

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2026
NAME OF PROVIDER OR SUPPLIER Avina of Fond Du Lac		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation and staff, resident, and family interview, the facility did not ensure a clean, comfortable, home-like environment for residents on the 100 wing. This practice had the potential to affect more than 4 of the 44 residents residing in the facility. A black and/or green, damp, and smudgeable substance was observed on walls and ceiling tiles on the 100 wing. In addition, a brown fuzzy growth was observed on a ceiling tile directly above the entrance to the common area/living room on the 100 wing. Findings include: The Centers for Disease Control and Prevention (CDC) website section titled Mold, dated 5/29/24, indicates: Stachybotrys chartarum is a greenish-black mold. It can grow on material with a high cellulose content, such as fiberboard, gypsum board, and paper. Growth occurs when there is moisture from water damage, water leaks, condensation, water infiltration, or flooding. Constant moisture is required for its growth. At present, no test exists that proves an association between Stachybotrys chartarum and particular health symptoms. Individuals with persistent symptoms should see their physician. However, if Stachybotrys chartarum or other molds are found in a building they should be removed. During an environmental tour of the facility on 4/22/26 beginning at 4:10 AM, Surveyor observed a ceiling tile outside the main dining area on the 100 wing. The tile contained two black fuzzy spots surrounded by a dark gray stain. Ceiling tiles behind the 100 wing nurses' station contained black fuzzy stains that spanned the corners of four tiles that connected in the middle and spread out into the tiles. Surveyor also noted a brown fuzzy stain covered the entire ceiling tile. A sprinkler head was mounted through the tile which was warped and did not correctly fit in the ceiling grid. On 4/22/26 at 6:52 AM, Surveyor interviewed Medication Technician (MT)-D who stated there was mold in the nourishment room next to the nurses' station due to a leaking ice machine. MT-D was concerned about the mold because it spread over the walls of the room, to ceiling tiles above and behind the nurses' station, and to a bathroom behind the nurses' station. MT-D informed Director of Nursing (DON)-B and Maintenance Director (MD)-J about the concern and stated the mold was a concern since MT-D started at the facility approximately two years ago. MT-D stated the facility stopped using the ice maker because the ice appeared to have mold. MT-D again stated MT-D informed MD-J of the concerns surrounding all areas observed with mold. MT-D indicated there was no action was taken for a long time; however, the bathroom and nourishment rooms were being remodeled in the last week. MT-D informed Surveyor of an area behind the nurses' station that shared a wall with the nourishment room that contained the ice machine. MT-D indicated the area contained mold and was open where residents were. On 4/22/26 at 7:02 AM, Surveyor observed an area underneath the nurses' station that shared a wall with the nourishment room. Surveyor observed a black/green fuzzy stain approximately 6 inches long by 4 inches wide on the wall. The wall appeared bubbled. A baseboard that connected the wall and the nurses' station was falling off and exposed dry wall that contained black stains. On 4/22/26 at 8:07AM, Surveyor interviewed MD-J who verified the ice machine in the nourishment room leaked for a while before it was discovered. MD-J was not sure when the leak was discovered. MD-J stated the leak damaged walls in the nourishment room and spread to bathroom walls behind the nourishment room and nurse's station. MD-J stated approximately six months ago, a resident ran into the ice machine in the (continued on next page)</p>		

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>nourishment room with a motorized wheelchair. MD-J was not sure when the incident occurred. MD-J had not received concerns from staff or residents regarding the leaky ice machine or wall damage. MD-J and Surveyor then toured the areas Surveyor had previously observed. MD-J verified the ceiling tile outside the main dining area on the 100 wing contained two black fuzzy spots surrounded by a dark gray stain. MD-J stated it was a water stain from when a pipe burst in the ceiling approximately two years ago. MD-J stated MD-J did not pay attention to ceiling tiles and would replace the tile. MD-J and Surveyor also observed ceiling tiles behind the 100 wing nurses' station that contained multiple black fuzzy stains that spanned the corners of four tiles, connected in the middle, and spread out onto the tiles. MD-J stated the stain looked like dirt. MD-J and Surveyor observed an area underneath the nurses' station that shared a wall with the nourishment room. The area contained a black/green