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	01/08/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to provide meal set-up assistance for one (Resident (R) 17) of three residents reviewed for activities of daily living (ADLs) out of a total sample of 17 residents. This failure could negatively impact residents' psychosocial wellbeing and overall quality of life and may contribute to unintended weight loss.Findings include:Review of R17's admission Record, located under the Profile tab of the electronic medical record (EMR), indicated he was admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke), parkinsonism (condition causing movement problems), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting left non-dominant side.Review of R17's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/15/25 and located in the MDS tab of the EMR, revealed he had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R17 had moderately impaired cognition. The MDS documented that R17 required assistance with meal setup and clean up.During a dining room observation on 01/06/26 at 12:32 PM, 14 residents ate in the dining room. R17 was seated alone at a table with his meal plate still covered with plastic wrap. He had partially torn the wrap on one side of the plate but had not fully removed it. When asked if assistance was needed, R17 did not respond. During the observation, the Dining Services Manager (DSM) approached the table, removed the plastic wrap from R17's plate, and said, I'm sorry, the serving staff should have removed the plastic wrap when your meal was served.During an interview on 01/06/26 at 12:38 PM, Certified Nurse Aide (CNA) 4 stated that she should have removed the plastic wrap from R17's meal tray but that R17 no longer required staff to feed him.During an interview on 01/06/26 at 2:15 PM, the Director of Nursing (DON) stated that the CNAs serving residents their meals were required to complete the task for meal setup when indicated.During an interview on 01/07/26 at 3:30 PM, the Nursing Home Administrator stated that she expected the staff to meet the needs of all ADL tasks, including meal setup and cleanup when indicated. Specifically, they should assist R17 with meal setup and cleanup.Review of the facility's policy titled, Activities of Daily Living (ADL's), with a revision date of 08/03/25, revealed, based on the comprehensive assessment and consistent with the resident needs and choices, the facility must provide the necessary care and services to ensure that a resident's activities of daily living [ADL] abilities are maintained, including assist with meal set up.

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 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. Based on record review and interviews, the facility failed to administer a prescribed medication to stabilize post-meal blood glucose as ordered for one resident (Resident (R) 5) of 17 sample residents reviewed. This failure had the potential to impair carbohydrate absorption and increase the risk of hypoglycemia (low blood sugar).Findings include:Review of R5's admission Record from the electronic medical record (EMR) Profile tab revealed a facility admission date of 10/17/25, with a readmission date of 10/31/25, with diagnoses that included hypoglycemia and diabetes.Review of R5's EMR Orders tab revealed an order for acarbose 25 milligrams (mg) by mouth before meals related to hypoglycemia and type two diabetes with diabetic chronic kidney disease, dated 11/20/25, and scheduled for 7:30 AM, 11:30 AM, and 4:30 PM.Review of R5's Medication Audit Report for R7's acarbose for 12/24/25 through 01/07/26, provided by the facility, revealed:12/24/25 the 7:30 AM ordered dose was administered at 9:24 AM12/24/25 the 4:30 PM ordered dose was administered at 8:01 PM12/26/25 the 7:30 AM ordered dose was administered at 11:16 AM12/26/25 the 4:30 PM ordered dose was administered at 5:50 PM12/27/25 the 7:30 AM ordered dose was administered at 10:19 AM12/28/25 the 11:30 AM ordered dose was administered at 1:16 PM12/28/25 the 4:30 PM ordered dose was administered at 6:17 PM12/30/25 the 7:30 AM ordered dose was administered at 10:27 AM12/31/25 the 7:30 AM ordered dose was administered at 10:46 AM01/02/26 the 7:30 AM and 11:30 AM doses were documented as administered at the same time of 11:49 AM.01/04/26 the 11:30 AM ordered dose was administered at 1:34 PM01/05/26 the 7:30 AM ordered dose was administered at 10:36 AMA message was left with the Medication Technician who worked the majority of these dates/times, but no return call was received.During an interview on 01/07/26 at 1:30 PM, the Nursing Home Administrator reported the facility did not have a policy regarding medication administration.During an interview on 01/08/26 at 9:50 AM, the Director of Nursing (DON) stated an expectation, that they [medications] are given as ordered. The DON reviewed the Medication Audit Report for the acarbose and stated she believed the medication was given 15 to 30 minutes before the meals, but the documented times were outside the normal administration leeway. That is something else, the nurses need to document if the med [medication] is administered outside of the parameters due to meal delivery time.Review of Acarbose, updated 02/12/24 and found on the National Institute for Health website located at https://www.ncbi.nlm.nih.gov/books/NBK493214/ revealed: . By delaying the digestion of carbohydrates, acarbose slows glucose absorption, reducing postprandial glucose blood concentrations . Acarbose is available as a 25 mg, 50 mg, or 100 mg oral tablet and should be administered orally 3 times daily with the first bite of each meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to maintain and serve food at safe temperatures. This failure created the potential for foodborne illness and compromised nutritional safety for five cognitively impaired residents who were able to self-propel