STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525282	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina on 32nd	8633 32nd Ave Kenosha, WI 53142

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure 3 (R34, R4, and R46) of 5 residents with an allegation of abuse or involved in a resident-to-resident altercation were reported to the State Survey Agency within the required reporting timeframe. *R34 informed facility staff that Certified Nursing Assistant, (CNA)-Y, was rough with cares. This allegation of abuse was not reported to the State Survey Agency. *A resident-to-resident altercation involving R4 and R46 was not reported to the State Survey Agency within the required reporting timeframe. Findings include: The facility policy with a last reviewed/revised date of 2/25/26 and titled, Abuse Neglect and Exploitation documents, in part: . The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, State Agency and to all other required agencies. within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 1.) R34 was admitted to the facility on [DATE]. R34's Quarterly Minimum Data Set assessment dated [DATE] documented that R34 is cognitively intact. R34 requires substantial/maximal assist for toileting hygiene and is always incontinent of bowel and bladder. On 6/22/26 at 10:04 AM, R34 informed Surveyor of an incident that occurred in April 2026. R34 stated that CNA-Y was being rough while providing incontinent cares. R34 stated that they told CNA-Y that CNA-Y was being too rough, but CNA-Y continued and stated, I'm sorry, but I need to get you clean. R34 stated that later on, CNA-Y was in R34's room. R34 asked for help getting a computer cord. R34 stated that CNA-Y refused to help because R34 won't allow CNA-Y to care for R34 anymore. R34 stated that they told facility staff that CNA-Y was rough when caring for R34. Surveyor noted R34 informed facility staff that sometime back in April 2026, CNA-Y was rough when providing cares to R34. Surveyor noted that this is an allegation of abuse. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed the Facility Reported Incidents (FRIs) for the last 6 months. Surveyor noted that the facility did not have a FRI for R34's allegation of abuse. Surveyor reviewed the facility grievance log and noted a grievance filed by R34. The grievance report filed 5/18/26 and an incident date of 5/17/26, documented, in part: [R34] stated [they] do not want [CNA-Y] to provide cares to [R34] because when [CNA-Y] is cleaning [R34], [CNA-Y] is too rough when [they] clean. Included in the grievance report was a handwritten, undated statement from CNA-Y that documented: During my round when I was changing [R34's roommate], R34 asked me to plug [their] computer in for [them]. I told [R34] that I was in the middle of changing [R34's] roommate. As this was happening, I saw [CNA-Z], and I asked [CNA-Z] to help [R34]. Surveyor noted that the statement did not include the allegation of being rough with cares and only documented about CNA-Y not helping R34 with the computer cord. On 6/23/26 at 1:25 PM, Surveyor interviewed CNA-Y. Surveyor asked if CNA-Y recalls an incident when R34 told CNA-Y that they were being rough. CNA-Y stated yes. CNA-Y indicated that R34 had a bowel movement. CNA-Y stated that R34's bowel movements can get stuck and be hard to clean. While trying to clean R34, R34 told CNA-Y that they felt like CNA-Y was being rough. CNA-Y informed R34 that they had to get R34 clean, and CNA-Y continued cleaning. About 3 weeks after that is when CNA-Y was caring for R34's roommate and R34 asked for help with the computer cord. CNA-Y told R34 that they were helping the roommate. CNA-Y indicated a different CNA came to help R34 with the cord. Surveyor noted CNA-Y confirmed that R34 told CNA-Y that they were being rough, and CNA-Y continued cleaning R34. The grievance report contained a handwritten statement from Licensed Practical Nurse (LPN)-E dated 5/17/26 which documented: [R34] complained about [CNA-Y] being too rough, [they] never had prior complaints. [Writer] hasn't heard any other complaints about [CNA-Y]. [CNA-Y] did not work the weekend the complaint was made. [R34] stated [they] will let [CNA-Y] in the room but