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Form Approved OMB
No. 0938-0391

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	02/11/2026

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 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 observation, staff interview and record review, the facility did not ensure a care plan was updated in a timely manner for 1 resident (R) (R2) of 4 sampled residents.R2's care plan was not updated in a timely manner after a resident-to-resident altercation.Findings include:The facility's Care Plan Revisions Upon Status Change policy, dated 1/6/25, indicates: .The comprehensive care plan will be reviewed and revised as necessary when a resident experiences a status change. On 2/11/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including dementia, urinary tract infection, and altered mental status. R2's Minimum Data Set (MDS) assessment, dated 1/16/26, had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated R2 had severe cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC).On 1/20/26, R2 had a physical and verbal altercation with another resident. The facility submitted a facility-reported incident (FRI) to the State Agency and completed an investigation. R2 was placed on 15 minute checks for 72 hours and moved to a different unit.A progress note, dated 1/23/26 at 10:55 AM, indicated R2 was physically aggressive with staff and punched, grabbed, and twisted a staff's breast. R2 laughed and refused to let go.Surveyor noted multiple other progress notes that indicated R2 was physically aggressive toward staff.On 2/11/26 at 10:30 AM, Surveyor reviewed a care plan in R2's electronic medical record. The care plan did not indicate R2 had a history of physical and verbal aggression toward residents and staff or had grabbed staff inappropriately. A care plan, created on 1/20/26 (date of incident), indicated R2 was at risk for sleep pattern disturbance due to using sleep medication and was dependent on staff for meeting emotional, physicial, intellectual, physical, and social needs due to cognitive deficits. The care plan contained interventions for activity-related ideas. A care plan, initiated on 1/26/26, indicated R2 had adjustment issues to admission related to a new environment. The care plan indicated R2 was used to getting up and using the bathroom at home and was used to R2's own environment. The care plan contained interventions that were initiated on 1/26/26. Surveyor requested copies of R2's care plans.On 2/11/26 at 11:28 AM, Nursing Home Administrator (NHA)-A provided Surveyor with copies of R2's care plans. Surveyor reviewed the copies and noted the copies indicated the above care plans and all interventions were created on 1/20/26. Surveyor noted the care plan now indicated R2 was confused at times and had episodes of physical aggression toward residents and staff. Interventions included to redirect R2 when possible, offer 1:1 activities, and call R2's spouse to visit during episodes of high agitation. The interventions were not on the care plan that Surveyor reviewed at 10:30 AM; however, the copies indicated the interventions were added on 1/20/26. Surveyor re-checked the care plans in R2's electronic medical record and noted the history dates indicated the care plan was updated on 2/11/26 and the above interventions were created on 2/11/26. On 2/11/26 at 12:28 PM, Surveyor interviewed NHA-A who was not aware of the 1/23/26 progress note regarding R2 grabbing and twisting a staff's (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breast. NHA-A confirmed R2's care plan should be updated to include sexual inappropriateness toward staff. Surveyor pointed out the discrepancy between the care plan in R2's electronic medical record and care plan initiation and revision dates on the paper copies provided by NHA-A. Surveyor showed NHA-A the screen history that indicated R2's care plan was updated on 2/11/26 to indicate R2 had a history of physical aggression toward residents and staff and two interventions were added on 2/11/26. NHA-A stated NHA-A accessed R2's care plan but did not make any changes and was not sure why the paper copies showed creation dates of 1/20/26 but R2's electronic medical record indicated the initial care plan was created on 1/26/26 and was updated on 2/11/26 with additional interventions.