WI 54935

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the right to make healthcare decisions was provided for 1 resident (R) (R1) of 1 sampled resident. R1's Power of Attorney for Healthcare (POAHC) was not activated; however, R1's medical record contained multiple documents signed by POAHC-F. The facility did not have documentation that R1 consented to POAHC-F signing documents on R1's behalf.Findings include:On 1/5/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including encounter for palliative care, severe protein calorie malnutrition, malignant neoplasm of bladder, and type 2 diabetes. R1's Minimum Data Set (MDS) assessment, dated 9/14/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R1 had severely impaired cognition. R1 passed away at the facility on 9/21/25. R1's medical record contained a Power of Attorney for Healthcare document that designated POAHC-F as R1's number 2 agent. R1 was not deemed incapacitated upon admission to the facility and was R1's own decision maker. The following documents were signed by POAHC-F: ~ An influenza vaccination consent on 9/8/25~ A COVID-19 vaccination declination on 9/8/25~ Do Not Resuscitate (DNR) paperwork on 9/8/25~ admission paperwork on 9/12/25On 1/5/26 at 11:57 AM, Surveyor interviewed Social Worker (SW)-E who confirmed R1 did not have an activated POAHC during R1's stay at the facility. SW-E stated there was mention of activating R1 prior to R1 passing away. SW-E stated R1 had a hard time signing documents so POAHC-F signed on R1's behalf. The facility did not have documentation that R1 was in agreement with POAHC-F signing documents on R1's behalf. On 1/5/26 at 2:05 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed R1 did not have an activated POAHC while at the facility. NHA-A indicated POAHC-F signed a Hospice agreement for R1 and the facility was working on getting R1's POAHC activated when R1 passed away. NHA-A confirmed the facility did not have documentation that R1 was in agreement with POAHC-F signing documents on R1's behalf.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure a clean, comfortable, or homelike environment for 1 resident (R) (R6) of 10 sampled residents. R6 reported to staff that the faucet in R6's bathroom did not work properly. The faucet was not repaired in a timely manner.Findings include:The facility's Reporting Maintenance Issues policy, revised 10/2025, indicates: All maintenance issues that may impact resident safety, clinical care, infection prevention, dignity, or facility operations must be reported immediately using the approved reporting process. Timely reporting is essential to minimize risk and ensure compliance with nursing home regulations and quality standards .7. Documentation: All maintenance issues must be documented, including: Date and time reported; Person reporting the issue; Description and location; Risk level and priority; Actions taken; and Completion date. Records must be retained in line with nursing home policy and regulatory requirements.On 1/5/26, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had a diagnosis of schizophrenia. R6's Minimum Data Set (MDS) assessment, dated 12/24/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6 had intact cognition. On 1/5/26 at 12:15 PM, Surveyor interviewed R6 who indicated R6's bathroom faucet did not work well. R6 told multiple staff about the concern who said Maintenance Director (MD)-C would fix the faucet. R6 stated it had been a month or longer and the faucet was not fixed yet. Surveyor tested the faucet and observed a light trickle of water come out. On 1/5/26 at 12:50 PM, Surveyor interviewed MD-C who stated there were no work orders for R6's room. MD-C stated when items need attention, staff call, text, or tell MD-C in person. MD-C stated housekeepers sometimes fill out work orders. MD-C stated MD-C throws work orders away after they are addressed. MD-C was not aware that R6's faucet needed to be fixed. When Surveyor and MD-C went to R6's room, MD-C acknowledged the faucet did not work properly and began to repair it. On 1/5/26 at 1:30 PM, Surveyor interviewed Housekeeper (HK)-D who was aware R6's faucet did not work well. HK-D stated HK-D wrote down the concern and turned it in approximately a month and a half ago. HK-D worked part-time and thought MD-C fixed things timely. On 1/5/26 at 3:50 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated ways to tell MD-C about a repair included calling, texting, discussing in morning meeting, or filling out a work order. NHA-A verified R6's faucet should have been repaired timely.