does not want cares from [CNA-Y]. On 6/23/26 at 1:13 PM, Surveyor interviewed LPN-E. Surveyor asked if LPN-E remembered an incident involving R34 and CNA-Y. LPN-E stated that R34 made a complaint about CNA-Y. LPN-E stated that CNA-Y is the best CNA and they work really well together. LPN-E stated that they asked CNA-Y about it. CNA-Y told LPN-E that R34's bowel movements get stuck and CNA-Y does have to wipe harder to get R34 clean. LPN-E stated that CNA-Y told them that is what happened. Surveyor asked if CNA-Y told them when this incident occurred. LPN-E stated No. Surveyor asked when R34 told LPN-E of the incident. LPN-E stated that R34 did not tell them. LPN-E stated that R34 told a different CNA, CNA-Z, who no longer works at the facility. CNA-Z told LPN-E on the weekend of 5/17/26 of R34's concern. LPN-E stated that they did not talk to R34 about the allegation of CNA-Y being rough, but LPN-E passed the information on to management. Surveyor noted that LPN-E stated that R34 informed CNA-Z of the allegation of abuse. CNA-Z then told LPN-E. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor was unable to interview CNA-Z. CNA-Z was no longer employed by the facility. Surveyor noted the grievance report does not include a statement from CNA-Z. Surveyor noted multiple staff members were aware that R34 stated that CNA-Y being rough with cares. Surveyor noted that this allegation of abuse was not reported to the State Agency. On 6/24/26 at 9:11 AM, Surveyor interviewed NHA-A. Surveyor asked what is expected if a resident tells a facility staff member that a CNA was rough. NHA-A stated if it is a CNA then they should tell the nurse. The nurse will tell the Director of Nursing (DON)-B and DON-B will inform me. Surveyor asked if the allegation of CNA-Y being rough with cares was reported to the State Agency. NHA-A indicated that if the resident reports that staff was rough with cares, they would need to determine if the act is intentional and then determine if it needs to be reported. That is why there is a grievance about this incident. NHA-A stated that CNA-Y was not working at the facility on the weekend that R34 reported that CNA-Y was rough with cares. Surveyor asked if it was determined when the incident actually occurred. NHA-A did not have an answer. Surveyor informed NHA-A that the grievance report and statements did not include any information of when the incident occurred, just that it was reported to facility staff on 5/17/26. In addition, according to LPN-E, R34 told CNA-Z of the allegation of CNA-Y being rough. There is no statement from CNA-Z in the grievance report. NHA-A stated that they would look to see if there is a statement from CNA-Z. Surveyor shared the concern that R34 reported to facility staff that CNA-Y was rough with cares. This allegation of abuse was not reported to the State Agency. NHA-A stated that they understood. 2.) R4 was admitted to the facility on [DATE] with a diagnoses of severe vascular dementia with psychotic disturbance, traumatic brain injury, psychotic disorder with delusions and anxiety. R4's Significant Change in Condition Minimum Data Set (MDS) assessment, dated 11/18/2025, documented they have a Brief Interview for Mental Status (BIMS) score of 9, indicating they have moderate cognitive impairment. R46 was admitted to the facility on [DATE] with a diagnoses of schizoaffective disorder, bipolar and anxiety. R46's admission Minimum Data Set (MDS) assessment, dated 7/30/2025, documented they have a Brief Interview for Mental Status (BIMS) of score of 14, indicating they are cognitively intact. A progress note dated 2/6/26 at 14:19 (2:19 PM) in R46's record indicated: Behavior Note: Describe behavior, notifications: patient was observed having aggressive behaviors towards another resident. Nurse spoke to resident (R46) and he admitted to punching the other resident in the stomach. The patient who (R46) punched has no bruises and denies any pain at this time. (R46) was later seen smacking (sic) things from the same patient who (R46) punched. (R46) seems to be more aggressive than usual at this time. Completed by Licensed Practical Nurse (LPN)-E. The Alleged Nursing Home Resident Mistreatment, Neglect, and Abuse