STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525523	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Milwaukee	9255 N 76th St Milwaukee, WI 53223

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure 1 (R7) of 1 resident reviewed received a prompt resolution of grievances filed, including steps taken to investigate the grievance, a summary of pertinent findings, conclusion, statements as to whether the grievance was confirmed or not confirmed, corrective actions taken by the facility, and the date the written decision was issued.*R7 called the main facility phone number to express concern of the need for incontinence care and had been on the call light for 4-5 hours. Facility staff were aware of the concern but did not initiate a formal grievance in writing and investigate the concern thoroughly.Findings include:The facility's Resident and Family Grievance policy and procedure dated 8/1/25 documents:Policy:It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal.Policy Explanation and Compliance Guidelines1. Nursing Home Administrator ((NHA)-A) has been designated as the Grievance Official and can be reached at [PHONE NUMBER] extension 5825.2. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations.4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their long-term care facility stay.5. The facility will not prohibit or in any way discourage a resident from communicating with external entities including federal and state surveyors or other federal or state health department employees. 8. Grievances may be voiced in the following forums:a. Verbal complaint to a staff member or Grievance Official.10. Procedure: .b. The staff member receiving the grievance will record the nature and specifies of the grievance on the designated grievance form or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further potential violations of any resident right.ii. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations.c. Forward the grievance form to the Grievance Official as soon as practicable.d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. i. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up.ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance official. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance.iii. All staff involved in the grievance investigation or resolution will take steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.f. The facility will take appropriate action in accordance with State law if an alleged violation of Quality Improvement Organization, or local law enforcement agency.11. Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision.12. The facility will make prompt efforts to resolve grievances.R7 was admitted to the facility on [DATE] with diagnoses of Radiculopathy (disease of the root of a nerve), Adult Failure to Thrive (decline in overall health in older adults), Scoliosis (sideways curvature of the spine), and Pulmonary Hypertension (high blood pressure in the pulmonary arteries).R7's Quarterly Minimum Data Set (MDS) completed 8/2/25 documents R7's Brief Interview for Mental Status (BIMS) score to be 15 indicating R7 is cognitively intact for daily decision making. No mood or behavior issues are documented. R7's MDS documents R7 is always incontinent of urine and has an ostomy. R7 requires substantial/maximum assistance for mobility and dependent for transfers.On 10/20/25, at 11:37 AM, Surveyor interviewed Director of Social Services (DSS)-E. Surveyor asked DSS-E if DSS-E remembered the resident DSS-E responded to after that resident had called the main phone to express a concern of being on the call light for 4-5 hours needing assistance. DSS-E stated DSS-E was notified R7 had been calling the main number trying to get assistance several times. DSS-E did go to R7's room but stated nursing staff were at the room at the time. DSS-E recalls the concern had to with R7's ostomy. DSS-E stated it was not unusual for R7 to do this. DSS-E did not document a formal grievance into R7's concerns at the time.On 10/21/25, at 1:00 PM

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents are accurately screened for a mental disorder prior to the expiration of a 30-day exemption for 1 (R3) of 1 resident reviewed for the PASARR (Preadmission Screening and Resident Review).*R1 did not have a PASARR level 1 screen resubmitted prior to the expiration of the 30-day exemption documented on the original PASARR level 1.Findings include:The facility's PASARR policy and procedure last revised 4/25 documents:Policy Statement.The purpose of this policy is to outline the screening of residents with a history of serious mental illness and developmental disability.ProcedureA. Complete Level 1 screen of the PASARR on new admissions.3.Those residents whose attending physician has certified, before admission to the community that the individual is likely to require less than 30 days of nursing facility services, do not require a PASRR (sic) to be completed. B. The resident or resident representative will receive a written notice (copy of Level 1 Screen) if the resident is suspected of having a serious mental illness or a developmental disability and therefore will require a Level 11 Screen.E. Psychiatric referrals will be made for those with mental illness or intellectual, developmental disability as appropriate and resident and/or responsible party agrees.F. A copy of PASRR (sic) screens will be kept in the resident's medical records.R3 was admitted to the facility on [DATE] with diagnoses of Anxiety Disorder (mental health disorder characterized by feelings of worry, fear that interfere with daily activities), Depression (mood disorder that causes persistent feelings of sadness and loss of interest), Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), Type 2 Diabetes Mellitus (adult onset of trouble controlling blood sugar), Chronic Obstructive Pulmonary Disease (lung disease that block airflow and make it difficult to breathe) and Atherosclerotic Heart Disease of the Native Coronary Artery (plaque buildup narrows the arteries that