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	12/04/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that each resident receives food and drink that is palatable and at a safe and appetizing temperature. This has the potential to affect 6 of 16 residents (R1, R11, R41, R47, R2, R12) reviewed and for food palatability and 9 supplemental residents (R7, R13, R17, R21, R43, R46, R52, R29, R50).R1, R2, R41, R12, R7, R13, R17, R21, R41, R43, R46, R50, R29, and R52 voiced concerns related to their meals being served at undesirable low temperatures. Resident Representative I indicated R47's hot meal is served cold at times. Surveyors conducted 2 test trays, and the results were not palatable. Evidenced by:Example 1R1 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 10/17/25 indicate R1's cognition is intact with a BIMS (Brief Interview for Mental Status) score of 15 out of 15. On 12/2/25 at 9:01 AM R1 indicated his hot food is served cold all the time at every meal. R1 stated, They have to know. I tell them every day. Example 2R2 admitted to the facility on [DATE]. R2's most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 11/28/25 indicates R2's cognition is intact with a BIMS score of 15 out of 15. On 12/2/25 at 10:37 AM, R2 indicated his hot food is always cold, at all meals. R2 indicated the staff know, because he tells everyone.Example 3On 12/3/25 at 11:34 AM, Surveyor observed dietary staff wheel insulated cart into hallway with resident meals on it. On 12/3/25 at 11:35 AM, Surveyor observed nursing staff pass the first resident meal tray. On 12/3/25 at 11:45 AM, Surveyor was served a test tray. Surveyor observed the plate to have a plastic cover and a plastic base, Surveyor took a temperature reading of the tray, noting the following: roast beef 126.7 degrees F, peas 133.3 degrees F, scalloped potatoes 141.4 degrees F, and a grape drink to be 44.8 degrees F. On 12/3/25 at 1:00 PM, Dietary Manager L indicated hot food should be held higher than 135 degrees F or higher and cold food should be held at 41 degrees F or lower. Example 4On 12/2/25 at 1:00 PM, during the resident council task meeting with Surveyors, R46, R7, R13, R11, R29, and R50 indicated their hot meal is often served at a cold and undesirable temperature. Example 5R47 admitted to the facility on [DATE]. On 12/2/25 at 9:42 AM, Resident Representative I indicated R47's hot food is served cold at times, food sits on the table prior to her arriving in the dining room, no one offers to reheat the food when she arrives. Example 6R41 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 11/17/25 indicates BIMS (Brief interview of mental status) of 4 out of 15. R41's speech is clear, and he usually makes himself understood with difficulty communicating some words or finishing thoughts. R41's MDS also indicates he usually understands others but misses some part/intent of the message. On 12/3/25 at 8:01 AM, R41 indicated he receives his hot food cold at times, especially his morning eggs. Example 7R43 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 11/26/25 indicates R43's cognition is intact with a BIMS score of 15 out of 15. On 12/3/25 at 7:58 AM R43 indicated he gets cold eggs some days and prefers them to be hot. Example 8R52 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 10/14/25 indicates BIMS of 9 out of 15 indicating R52's cognition is moderately impaired. On 12/2/2025 at 9:13 AM R52 knocked on the window at Surveyor who was in the conference room. R52 stated, My (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	breakfast was cold again. I rarely get a hot meal here. I eat in the dining room. Example 9R12 was admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/5/25 indicates R12's cognition is intact with a BIMS score of 15 out of 15. On 12/1/25 at 11:27 AM, R12 indicated his hot food is served cold at times. Example 10R17 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 10/3/25 indicates R17's cognition is intact with a BIMS score of 15 out of 15. On 12/2/2025 at 9:14 AM, R17 stated, We do not get hot meals here. Breakfast was cold again.Example 11R21 admitted to the facility on [DATE]. His most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 10/24/25 indicates BIMS (Brief interview of mental status of 3 out of 15. R21's speech is clear with distinct intelligible words, he is understood by others, and he understands others with clear comprehension. On 12/1/25 at 2:54 PM, R21 indicated he gets served his hot food at a cold, undesirable temperature at times. Example 12R50 admitted to the facility on [DATE]. Her most recent MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/18/25 indicates R50's cognition is intact with a BIMS score of 13 out of 15. On 12/3/25 at 12:10 PM, Surveyor observed staff place a meal tray on the table where R50 was supposed to sit. R50 was not present. The tray contained a plate covered by a plastic base and cover. The liquids sat on the tray covered. On 12/3/25 at 12:37 PM, Surveyor and Dietary Manager L observed nursing staff serve R50 a meal tray. Surveyor asked R50 how the temperature was of her food. R50 stated, It is halfway warm. Surveyor sked R50 if it was at a desirable temperature. R50 indicated she preferred a hot meal. Surveyor took a temperature reading of the meal at 12:38 PM and recorded the following: roast beef- 102.9 degrees F (Fahrenheit), potatoes 109.6 degrees F, milk-58.1 degrees F. Dietary Manager L indicated these temperatures were not palatable and she would replace the meal with a hot one. During an interview, Dietary Manager L indicated the dietary staff plate the food and set up the trays then the nursing staff serve the residents. DM L indicated there is a problem with nursing department leaving trays sit in hallway carts and at tables for long periods of time causing the food temps to lower before resident is given the meal. On 12/4/25 at 10:14 AM DON B (Director of Nursing), NHA A (Nursing Home Administrator), and ANHA C (Assistant Nursing Home Administrator) indicated residents should be served meals that are at a safe and desirable temperature. NHA A and DON B indicated trays should not be set at tables until the resident is at the table and ready for the meal. NHA A and DON B indicated staff should keep the insulated cart doors shut while passing hallway trays and this could help keep the meals warmer.