Report was submitted to the State Agency on 2/7/2026 at 1:04 PM. On 06/23/2026 at 1:48 PM, Surveyor asked Director of Operations (DOO)-C what the expectation is for reporting abuse, and they stated within 2 hours of learning of the incident. Surveyor asked DOO-C when the facility was aware of the resident to resident altercation involving R46 and R4.DOO stated not until 2/7/26 when LPN-E had learned about the abuse and reported the abuse to Nursing Home (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator (NHA)-A. On 06/24/2026 at 9:22 AM Surveyor asked NHA-A when did LPN-E know of the abuse between R46 and R4. NHA-A stated LPN-E reported it to NHA-A as soon as they knew on 2/7/26. Surveyor shared with NHA-A there is a progress note dated and time stamped on 2/6/2026 at 2:19 PM that documented aggressive behaviors were observed between R46 and R4 where R46 admitted to punching R4 in the stomach. Surveyor shared the note was written By LPN-E. NHA-A stated they were not aware LPN-E was aware of the potential abuse prior to LPN-E reporting it to NHA-A on 2/7/26. NHA-A stated they assumed when LPN-E reported the incident to NHA-A that LPN-E had just learned of incident. Surveyor informed NHA-A that there is a concern regarding the abuse not being reported 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure an allegation of abuse and a resident-to-resident altercation was thoroughly investigated for 1 (R34) of 5 sampled residents reviewed for allegations of abuse.*R34 informed facility staff that Certified Nursing Assistant, (CNA)-Y, was rough with cares. This allegation of abuse was not thoroughly investigated.Findings include:The facility policy with a last reviewed/revised date of 2/25/26 and titled, Abuse Neglect and Exploitation documents, in part: . An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigation include: Identifying staff responsible for the investigation. Investigating different types of alleged violations. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and provide complete and thorough documentation of the investigation.R34 was admitted to the facility on [DATE].R34's Quarterly Minimum Data Set assessment dated [DATE] documented that R34 is cognitively intact. R34 required substantial/maximal assist for toileting hygiene and is always incontinent of bowel and bladder.On 6/22/26 at 10:04 AM, R34 informed Surveyor of an incident that occurred in April 2026. R34 stated that CNA-Y was being rough while providing incontinence cares. R34 stated that they told CNA-Y that CNA-Y was being too rough, but CNA-Y continued and stated, I'm sorry, but I need to get you clean. R34 stated that later on, CNA-Y was in R34's room. R34 asked for help getting a computer cord. R34 stated that CNA-Y refused to help because R34 won't allow CNA-Y to care for R34 anymore. R34 stated that they told facility staff that CNA-Y was rough when caring for R34.Surveyor noted R34 informed facility staff that back in April 2026, CNA-Y was rough when providing cares to R34. Surveyor noted that this is an allegation of abuse.Surveyor reviewed the Facility Reported Incidents (FRIs) for the last 6 months. Surveyor noted that the facility did not have a FRI for R34's allegation of abuse.Surveyor reviewed the facility grievance log and noted a grievance filed by R34.The grievance report filed 5/18/26 and an incident date of 5/17/26, documented, in part: [R34] stated [they] do not want [CNA-Y] to provide cares to [R34] because when [CNA-Y] is cleaning [R34], [CNA-Y] is too rough when [they] clean.Included in the grievance report was a handwritten, undated statement from CNA-Y that documented: During my round when I was changing [R34's roommate], R34 asked me to plug [their] computer in for [them]. I told [R34] that I was in the middle of changing [R34's] roommate. As this was happening, I saw [CNA-Z], and I asked [CNA-Z] to help [R34].Surveyor noted that the statement did not include the allegation of being rough with cares and only documented about CNA-Y not helping R34 with the computer cord. Surveyor noted a complete statement about the incident was not gathered by facility.On 6/23/26 at 1:25 PM, Surveyor interviewed CNA-Y. Surveyor asked if CNA-Y recalled an