supply blood to the heart).R3's Quarterly Minimum Data Set (MDS) completed [DATE] documents R3's Brief Interview for Mental Status (BIMS) score to be 15, indicating R3 is cognitively intact for daily decision making. R3's admission PASARR completed [DATE] documents R3 has a major mental disorder and is receiving psychotropic medications. R3's PASARR documents R3 has a 30-day hospital discharge exemption.Surveyor reviewed R3's electronic medical record and notes a new PASARR Level 1 was not completed after the admission Level 1 PASARR was completed and the 30-day hospital exemption had expired. Surveyor notes R3 has been a resident at the facility for a little over a year.On [DATE], at 11:37 AM, Surveyor interviewed Social Services Director (SSD)- E in regard to PASARR assessment completion. SSD-E stated SSD-E has been in the social services position since the end of August. SSD-E stated the admissions department completes the initial PASSAR and if a Level 11 needs to be completed or a new PASARR needs to be completed, the social service department is responsible.On [DATE], at 3:05 PM, Nursing Home Administrator (NHA)-A confirmed the admissions department completes the initial PASARR and if a Level 11 PASARR needs to be completed it is referred to the social service department. Surveyor shared the concern R3's Level 1 PASARR is marked for a 30-day exemption and R3 has been a resident in the facility longer than 30 days and a new PASARR has not be completed. NHA-A confirmed the admissions employee who completed the initial 30-day exemption Level 1 PASARR for R3 is no longer employed at the facility. On [DATE], at 10:48 AM, NHA-A informed Surveyor NHA-A believes R3's Level 1 PASARR was incorrectly checked for 30-day exemption. NHA-A stated NHA-A has completed a new Level 1 PASARR date [DATE].No further information has been provided by the facility as to why a new Level 1 PASARR was not completed when R3 continued to reside in the facility past the 30-day exemption date.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility did not ensure 1 out of 2 residents (R5) reviewed for being at high risk for falls, received adequate supervision and assistance devices to prevent accidents. *R5 is at high risk for falls and had 3 unwitnessed falls at the facility. The facility did not ensure they thoroughly investigated each fall to determine the root cause and to assure that all interventions were in place at the time of the fall and were effective.Findings include:The facility's Fall policy and procedure implemented 2/11/25 documents:Policy: . Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Policy Explanation and Compliance Guidelines:1. The facility utilizes a risk assessment tool for determining a resident's fall risk.3. An individualized care plan will be implemented according to the risk factors identified on the fall assessment tool.4. Interventions will be monitored for effectiveness and reviewed/revised following a fall event, quarterly, annually, and with significant change or as needed.5. When any resident experiences a fall, the following will result: .e. Document all assessments and actionsf. Complete a Root Cause Analysis with Interdisciplinary (IDT) Team and update the plan of care based on resident care area.R5 was admitted to the facility on [DATE] with diagnoses of Hypertensive Encephalopathy (high blood pressure damages small arterioles in the brain), Hemiplegia (paralysis on one side of the body), Malignant Neoplasm of Prostate (prostate cancer, abnormal cells in the prostate gland grow in uncontrolled way to form a tumor), Chronic Pulmonary Embolism (long-term condition where blood clots in the pulmonary arteries don't fully dissolve), Anemia (lack of blood), Gout (inflammatory arthritis that causes pain and swelling in joints), Dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), and Depression (mood disorder that causes persistent feelings of sadness and loss of interest). R5 has an activated health care power of attorney (HCPOA).R5's Quarterly Minimum Data Set (MDS) completed 8/19/25 documents R5's Brief Interview for Mental Status (BIMS) score of 15, indicating R5 is cognitively intact for daily decision making. R5's MDS documents R5 is frequently incontinent of bowel and bladder. R5 has range of motion impairment on one side of both upper and lower extremities. R5 is independent with eating and requires supervision for showers. R5 requires supervision for both upper and lower dressing. R5 is independent for mobility and is set-up for transfers. On 8/13/25, R5 was assessed to be at moderate risk for falls with a score of 8.0.On 9/9/25, R5 was assessed to high risk for falls with a score of 15.0.R5's care plan documents R5 is at risk for falls due to gait/balance problems, impaired cognition secondary to dementia, incontinence, history of falls. Interventions:10/12/25 Make sure staff walk R5 to and from meals with assist10/4/25 Antibiotic started due to change of condition9/9/25 Offer toileting upon rising, before and after meals, bedtime, and NOC (night shift) rounds.-Follow facility fall protocol-PT (physical therapy) evaluate and treat as ordered or as neededSurveyor notes R5 has had three unwitnessed falls.Fall 1On 9/9/25-R5 had an unwitnessed fall in R5's room. R5 was found on the floor between the foot of the bed and the wheelchair which was positioned away from R5. Surveyor notes a Post-Fall Investigation Form was not completed including a thorough investigation of the fall with resident and staff statements indicating what R5 was observed doing prior to the fall and was attempting to do at the time of the fall, and what fall prevention interventions were in place at the time of the fall. A thorough investigation would help with establishing a root/cause analysis and identify interventions to avoid further falls.Fall 2On 10/4/25-R5 had an unwitnessed fall. R5 was found on the floor of R5's room. R5 was sent to the hospital due to currently taking Eliquis. Surveyor notes a Post-Fall Investigation Form was not completed including a thorough investigation of