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of drugs and biologicals for 2 residents (R) (R1 and R7) of 8 sampled residents.On 9/11/25, Medication Technician (MT)-G administered another resident's medications to R1 and R7. Findings include:The facility's Medication Administration policy, revised 3/2025, indicates: .3. Identify resident by photo in the Medication Administration Record (MAR) .10. Ensure that the six rights of medication administration are followed: a. Right resident; b. Right drug; c. Right dosage; d. Right route; e. Right time; f. Right documentation .11. Review MAR to identify medication to be administered. 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication, form, dose, route, and time.1. On 1/5/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of bladder, unspecified, infection and inflammatory reaction due to indwelling urethral catheter, and encounter for palliative care. R1's Minimum Data Set (MDS) assessment, dated 9/14/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R1's cognition was severely impaired.On 1/5/26, Surveyor reviewed a Resident's Medication Occurrence, dated 9/11/25 and documented by Director of Nursing (DON)-B. The Medication Occurrence indicated R1 was administered another resident's medications on 9/11/25 and did not have a picture in the facility's medical record system. R1 was monitored. R1's vital signs were within normal limits. DON-B, the Nurse Practitioner (NP), Hospice, and R1's family were notified. R1's medical record did not contain a progress note regarding the medication error.R1's MAR indicated R1 was administered: allopurinol 100 milligrams (mg), amlodipine 2.5 mg, a multivitamin, cyanocobalamin 1000 micrograms (mcg), and isosorbide mononitrate extended release 30 mg on the 9/11/25 AM shift. On 1/5/26 at 2:15 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who confirmed R1 was administered the following medications in error by MT-G on the morning of 9/11/25: furosemide 40 mg, potassium extended release 10 milliequivalents (mEq), donepezil 25 mg, metoprolol extended release 50 mg, sertraline 50 mg, memantine 5 mg, and ursodiol 300 mg.On 1/5/26, Surveyor reviewed a grievance filed by R1's daughter on 9/12/25 regarding notification of the medication error. 2. On 1/5/26, Surveyor reviewed R7's medical record. R7 was admitted to the facility on [DATE] and had diagnoses including acute osteomyelitis of the left ankle and foot, aneurysm of the ascending aorta, cerebral infarction, and transient ischemic attack. R7's MDS assessment, dated 12/16/25, had a BIMS score 11 out of 15 which indicated R7's cognition was moderately impaired. On 1/5/26, Surveyor reviewed a Resident Medication Occurrence, dated 9/11/25 and written by DON-B. The Medication Occurrence indicated R7 was administered another resident's medication on 9/11/25 and did not have a picture in the facility's medical record system. R7 was monitored. R7's vital signs were within normal limits. DON-B, the NP, and R7's family were notified.R7's medical record did not contain a progress note regarding the medication error.On 1/5/26, Surveyor reviewed R7's MAR which indicated R7 was administered furosemide 40 mg, potassium extended release 10 mEq, donepezil 25 mg, metoprolol extended release 50 mg, sertraline 50 mg, memantine 5 mg, and ursodiol 300 mg on the 9/11/25 AM shift.On 1/5/26 at 2:15 PM, Surveyor interviewed NHA-A who confirmed R7 was administered the following medications in error by MT-G on 9/11/25: allopurinol 100 mg, amlodipine 2.5 mg, a multivitamin, cyanocobalamin 1000 mcg, and isosorbide mononitrate extended release 30 mg. On 1/5/26 at 1:28 PM, Surveyor left messages for DON-B and MT-G but did not receive return calls.On 1/5/26 at 3:30 PM, Surveyor interviewed NHA-A who indicated R1 was given R7's AM medication and R7 was given R1's AM medication on 9/11/25. NHA-A indicated MT-G reported the medication error to DON-B on 9/11/25 AM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the error occurred. NHA-A stated R1 was admitted on [DATE] and R7 was admitted on [DATE] and their pictures were not in the facility's medical record system. NHA-A also stated the name plaques outside R1 and R7's doors were incorrect. NHA-A indicated R1's family requested a different room when R1 was admitted and R1 was moved across the hall. Prior to R7's admission, NHA-A posted R7's name plaque outside the door but did not change the name plaque after R1 was moved into that room. NHA-A verified MT-G did not complete the 6 rights of medication prior to administering R1 and R7's medications. NHA-A stated MT-G was educated on the 6 rights of medication on 9/16/25 after a medication administration observation was completed. Medication administration observations were completed with 10 staff. NHA-A verified there was no education regarding the accuracy of residents' name plaques or the importance of entering residents' pictures in the medical record system upon admission.