incident when R34 told CNA-Y that they were being rough. CNA-Y stated yes. CNA-Y indicated that R34 had a bowel movement. CNA-Y stated that R34's bowel movements can get stuck and be hard to clean. While trying to clean R34, R34 told CNA-Y that they felt like CNA-Y was being rough. CNA-Y informed R34 that they had to get R34 clean, and CNA-Y continued cleaning. About 3 weeks after that is when CNA-Y was caring for R34's roommate and R34 asked for help with the computer cord. CNA-Y told R34 that they were helping the roommate. CNA-Y indicated a different CNA came to help R34 with the cord.Surveyor noted CNA-Y confirmed that R34 told CNA-Y that they were being rough, and CNA-Y continued cleaning R34.The grievance report contained a handwritten statement from Licensed Practical Nurse (LPN)-E dated 5/17/26 which documented: [R34] complained about [CNA-Y] being too rough, [they] never had prior complaints. [Writer] hasn't heard any other complaints about [CNA-Y]. [CNA-Y] did not work the weekend the complaint was made. [R34] stated [they] will let [CNA-Y] in the room but does not want cares from [CNA-Y].On 6/23/26 at 1:13 PM, Surveyor (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed LPN-E. Surveyor asked if LPN-E remembered an incident involving R34 and CNA-Y. LPN-E stated that R34 made a complaint about CNA-Y. LPN-E stated that CNA-Y is the best CNA and they work really well together. LPN-E stated that they asked CNA-Y about it. CNA-Y told LPN-E that R34's bowel movements get stuck, and CNA-Y does have to wipe harder to get R34 clean. LPN-E stated that CNA-Y told them that is what happened. Surveyor asked if CNA-Y told them when this incident occurred. LPN-E stated No. Surveyor asked when R34 told LPN-E of the incident. LPN-E stated that R34 did not tell them. LPN-E stated that R34 told a different CNA, CNA-Z, who no longer works at the facility. CNA-Z told LPN-E on the weekend of 5/17/26. LPN-E stated that they did not talk to R34 about the allegation of CNA-Y being rough, but LPN-E passed the information on to management.Surveyor noted that LPN-E stated that R34 informed CNA-Z of the allegation of abuse. CNA-Z then told LPN-E.Surveyor was unable to interview CNA-Z. CNA-Z was no longer employed by the facility. Surveyor noted the grievance report does not include a statement from CNA-Z.Included in the grievance report was a statement from Social Worker (SW)-H. The statement was dated 5/18/25 and documented: Writer met with [R34] [related to] a concern reported. [R34] stated [they] felt as if CNA was too rough when doing per cares. [R34] stated it occurred on a one-time basis and [they verbalized to CNA that [CNA] was rough. CNA acknowledged and [R34] stated there was no further concerns. [R34] stated [they] feel safe in the facility. No further concerns.On 6/23/26 at 1:39 PM, Surveyor interviewed SW-H. Surveyor asked how SW-H was made aware of R34's concern about CNA-Y. SW-H stated that Nursing Home Administrator (NHA)-A brought the concern to SW-H and that is when SW-H interviewed R34. R34 told SW-H that CNA-Y was a bit rougher than other CNAs when providing cares. Surveyor asked if other residents were interviewed to see if they had any concerns about CNAs being rough with cares. SW-H stated that typically, Administration will give SW-H interview questions to ask a percentage of residents if that is needed. SW-H stated that they did not recall Nursing Home Administrator (NHA)-A saying that SW-H needed to do that.Surveyor noted that other residents were not interviewed as part of the investigation to determine if any other residents had concerns about their care.On 6/24/26 at 9:11 AM, Surveyor interviewed NHA-A. Surveyor asked what is expected if a resident tells a facility staff member that a CNA was rough. NHA-A stated if it is a CNA then they should tell the nurse. The nurse will tell the Director of Nursing (DON)-B and DON-B will inform me. Surveyor asked about the allegation of CNA-Y being rough with cares. NHA-A indicated that there is a grievance about this incident. NHA-A stated that CNA-Y was not working at the facility on the weekend that R34 reported that CNA-Y was rough with cares. Surveyor asked if it was determined when the incident