the fall with resident and staff statements indicating what R5 was observed doing prior to the fall and was attempting to do at the time of the fall, and what fall prevention interventions were in place at the time of the fall. A thorough investigation would help with establishing a root/cause analysis and identify interventions to avoid further falls.Fall 3On 10/12/25-R5 was found in the dining room lying on R5's left side.A Post-Fall Investigation Form was completed, however, there is no staff statements providing input for interventions to prevent further falls for R5. The facility was not able to provide a thorough investigation of R5's fall on 10/12/25.On 10/21/25, at 9:10 AM, Surveyor interviewed Director of Nursing. (DON)-B stated the expectation is that staff statements should be obtained at the time of a resident fall. DON-B explained prior to DON-B starting 8/20/25, thorough investigations of resident falls were not being completed. DON-B explained training going over new policy and procedures was implemented at the end of September. Surveyor shared

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that each resident maintained acceptable parameters of nutritional status, such as usual body weight unless the resident's clinical condition demonstrates that this is not possible, or resident preferences indicate otherwise for 1 of 1 (R1) resident reviewed for weight loss. R1 sustained a weight loss of 10.1 pounds / 6.61% over a period of 3 weeks with no physician or dietician notification.Findings include:R1 admitted to the facility on [DATE] with diagnoses that included T11-T12 compression fracture, severe protein calorie malnutrition, peripheral vascular disease, legal blindness, hypertensive chronic kidney disease stage 4, urine retention, osteoarthritis, anemia and gastroesophageal reflux disease.The facility policy titled Weight Monitoring last approved 07/2025 documents (in part) .It is the policy of (facility name) that appropriate nutritional care shall be provided to residents who have a significant weight change. A significant weight change is identified as a weight loss or gain of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days.B. Residents with a weight change of 5 lbs. (pounds) or greater should be reweighed to determine an accurate weight. The accurate weight should be entered in the resident's medical record.C. A report should be generated from the electronic medical record (EMR) system identifying all residents with a significant weight change in 30 days, 90 days and/or 180 days.D. At the weekly Resident at Risk Review huddle, the IDT (interdisciplinary) team should discuss residents who trigger for a significant weight loss and who lose more than 5 lbs. since the last weight.E. The RD (Registered Dietician) should make recommendations for nutritional interventions based on the information obtained from the weekly Resident at Risk huddle meetings. RD recommendations should be reviewed and initiated by nursing associates.F. A nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD has requested a nutritional intervention.R1's BIMS (Brief Interview for Mental Status) documented a score of 14 indicating no cognitive impairment.R1's Care plan documented: At risk for impaired nutrition related to weight loss over last 6 months, diuretic use, need for therapeutic diet, legally blind. Offer diet as prescribed, offer alternative. Eating - needs no assistance with set up staff support.R1's Mini Nutritional assessment dated [DATE] documents R1's weight as 147. Screen score 6 (0-7 = malnourished).R1's Nutrition Risk assessment dated [DATE] comments: Resident reports weight has been around 159 lbs. Awaiting admit weight to assess any further changes. Resident reports dislike of Ensure, trying her best to eat enough. RD to monitor weights and po (by mouth) intake to determine if needing to try alternative ONS (oral nutritional supplement). Resident on diuretic so potential for weight/fluid shifts secondary to this. Reviewed menu and alternatives. RD to continue to monitor weights, po intake and skin integrity.Surveyor noted there was no further RD documentation, notes or assessments in R1's medical record. Surveyor was advised the RD no longer works for the facility, thus was unavailable for interview.R1's first weight entered on 7/5/25 was 152.8 lbs. The last weight entered on 7/24/25 was 142.7 lbs. - this indicated a weight loss of 10.1 lbs. / 6.61%. Surveyor noted R1's weight entered on 7/23/24 was 151.2 and the next day (7/24/25) R1's weight entered was 142.7 indicating an 8.5 lb. weight loss. Surveyor noted there was no evidence the physician or RD was notified of R1's weight loss and no new interventions were implemented. Surveyor reviewed R1's meal intake record from 7/1/25 through 7/31/25. R1's meal intake documented the following meal percentages consumed: Breakfast: 76-100% eight meals, 51-75% five meals and 26-50% three meals. There were 15 meals that were blank/had no percentage documented. Lunch: 76-100% seven meals, 51-75% six meals and 26-50% two meals. There were 15 meals that were blank/had no percentage documented. Dinner: 76-100% three meals and 51-75% four meals. There were 21 meals that were blank/had no percentage documented. Surveyor noted of the 91 meals available/served to R1, over half (51 meals) had no documentation indicating how much R1 ate at each meal. On 10/21/25 at 10:40 AM, Surveyor met with Nursing Home Administrator (NHA)-A and Director of Operations-C. Surveyor reviewed R1's meal consumption record, advising of over half of the meals not having anything documented, therefore there is not enough information to complete an accurate assessment of R1's weight loss related to intake. Surveyor advised of concern regarding R1's weight loss with no evidence the physician or RD was notified. NHA-A reported since the new company took over and she began working at the facility, there have been many areas of improvement identified, and they are working very hard going forward. No additional information was provided prior to survey exit.