fuzzy stain that was approximately 6 inches long by 4 inches wide. The wall appeared bubbled. A baseboard that connected the wall and the nurses' station was falling off and exposed dry wall that contained black fuzzy stains. MD-J was not aware of the stain and stated the area appeared to be dried water. MD-J and Surveyor continued to the 100 wing common area/living room and stopped in front of the entrance to the room where MD-J and Surveyor noted the ceiling tile contained a sprinkler head, had a brown fuzzy stain that covered the entire tile, and was warped and did not fit the ceiling grid. MD-J stated the tile contained water damage from a leaky heating, ventilation, and air conditioning (HVAC) system on the roof. MD-J stated due to the amount of rain in the last week, leaks occurred and damaged the tile. MD-J had not contacted anyone for roof or HVAC repairs. On 4/22/26 at 8:24 AM, Surveyor interviewed R1 who stated the facility had mold on ceiling tiles and areas that were not observed, including bathrooms and walls. R1 felt the mold in common areas affected R1's asthma. R1 stated staff informed R1 there is mold in the facility which made R1 more concerned about things that are not seen. including leaky showers and pipes. (On 4/22/26, Surveyor reviewed R1's medical record. R1 had diagnoses including mild intermittent asthma, migraine with aura, and anxiety disorder. R1's Minimum Data Set (MDS) assessment, dated 2/20/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1 had intact cognition.) On 4/22/26 at 9:20 AM, Surveyor toured the facility with Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B who were not aware ceiling tiles contained black/green fuzzy stains, a leaky HVAC system damaged ceiling tiles, and a resident ran into the ice maker in the nourishment room which caused a leak. NHA-A and DON-B observed the ceiling tile above the 100 wing dining room area. NHA-A stated NHA-A could not tell if the stain was mold and indicated the pipe leaked a few years ago. NHA-A and DON-B observed the ceiling tile in the nurses' station and indicated the stain could be dirt. NHA-A and DON-B observed the wall and baseboard underneath the nurses' station and indicated they were not sure the area contained mold, however, it needed to be addressed. NHA-A and DON-B observed the ceiling tile above the entrance to the living room/common area and confirmed the tile was brown, damaged, and warped. NHA-A and DON-B stated they were not aware of the water damage or that there was a leak in the HVAC unit or any unit on the roof.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of drugs and biologicals for 1 resident (R) (R1) of 5 sampled residents. On 3/13/26, Licensed Practical Nurse (LPN)-I did not administer R1's dose of Estradiol as ordered. Findings include: The Facility's Medication Administration policy, revised January 2026, indicates: .1. Keep the medication cart clean, organized, and stocked with adequate supplies .23. Administer medication(s) according to physician order. 24. Correct any discrepancies and report to nurse manager. On 4/21/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including conversion disorder with motor symptom deficit, polycystic ovarian syndrome, asymptomatic premature menopause, and dysmenorrhea. R1's Minimum Data Set (MDS) assessment, dated 2/20/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1 had intact cognition. R1's medical record contained following order: ~ Estradiol transdermal patch twice weekly 0.025 milligrams (mg)/24 hours (hr) Apply 1 patch transdermally once daily every Monday and Friday for hormones (dated 11/17/25) R1's Medication Administration Record (MAR) contained a 10 (MAR code 10 = Other/See progress note) for Estradiol administration on 3/13/26. (Of note: R1's progress notes did not contain a medication administration, omission, or provider update for 3/13/26.) On 4/21/26 at 12:22 PM, Surveyor interviewed R1 who stated R1 did not receive an Estradiol patch a few weeks ago because staff could not find it. R1 stated R1 has pain when the patch is not on. On 4/22/26 at 12:54 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-I who stated LPN-I did not administer R1's Estradiol patch on 3/13/26 because LPN-I could not find the patch and there weren't any nursing staff around to ask. LPN-I verified LPN-I did not enter a progress note in R1's medical record that the medication was not administered and did not notify the provider. LPN-I stated staff administering medication are expected to call the pharmacy or ask another staff if a medication is missing from the medication cart. On 4/22/26 at 1:44 PM, Surveyor interviewed Director of Nursing (DON)-B who stated staff should find the medication or call the pharmacy if the medication is not in the facility. DON-B stated staff should enter a progress note in the resident's medical record if ordered medication is not given and should update the provider.</p>		