actually occurred. NHA-A did not have an answer. Surveyor informed NHA-A that the grievance report and statements did not include any information of when the incident occurred, just that it was reported to facility staff on 5/17/26. In addition, according to LPN-E, R34 told CNA-Z of the allegation of CNA-Y being rough. There is no statement from CNA-Z in the grievance report. NHA-A stated that they would look to see if there is a statement from CNA-Z. Surveyor asked if other residents were interviewed after this allegation from R34. NHA-A stated that they would typically interview other residents to see if that staff member is a concern to others. Surveyor shared the concern that R34 reported to facility staff that CNA-Y was rough with cares. CNA-Z, who took the initial report from R34, was not interviewed and did not provide a statement. Other residents were not interviewed. This allegation of abuse was not thoroughly investigated. NHA-A understood the concern.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility did not ensure that residents received proper foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and assisting the resident in making necessary appointments with qualified healthcare providers such as podiatrists for 1 of 1 (R34) residents reviewed for foot care.*Facility staff found that R34 had an ingrown toenail in August of 2026. R34 developed multiple infections due to the ingrown toenail. R34's Wound MD-W, R34's Nurse Practitioner (NP)-X and emergency room physicians all recommended that R34 be referred to a podiatrist for care and treatment. Facility staff did not always follow the doctor's recommendations for treatment and did not provide podiatry services until February 2026. Surveyor observed R34's toe nails to be long and unkept.Findings include:The facility policy dated 1/1/26 documents, in part: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. Residents requiring foot care who have complicating disease processes will be referred to qualified professionals such as a Podiatrist, Doctor of Medicine and/or Doctor of Osteopathy. Foot disorders which may require treatment include but are not limited to: . Nail disorders. Employees should refer any identified need for foot care to the nurse managers. The front desk or designee will assist residents in making appointments and arranging transportation to obtain needed services.R34 was admitted to the facility on [DATE] with diagnosis that include Morbid obesity and Peripheral Vascular disease.R34's Quarterly Minimum Data Set assessment dated [DATE] documents that R34 is cognitively intact. R34 requires substantial/maximum assistance for showering and bathing. R34 does not have any skin or wound concerns.R34's at risk for skin breakdown care plan initiated 12/13/24 documents the following pertinent interventions: Administer [treatments] as ordered and monitor for effectiveness. Skin checks on shower days.Surveyor reviewed R34's Comprehensive Care plan and did not find a foot care plan or any interventions in place for R34's feet or toes.On 6/22/26 at 10:04 AM, R34 informed Surveyor that they are concerned about R34's toe nails and toe nail care. R34 stated that it takes months to get their toe nails clipped. R34 stated that they had issues with an ingrown toenail, and it took a long time to get it taken care of. R34 stated that they did not think that they should have to wait so long to get an appointment for a podiatrist. R34 pulled the blankets up and showed Surveyor their feet. Surveyor observed R34's right great toenail to be long with black scabbing along both sides and the top of the nail. R34's other nails on R34's right and left foot were long and unkept.R34's SBAR note dated 8/2/25 at 9:21 PM documents, in part: . [Right] great toe has ingrown nail with slight bleeding, no swelling. Primary Care Provider responded with the following feedback: . Bacitracin ointment to [right] great toenail, cover with a band aid, and referral to podiatry for treatment of ingrown toenail.R34's MD order dated 8/2/25 documents, To see Podiatrist for treatment of ingrown toenail to the [right] great toe.Surveyor reviewed R34's Comprehensive care plan and noted when R34's ingrown toe nail was