STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525315	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Weyauwega	717 E Alfred St Weyauwega, WI 54983

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 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, record review, and policy review, the facility did not ensure documentation that medications were administered was accurate for 1 resident (R) (R3) of 7 sampled residents. R3 was sent to the emergency room (ER) on 2/23/26 when staff indicated R3 was lethargic, sweaty, and difficult to arouse. Documentation sent with R3 indicated R3's bedtime (HS) medications were administered; however, the medications were not administered.Findings include: The facility's Medication Administration policy, dated 4/9/25, indicates: Medications are administered by licensed nurses .as ordered by the physician in accordance with professional standards of practice .20. Sign Medication Administration Record (MAR) after administered .Document.refusals . Review of R3's Face Sheet revealed R3 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), heart disease, bipolar disorder, and pain disorder. Review of R3's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/9/26 indicated R3 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R3 was cognitively intact.A progress note, dated 2/23/26 at 11:39 PM, indicated a Certified Nursing Assistant (CNA) notified the writer that R3 was not R3's self. R3 was lethargic, did not talk, and did not wake up during a transfer from wheelchair to bed or during bedtime (HS) cares. The writer was unable to wake R3 who was minimally responsive to a sternal rub, non-verbal, and unable to keep R3's eyes open. The writer instructed a nurse to call 911. R3 was sent to the ER.A progress note, dated 2/24/26, indicated R3 returned from the ER at approximately 8:00 AM. A progress note, dated 2/25/26, indicated R3 had a follow-up evaluation after a recent ER visit. R3 was sent to the ER on [DATE] when staff indicated R3 would not open R3's eyes, did not talk, and was unresponsive. R3 was on multiple sedative medications, including morphine, lorazepam, and gabapentin. The ER assessment indicated R3's condition was likely due to the additive effects of home sedatives and oversedation. R3 was discharged to the facility on 2/24/26. R3's February 2026 Medication Administration Record (MAR) contained the following orders: Lorazepam (an antianxiety medication) oral tablet 0.5 milligrams (mg) give 1 tablet by mouth at bedtime; Acetaminophen oral tablet 200 mg give 1000 mg by mouth three times daily (8:00 AM, 12:00 PM, and 8:00 PM); Gabapentin oral capsule 300 mg give 3 capsules by mouth three times daily (8:00 AM, 12:00 PM, and 8:00 PM). Morphine sulfate oral solution 20 mg/milliliter (ml) give 0.25 ml by mouth every 2 hours as needed for moderate to severe pain or shortness of breath. The medication was administered on 2/23/26 at 1:37 PM for a pain level of 7 out of 10 and on 2/22/26 at 7:28 PM for a pain level of 10 out of 10. During an interview on 3/5/26 at 12:15 PM, the Assistant Director of Nursing (ADON) stated a staff member told the ADON that R3 was lethargic, diaphoretic, and clammy during the night shift on 2/23/26. The ADON said R3 did not respond to a sternal rub and staff called 911. The ADON stated she received different stories regarding whether R3's HS medications were administered; however, Registered Nurse (RN)1 verified the medications were not administered. The ADON located the HS medications in the medication cart and stated the MAR RN1 sent with R3 to the ER indicated R3's HS medications were administered. The ADON stated it was not the correct procedure to mark medications as administered prior to (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
	525315	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Weyauwega	717 E Alfred St Weyauwega, WI 54983

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering them. During an interview on 3/5/26 at 2:10 PM, RN1 stated on the night of 2/23/26, she attempted to administer R3's HS medications, however, R3 was sweaty and refused the medications. RN1 verified she documented that she had administerd the medications prior to attempting to administer them. RN1 was aware she should not document medications as administered prior to administering them.During an interview on 3/6/26 at 11:57 AM, the Director of Nursing (DON) confirmed staff should not document that a resident's medication was administered prior to administering the medication. The DON stated nursing staff should follow the facility's medication administration policy.