to the activities room/dining area, as well as residents receiving meal trays in their room.Findings include:1. Review of R7's admission Record from the electronic medical record (EMR) Profile tab showed an admission date of 01/07/25, readmission on [DATE], with medical diagnoses that included severe protein-calorie malnutrition, spinal stenosis, history of cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD), poly-osteoarthritis, and anxiety disorder.Review of R7's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/17/25 from the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicative of being cognitively intact.During an interview on 01/07/26 at 4:00 PM, R7 stated the food is cold and that not all the aides will go warm it up.Observation of the evening meal on 01/07/26 at 5:50 PM with the Dietary Manager (DM), R7 granted permission to take the temperature of her food tray. The DM took the temperature of the chicken and noodles (not soup) as it was pulled from the transport cart for delivery to R7, and the thermometer showed 93.7 degrees Fahrenheit [F]. The DM stated, The last cart came up [to third floor from the second-floor satellite kitchen] at 5:20 PM, and the food is not hot enough. I need to reheat this to 165 degrees [F].Review of the facility policy titled Food Safety, implemented 02/01/25, revealed: . Food will also be stored, prepared, distributed, and served in accordance with professional standards for food service safety . staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed . food that is cooked and cooled must be reheated so that all parts of the food reach an internal temperature of 165 F. Ready-to-eat foods that require heating before consumptions must be heated to at least 135 F.Review of the FDA's 2022 Food Code, found at https://www.fda.gov/media/184685/download?attachment revealed: . Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature 'Danger Zone' of [41oF to 135oF] too long. Review of the Food and Drug Administration (FDA) website's Danger Zone, updated 06/28/17 and located at https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/danger-zone-40f revealed: Danger Zone [40 F - 140 F] Leaving food out too long at room temperature can cause bacteria . to grow to dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40 F and 140 F, doubling in number in as little as 20 minutes. This range of temperatures is often called the 'Danger Zone.' Keep Food Out of the 'Danger Zone' Keep hot food hot-at or above 140 F .

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, interview, review of the Food and Drug Administration (FDA) guidelines, and review of Manufacturer's Instructions for Use (MIFU), the facility failed to document inspections and maintenance per the MIFU recommendations of bed frames and bed rails, if present, for any of the 77 resident beds and did not perform FDA entrapment risk measurements for any of the 36 residents the facility identified as having bed rails, mobility bars, or assist bars. These failures created the potential for bed malfunctions and or resident injury.Findings include:Observations of the facility on 01/05/26 revealed resident beds with assist/mobility bars.During an interview on 01/06/26 at 3:37 PM, regarding bed inspections, in response to a complaint regarding dysfunctional or broken beds, the Nursing Home Administrator stated, I don't believe we have any [bed inspections]. Bed MIFUs and an inspection policy were requested. During a follow up interview on 01/07/26 at 3:35 PM, the Nursing Home Administrator stated there was no policy regarding bed inspections. During an interview on 01/08/26 at 8:58 AM, regarding bed maintenance/inspections, the Maintenance Director stated, When we have a new admit they give us a heads up and we go in the room, remove safety bars, make sure there is a mattress, inspect the bed, test the remote, and look for exposed wires. Once the resident is here, therapy assesses and will put in orders for safety bars to the bed. Also, they may ask us to extend the bed out depending on the resident's size or maybe request an air mattress. Inspections are done but not documented. When asked about an FDA entrapment safety inspection documentation, the Maintenance Director responded, We have a sheet [to refer to] that shows seven or eight zones and a sheet with a numbers breakdown, but we don't do the FDA safety zone inspections.Review of the facility provided MIFU pamphlet User/Service Manual for Joerns Model U770, U790 and U795 Beds revealed: . Maintenance/Inspection Information: Visually inspect the bed and accessories for broken welds or cracks and check for loose hardware on a monthly basis. If any broken welds or cracks are found, remove the bed from service immediately and replace the affected part(s) . Review of the Food and Drug Administration's Guidance for Industry and FDA Staff, recommendations for rail entrapment, issued 03/10/06 and located at https://www.fda.gov/regulatory-information/search-fda-guidance-documents/hospital-bed-system-dimensional-revealed, .Potential Zones of Entrapment, This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance.The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below: Zone 1: Within the Rail, Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support, Zone 3: Between the Rail and the Mattress, Zone 4: Under the Rail, at the Ends of the Rail, Zone 5: Between Split Bed Rails, Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board, Zone 7: Between the Head or Foot Board and the Mattress End.Dimensional Limits for Identified Entrapment Zones 1-4, FDA is recommending dimensional limits for zones 1 through 4 at this time because we believe the majority of the entrapments reported to FDA have occurred in these zones. We based these recommended limits upon the body parts entrapped in these individual zones identified through adverse event reports and entrapment scenarios described in the reports.