identified, a foot or toenail care plan was not initiated to prevent the worsening of R34's ingrown toe nail.On 6/29/26 at 12:51 PM, Surveyor interviewed Director of Nursing (DON)-B. Surveyor asked if R34 should have a foot/toe care plan after the development of the ingrown toenail wound. DON-B stated Absolutely.R34's Nurse Practitioner (NP)-X visit note dated 8/5/25, documents, in part: . [R34] reports on going issues of right great toe ingrown nail with tenderness and mild swelling started about 4 days ago. The area has no active drainage and signs of infection. She will be seen by in house podiatry this week.R34's Wound MD-W's note dated 8/7/25 documents, in part: . non-pressure wound of the right, first toe full thickness. Etiology: Trauma/injury. Further Etiology detail: Ingrown toenail. 2 x 0.3 x 0.1. 100% granulation. Patient requiring an increase in the level of care. Podiatry consult for ingrown toenail.R34 is seen by Wound MD-W weekly.On 8/25/25, R34 was sent to the emergency room (ER) for a concern unrelated (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to R34's ingrown toenail.R34's progress note dated 8/25/25 at 7:30 PM, documents, in part: [R34] returned from hospital, has new orders for [antibiotic] for toe infection.R34's hospital After Visit Summary dated 8/25/25 documents, in part: . Diagnoses: . Toe infection. Instructions: . Take antibiotics after food twice a day as prescribed. Follow-up with podiatry service for further care of your toes.R34's MD order dated 8/26/25 documents: Cefadroxil 500 milligrams. Give 1 capsule by mouth two times a day for infection to great toe for 7 days.Surveyor noted R34 was diagnosed with a toe infection and needed antibiotics to treat the infection. The ER physician recommended that R34 follow up with podiatry.Surveyor reviewed R34's medical record and did not find evidence that R34 was seen by a podiatrist for R34's ingrown toenail anytime during the month of August.R34's NP-X visit note dated 9/2/25 documents in part: . [R34] reports no new health issues aside from [the] right great toe that is less swollen. Right great toenail with swelling and tenderness, no drainage, no signs of infection. Refer to in house podiatry. open shoes. 8/25 ER visit, started Cefadroxil. To see podiatry. 9/02 less swollen. Contingency plan : if has signs for infection, start Bactrim. refer to podiatry for removal.Surveyor noted NP-X stated that R34 should use open shoes. Surveyor reviewed R34's care plan and did not see that this was added as an intervention.Wound MD-W continued to see R34 weekly. R34 did not see a podiatrist in the month of September 2025.R34's Wound MD-W visit note dated 10/2/25 documents, in part: non-pressure wound of the right, first toe full thickness. Etiology: Trauma/injury. Further Etiology detail: Ingrown toenail. 1 x 0.3. Wound progress: exacerbated due to infection. Infection assessment: One or more signs of clinical infection. Patient requiring an increase in level of care. Podiatry re-consult. Recommends oral antibiotics for cellulitis. Over the past month: podiatry re-consult. This month's approach: follow up with consult.Surveyor reviewed R34's medical record and noted no documentation that R34 saw podiatry or that R34 was started on antibiotics per Wound MD-X recommendations.On 6/29/26 at 11:26 AM, Surveyor interviewed Wound MD-W. Surveyor asked about the infection noted on 10/2/25. Wound MD-W stated that they recommended antibiotics. Wound MD-W stated that they typically will recommend the antibiotic, and the primary MD will say ok and/or order the medication. Sometimes Wound MD-W will order it. Surveyor asked if Wound MD-W was aware that R34 did not receive antibiotics after recommendation. Wound MD-X stated did not have an answer but stated that the toe did start looking better.R34's Wound MD-W visit note dated 10/9/25 documents, in part: non-pressure wound of the right, first toe full thickness. Etiology: Trauma/injury. Further Etiology detail: Ingrown toenail. 