

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  525315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/28/2026
NAME OF PROVIDER OR SUPPLIER  Avina of Weyauwega		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview and record review, the facility did not provide pharmacy services to ensure the accurate administration of medication for 1 resident (R) (R1) of 3 sampled residents. R1 did not receive insulin, intravenous (IV) cefepime, levofloxacin, or blood sugar checks as ordered. Findings include: The facility's admission Orders policy, dated 1/5/26, indicates: .1. The written and/or verbal orders should include at a minimum .b. Medication orders if indicated .2. The orders should allow staff to provide essential care to the resident consistent with the resident's mental and physical status on admission. The facility's Medication Orders policy, dated 1/5/26, indicates: Written Transfer Orders (sent with a resident by a hospital or other health care facility): Implement a transfer order without further validation, if it is signed and dated by the resident's current attending physician. The facility's Medication Administration policy, dated 1/1/25, indicates: .23. Administer medication(s) according to physician order. From 4/27/26 to 4/28/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and discharged on 2/28/26. R1 had diagnoses including adult failure to thrive, diabetes, protein calorie malnutrition, stasis dermatitis left lower extremity with venous ulcer due to chronic peripheral hypertension, pressure injury stage 3 left and right thigh, diabetic ulcer toe left foot associated with type 2 diabetes, and an abdominal wound. R1's Minimum Data Set (MDS) assessment, dated 2/27/26, indicated R1 had moderately impaired cognition. Surveyor reviewed R1's discharge medication list, dated 2/25/26, and noted the following orders: ~ Insulin, Isophane 100 units/milliliter (ml) subcutaneous (SQ) injection. Inject 20 units into skin every day in the morning. May also inject 10 units at bedtime (HS) nightly as needed (for blood sugar &gt;100) for type 2 diabetes (start date: 12/9/25). ~ Insulin, Regular (Novolin) Kwik Pen SQ 100 units/ml injection. Inject 10 units into skin three times daily (TID) before meals. Inject 10 units every morning before breakfast; inject 10 units every evening before supper; inject 10 units every night before bed unless blood sugar is less than 100 mg/deciliter (dl). Max 30 units per day for type 2 diabetes (start date: 11/25/25). ~ Levofloxacin 750 milligrams (mg). Take 1 tablet every evening for 10 days (start date: 2/25/26). ~ Sodium Chloride (NaCl) 0.9 % solution 100 ml cefepime 2 grams (gm) (2000 mg) IV. Inject 2000 mg into the vein two times daily (BID) for 14 doses for Pseudomonas skin infection (start date: 2/25/26). ~ Blood glucose test strips use 1 TID for type 2 diabetes. Surveyor reviewed R1's Medication Administration Record (MAR) for 2/25/26 to 2/28/26 and noted the following: ~ Insulin NPH (Human)(Isophane) pen-injector 100 unit/ml. Inject 10 units SQ at bedtime related to type 2 diabetes mellitus with foot ulcer. Hold if blood sugar &lt;100. The insulin was not administered on 2/25/26 and was documented with a code 5 (Hold/See Progress Notes). An Orders-Administration note, dated 2/25/26 at 10:24 PM, indicated the insulin was not in the facility's contingency stock. The physician was notified and indicated to hold until the insulin arrived from pharmacy. The insulin was discontinued on 2/26/26. ~ Novolin R Flex Pen Injection solution Pen-injector 100 units/ml (Insulin Regular (Human) Inject 10 units SQ with meals related to type 2 diabetes mellitus with foot ulcer. The insulin was not administered on 2/25/26 and was started on 2/26/26 at 5:00 PM. R1 missed 3 doses of the insulin. ~ Levofloxacin oral tablet 750 mg. Give 1 tablet by mouth at bedtime for 10 days related (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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to pressure ulcer of right hip stage 3, pressure ulcer left hip stage 3. The medication was not administered at bedtime on 2/25/26 and was not started until 2/26/26. ~ Cefepime HCL intravenous solution 2 gm/100 ml. Use 2 grams intravenously BID for 7 days related to pressure ulcer right hip stage 3, pressure ulcer left hip stage 3, and open wound of abdominal wall. The antibiotic was not administered on 2/25/26 at bedtime and was not administered on 2/26/26 AM. Cefepime was first administered on 2/26/26 at 7:00 PM. ~ Fingertick glucose monitoring after meals and at bedtime four times daily (QID). R1's blood sugar was not checked after supper on 2/25/26 or after breakfast on 2/26/26. On 4/28/26 at 12:36 PM and 3:43 PM, Surveyor interviewed Regional Director of Operations (RDO)-C who was uncertain if staff were aware of the orders for insulin, fingerstick glucose monitoring, IV cefepime, and levofloxacin. RDO-C stated it was difficult to determine or anticipate a resident's medications prior to admission and indicated the facility could receive three or four copies of orders which could change prior to the resident's arrival. RDO-C verified the orders were missed and the medications were not administered on 2/25/26. RDO-C stated the errors were discovered via an audit of admission documents. Staff education was initiated but not completed and proof of education was not provided.</p>		