STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525616	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avina of Mayville	305 S. Clark St. Mayville, WI 53050

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. (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
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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 0755 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, record review, and facility policy review, the facility failed to ensure antibiotics were administered as ordered by the physician for 1 (Resident #23) of 3 residents reviewed for medication administration. Findings included:A facility policy titled, Medication Administration, implemented 02/01/2025, revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.An admission Record revealed the facility admitted Resident #23 on 05/16/2025. According to the admission Record, the resident had a medical history that included diagnoses of acute kidney failure, malignant neoplasm, and anxiety disorder. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2025, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #23's Order Listing Report, for the timeframe from 05/07/2025 through 07/31/2025, revealed an order started on 05/27/2025 and revised on 05/28/2025 for azithromycin 250 milligram (mg) tablet, two tablets, one time a day on day 1, then one daily for four days for a sinus infection. Resident #23's 05/2025 Medication Administration Record [MAR] revealed staff documented that azithromycin 250 mg, two tablets were administered on 05/28/2025, and one tablet was administered on 05/29/2025, 05/30/2025 and 05/31/2025. Resident #23's 06/2025 Medication Administration Record revealed Licensed Practical Nurse A (LPN) documented 10, which indicated Other/See Progress Notes for the resident's 06/01/2025 dose (final dose) of azithromycin. Resident #23's Progress Notes, dated 06/01/2025, revealed azithromycin was unavailable. During an interview on 07/24/2025 at 3:45 PM, a Pharmacy Representative stated that azithromycin for Resident #23 was delivered to the facility on [DATE] at 1:56 AM. Per the Pharmacy Representative, the pharmacy delivered six tablets, with instructions to take two tablets on day one and one tablet daily thereafter. During an interview on 07/23/2025 at 10:52 AM, Resident #23 revealed they had a sinus infection and there was a mistake during their first round of antibiotic treatment. Resident #23 stated that they currently had no sinus pain or ongoing issues. During an interview on 07/24/2025 at 10:09 AM, LPN A stated that Resident# 23's azithromycin was unavailable (on 06/01/2025). She stated that she contacted the pharmacy, who promised delivery that night. She said the medication did not arrive and was not administered to the resident. LPN A stated that she was off for the next two days and did not leave notes for other nurses or notify the physician that the final dose of the antibiotic was not available. She stated that when she returned to work, the medication had arrived at the facility; however, she did not administer the medication because the resident had started a new round of antibiotics. During an interview on 07/24/2025 at 9:21 AM, the Director of Nursing (DON) stated that after speaking with LPN A, they discovered that the pharmacy had sent only five, instead of six, azithromycin tablets for Resident #23, resulting in a missed final dose. The DON stated the missing pill arrived the following night, but it was too late to administer. Per the DON, HUCU (Patient-Centered Secure Communication Application) was used to communicate with physicians, and a review of the system showed no documentation that the missed dose was reported. During an interview on 07/24/2025 at 2:17 PM, Nurse Practitioner C (NP) stated that regarding Resident #23, antibiotics were prescribed on 05/27/2025. She stated the resident missed a dose on 06/01/2025 but she was not notified. NP C stated it was important to complete an antibiotic course. During an interview on 07/24/2025 at 4:27 PM, the Administrator (ADM) stated when medications were unavailable, nursing staff were expected to contact the pharmacy, notify the physician or nurse practitioner, and provide updates. Per the ADM, staff utilized a messaging application to communicate such requests and updates to providers.