1 x 0.3. Wound progress: Improved evidenced by decreased infection.R34's NP progress note dated 10/9/25 at 11:15 documents, in part: . [R34] really wants to see podiatry secondary to elongated toenails. Will discuss with unit manager.Surveyor noted R34 requested to see podiatrist.R34 is seen by Wound MD-W weekly. On 10/24/25, R34 requested to go to the ER for an earache.R34's progress note dated 10/24/25 at 11:49 AM, documents, in part: [R34] returned from [Hospital]. [R34 has new orders. Started on . Bactrim for infected ingrown toe nail.R34's hospital After Visit Summary dated 10/24/25 documents, in part: . Take full course of antibiotics as prescribed for infection of ingrown toenail and schedule follow-up appointment with podiatry. Soak this toe in warm water for 15 minutes 3 times a day. Service to podiatry requested.R34's MD order with a start date of 10/24/25 documents: Sulfamethoxazole-Trimethoprim oral tablet. 800-160mg. Give 1 tablet by mouth two times a day for infection to right great toe for 5 days.Surveyor noted facility staff entered the antibiotic order for R34's infection but did not enter an order for podiatry referral or for toe soaks in warm water 3 times a day as recommended by the ER physician.Surveyor reviewed R34's medical record and noted R34 did not see a podiatrist in the month of October 2025.R34's Wound MD-W visit note dated 10/30/25 documents, in part: non-pressure wound of the right, first toe full thickness. Etiology: Trauma/injury. Further Etiology detail: Ingrown toenail. Wound progress: resolved.R34's NP-X visit note dated 11/5/25 documents, in part: . [R34] reports on going issues of right great toe ingrown inflamed and tender. She completed the 5 day [antibiotic] for toe infection. 10/24 sent to ER [due to] left ear pain, back to [facility] with [antibiotic] for right to ingrown infection- Podiatry coming this 10/31/25 per (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525282	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina on 32nd	8633 32nd Ave Kenosha, WI 53142

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Director of Nursing (DON)-B]. 11/4 completed [antibiotic]. Right great toenail dry and not inflamed. Podiatry did not arrive.Surveyor reviewed R34's medical record and noted R34 did not see a podiatrist in the months of November and December of 2025 or in January of 2026.Wound MD-W's visit note dated 1/22/26 documents, in part: non-pressure wound of the right, first toes. Ingrown toenail. Duration >1 day. 2 x 2. [R34] requiring an increase in the level of care. Podiatry consult.Surveyor noted that Wound MD-W began treating R34's toe again starting on 1/22/26.R34's NP-X visit note dated 2/4/26 documents, in part: [R34] has issues of recurrent right great toenail ingrown. will see podiatry this 2/11/26.On 6/29/26 at 11:13 AM Surveyor interviewed NP-X. Surveyor asked about R34's issues with R34's toe. NP-X stated that it started last year. R34 was being seen by Wound MD-W for treatment. NP-X had issues sending R34 to podiatry. NP-X stated there was something that happened with the facility and podiatry that paused the service. NP-X stated that usually podiatry comes quarterly. NP-X indicated that the delay of care and recurrent infections was partly because of the unavailability of podiatry and R34's refusal to be sent out to an outside podiatrist.R34's Podiatry note dated 2/11/26 documents, in part: [R34] is being seen for foot evaluation and treatment. Notable exam findings include severe ingrown right [big toe], dried blood drainage noted and tenderness along both sides of the nail. [R34] was able to tolerate a slant back removal of both sides of the nail, to reduce pressure caused and allow site to heal. [R34] will continue to be seen for at risk foot care every 2-3 months or sooner if needed.Surveyor noted that R34 was referred to podiatry on 8/2/25 and was seen by a Podiatrist on 2/11/26, over 7 months after the first referral. Surveyor noted that Podiatry wants R34 to be seen every 2 to 3 months.On 6/30/26 at 10:31 AM, Surveyor interviewed Podiatrist-CC. Surveyor asked when Podiatrist-CC first became aware of R34's need for podiatry. Podiatrist-CC stated that he first heard of R34's need in February of this year. Podiatrist-CC stated that they looked back at email correspondence and did not find any emails from the facility about R34. Podiatrist-CC stated that the facility was not on their radar for much