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	06/17/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure a Resident (R5) was free from physical abuse by Resident Representative (RR 2). RR2 slapped R5. Findings include: Review of the facility's undated policy and procedure titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, revealed physical abuse included hitting and slapping. The policy indicated the facility would identify and intervene in situations in which abuse of a resident was likely to occur or had occurred. The policy also revealed, under Procedure for Response, that staff should remove the accused/perpetrator from the resident's care area. Staff were to respond to the needs of the resident and protect the resident from further incidents. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 02/01/25, revealed physical abuse included hitting and slapping. Under the section Protection of Resident: It indicated the facility will Make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to; A. Responding immediately to protect the alleged victim and integrity of the investigation. B. Examining the alleged victim for any signs of injury, including a physical examination or psychosocial assessment if needed. Review of R5's admission Record located under the Profile tab of the electronic medical record (EMR) indicated that he was admitted to the facility on [DATE]. Diagnoses included Parkinson's disease, dementia, cognitive communication deficit, and need for assistance with personal care. Review of R5's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/21/26 and located under the MDS tab of the EMR indicated a Brief Interview for Mental Status (BIMS) score of zero out of 15, indicating severe cognitive impairment. The assessment also revealed the resident was dependent on others for eating and required staff or a family member to feed him. Review of R5's EMR Care Plan, located under the Care Plan tab and revised on 06/05/26, indicated the resident had an activity of daily living (ADL) self-care performance deficit and limited physical mobility related to Parkinson's disease and dementia. Care plan interventions included that R5 required assistance of one person for eating and should eat in the dining room. R5 also had a care plan for impaired cognitive function/dementia, which indicated the resident had an active healthcare surrogate and power of attorney. The goal of the care plan was for the resident to be able to communicate basic needs daily. An intervention was to discuss concerns about confusion and the (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease process with the family member. Review of the facility's Initial Report, dated 06/03/26 and provided by the facility, revealed R5 was eating dinner in the facility dining room. R5's family member, RR2 (Resident Representative), was sitting with the resident and assisting him with eating. A staff member in the dining room at the time indicated R5 grabbed RR2 by the hand/wrist. RR2 yelled, Oww! Stop it! You are hurting me! Before the staff member could intervene to assist RR2, RR2 reached up with her other hand and slapped R5 in the face. R5 then let go of RR2's hand/wrist and asked RR2 why she hit him. RR2 responded that R5 was hurting her. R5 made a comment about RR2 hitting him in his ear, and RR2 said she did not hit his ear; she was trying to get him to let go of her wrist. The staff member stated she monitored R5 and RR2 until the end of the meal to ensure R5 was safe. RR2 left after the meal. During an interview on 06/16/26 at 1:51 PM, RR2 stated she was sitting in the dining room with R5, assisting him with his meal, when he suddenly grabbed her wrist, squeezed it very hard, and would not let go. RR2 stated she yelled and told him he was hurting her, but he still did not let go. RR2 stated he was gripping her wrist so hard that he had a grimacing look on his face. RR2 stated, I then instinctively, like a jerk response, reached up and slapped him across the face, hoping it would startle him so he would let me go, which he did. RR2 stated there was a staff member in the dining room, but the staff member was assisting other residents with meals, and RR2 did not want to interrupt her. RR2 stated the staff member did not get up, come over to help, or ask what happened. RR2 stated no one talked to her about the incident until the next day. During an interview on 06/16/26 at 3:15 PM, Certified Nurse Aide (CNA) 8 stated that on the date of the incident, she was in the dining room helping another resident with a meal. CNA8 stated R5 and RR2 were at a table behind her, and she could not see them, but she could hear RR2 assisting R5 with his meal and saying things such as, Take a drink, and Here is a bite. CNA8 stated she suddenly heard RR2 yell, Oww! Stop it! You are hurting me! CNA8 stated she turned to look and saw R5 holding RR2's hand/wrist and gripping it hard. CNA8 stated RR2 then reached up with her other hand and slapped R5 across the face. CNA8 stated R5 then let go of RR2 hand/wrist. CNA8 stated she did not get up or go over to the resident or RR2 to intervene. CNA8 acknowledged that a slap across the face was an act of abuse and that the facility policy stated staff should intervene and separate the two individuals involved in the act. CNA8 stated she was confused because RR2 was a family member and R5's caregiver. CNA8 stated she monitored them for the rest of the meal and then reported the incident to the nurse after the meal was over and R5 and RR2 had left the dining room. During an interview on 06/17/26 at 10:15 AM, Licensed Practical Nurse (LPN) 1 stated that on the day of the incident, CNA8 came to her after the dinner meal and reported that R5's RR2 had slapped him across the face in the dining room after he grabbed her wrist. LPN1 stated she went to R5's room to assess him for injury and to determine whether he was upset or in distress. LPN1 stated R5 was not in distress and did not have any marks or redness on his face from the slap. LPN1 stated R5 appeared agitated, but he could present that way in the evening due to his dementia. LPN1 stated RR2 was no longer with the resident and had gone home. LPN1 stated she immediately called the Director of Nursing (DON) and Administrator, reported the incident, and asked CNA8 to write a statement of what happened. During an interview on 06/17/26 at 11:40 AM, the DON stated she was notified of the incident involving RR2 slapping R5 across the face in the dining room on the evening it occurred. The DON stated the investigation started at that point. The DON stated she did not speak to RR2 until the next day to obtain her statement. The DON acknowledged that the slap across the face was a form of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse but stated she felt it was reactionary and was not intended to hurt R5. The DON also acknowledged that RR2 stated her intention was to startle R5 into letting go of her hand/wrist. The DON stated CNA8 should have gone over to the resident and family member, intervened, asked RR2 to step away for a minute, and had someone else assist R5 with his meal. During an interview on 06/17/26 at 11:50 AM, the Administrator stated her expectation for this incident, in which RR2 slapped R5 across the face, was that the CNA who was in the dining room and observed the altercation should have gotten up and intervened by asking if she could help or by asking RR2 to take a break for a while. The Administrator stated CNA8 should have also notified the nurse immediately so the nurse could intervene. The Administrator stated the slap across the face was abuse.