of 2025 because of their name change. Podiatrist-CC stated that the facility will typically communicate when a resident needs to be seen. Podiatrist-CC stated that if they had known of R34's need, they would have been able to help R34 sooner. Surveyor asked about treating R34's ingrown toenail infections with antibiotics. Podiatrist-CC stated that antibiotics are effective for the infection, but they do not treat the problem. An ingrown toenail is like a splinter and until the splinter is removed, the process keeps repeating itself.R34's MD-W's visit note dated 2/19/26 documents that R34's ingrown toenail has resolved.On 6/24/26 at 1:25 PM, Surveyor interviewed the facility Wound Nurse, Registered Nurse (RN)-Q. Surveyor asked about RN-Q's ingrown toe nail. RN-Q stated that they and Wound MD-W started seeing R34 as soon as the ingrown toenail was found. Wound MD-W referred R34 to podiatry. After podiatry saw R34 the issues with R34's toe resolved. Surveyor asked why there was a delay in R34 seeing the podiatrist. RN-Q stated that typically podiatry comes to the facility every couple months. Unfortunately, the podiatrist did not know that the facility name changed and stopped coming to the facility for a while.On 6/29/26 at 11:26 AM, Surveyor interviewed Wound MD-W. Surveyor asked about R34's issues with the right great toe. Wound MD-W stated that R34 had an ingrown toenail and that they recommended that R34 see a podiatrist. Surveyor asked what the expected time frame for a podiatry consult would be. Wound MD-W stated that it varies. Wound MD-W stated that they would expect that they would see the resident the next time in the building. Surveyor asked if over seven months is an acceptable time frame. Wound MD-W stated that with the history of podiatrist it is expected. Wound MD-W stated that they would try to remove the area of concern but R34 would not want Wound MD-W to touch the toe. That is why Wound MD-W referred R34 to podiatry with the hopes that R34 would let them touch it.On 6/29/26 at 10:05 AM, Surveyor observed R34's feet. Surveyor noted that all of R34's toe nails look long and unkept. R34's right great toe has black scabbing on both sides and along the top R34's toe.Surveyor reviewed R34's medical record and noted R34 had not seen podiatry since 2/11/26 despite the podiatrist recommending foot care every 2-3 months.On 6/23/26 at 1:51 PM, Surveyor interviewed Receptionist-N, who takes care of appointments, travel to (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointments and arranging in-house podiatry. Surveyor asked how podiatry is aware of who they need to see when they come to the facility. Receptionist-N stated that they communicate with the podiatry provider through email. Receptionist-N stated that they come to the facility every 2 to 3 months. Receptionist-N stated that podiatry was last at the facility in February of this year. Receptionist-N indicated that there was confusion and a period of time last year that the podiatrist was not coming to the building. The facility had changed their name, and the podiatrist thought that the facility had closed. On October 31st last year, Receptionist-N had email communication with the podiatrist making them aware that they are still open.On 6/29/26 at 12:51 PM, Surveyor informed DON-B of the concerns that facility staff identified that R34 had an ingrown toenail on 8/2/25. An order for a podiatry consult was entered. R34's toe got infected multiple times and required antibiotics twice. During this time, Wound MD-W, NP-X and ER physicians all recommended that R34 see podiatry, which was not completed until February of 2026. The facility did not follow After Visit instructions for toe soaks 3 times a day. The facility did not implement a care plan with resident centered interventions for R34's ingrown toenail. Surveyor observed R34's toenails to be long and unkept. R34's right great toe has black scabbing along the edges and over the top of the toe. DON-B indicated that they understood the concern and confirmed that there was a time that the podiatrist was not coming to the building.On 6/30/26 at 11:00 AM, Surveyor informed Nursing Home Administrator (NHA)-A and DON-B of the above concerns.