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 54 residents who reside in the facility. Surveyor observed Mighty shakes to be in the refrigerator without a thaw date. Surveyor observed the facility's stove hood to have hair like dust on it above the food cooking surface. Surveyor observed the facility's mixer and meat slicer to be stored unclean. Surveyor observed staff drying dishes with a towel after cleaning and sanitizing them in the 3-compartment sink. Surveyor observed staff wet stacking dishes while observing the dishwashing process. Surveyor observed [NAME] O serving food without donning a hairnet. Evidenced by: Example Mighty ShakesManufacturer's recommendations for use, includes: store frozen. Thaw at or below 40 degrees Fahrenheit. Use thawed product within 14 days. Keep refrigerated. On 12/1/25 at 9:40 AM during initial tour of the facility's kitchen, Surveyor observed 2 boxes of Mighty Shakes inside of the facility's walk-in refrigerator system. The boxes were labeled with the following dates: 10/28/25 and 11/11/25.Dietary Manager L indicated these are the dates the product was delivered to the facility. Surveyor asked how long the product was good for once it was thawed. Dietary Manager L was not sure. Surveyor and Dietary Manager L reviewed the manufacturer's guidelines for use printed on the side of the carton. Dietary Manager L indicated she would toss the product in the garbage. Example Stove hoodOn 12/1/25 at 9:40 AM during initial tour of the kitchen, Surveyor and Dietary Manager L observed the facility's stove hood's front, inside panel to have hairlike dust on it directly over the food cooking area. Dietary Manager L indicated there is potential for the dust to dislodge into open food.On 12/3/25 at 1:06 PM Dietary Manager L indicated she sent photos to the company who just cleaned their stove hood unit and the person who cleaned the unit told her he missed that area when he was cleaning. Example Hair restraintsUSDA Food Code, 2022, includes, in part: . Hair Restraints. 2-402.11 Effectiveness. Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food. On 12/3/25 at 11:14 AM Surveyor observed [NAME] O to have a beard and to be dishing up plates without donning a hair restraint. On 12/3/25 at 1:06 PM Dietary Manager L indicated the facility used to have beard restraints, but she was unable to find them. Dietary Manager L indicated they will order some and she will educated staff again on using them. Example Dirty Meat Slicer and MixerOn 12/1/25 at 9:40 AM during initial tour of the kitchen, Surveyor observed the mixer and meat slicer to be stored with a plastic covering. Surveyor requested that the plastic cover be removed for further observation. Surveyor and Dietary Manager L observed both pieces of equipment to have food debris dried on it. Dietary Manager L indicated staff are to clean equipment before storing it under the plastic. On 12/3/25 at 1:06 PM Dietary Manager L indicated the equipment should be cleaned and dried before storing under plastic. Example not allowing air dry/using towelOn 12/2/25 at 9:29 AM Surveyor observed [NAME] O washing dishes in the three-compartment sink. Surveyor then observed [NAME] O use a towel to dry three items. During an interview [NAME] O indicated he was unaware that he should allow dishes to air dry and not use a towel for drying.On 12/3/25 at 1:06 PM Dietary Manager L indicated staff should allow dishes to air dry completely and should not use a towel to dry. Example wet stackingOn 12/2/25 at 9:31 AM Surveyor observed Dietary Aide P stacking wet cups. Surveyor asked Dietary Aide P to unstack a couple of the cups and turn them over. Surveyor and Dietary Aide P observed water inside of the cups and white film in a straight line at the bottom one third of the cup. Dietary Aide P indicated she was not aware she could not stack wet cups. Dietary Aide P indicated she thinks the white line is from stacking wet cups prior to survey because that white line is right where the cup underneath would line up and trap the chemicals and water. On 12/3/25 at 1:06 PM Dietary Manager L indicated staff should allow dishes to air dry completely before stacking.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that every resident was treated with dignity and respect when providing activities of daily living for 1 of 16 sampled residents (R28) and 5 of 5 supplemental residents (R16, R25, R26, R49, and R62). Surveyor observed AA J (Activity Assistant) approach R28 from behind in the dining room and pull his wheelchair backwards without warning and move to a different table. Surveyor observed AA J approach R16, R26 and R49 from behind in the dining room and move them to a different spot without talking to the resident and explaining what she was doing. R26, R28, and R49 had a startled look on their face and gripped the chair handles of their wheelchair. Surveyor observed LPN H (Licensed Practical Nurse) approach R25 and R62 from behind in the dining room and move them to a different spot without talking to the resident or explaining what she was doing. The residents looked startled, confused and disoriented. Evidenced by: Facility policy entitled, Resident Rights dated 2/28/2025 states, in part: .4. Respect and dignity. The resident has a right to be treated with respect and dignity. Example 1R28 admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, congestive heart failure, and cognitive communication deficit. R28's most recent MDS (Minimum Data Set) states R28 has a BIMS (Brief Interview for Mental Status) score of 12 out of 15, indicating R28's cognition is moderately impaired. On 12/3/25 at 11:50 AM, Surveyor was in the dining room getting ready to observe the lunch meal service. There was a music program in the dining room that had just ended, and staff were transporting residents from where they were seated for the music to a dining table for lunch. Surveyor observed AA J (Activity Assistant) approach R28 from behind in the dining room and pull his wheelchair backwards about 10 feet without warning and move R28 to a different table. R28 looked startled, confused, and disoriented. R28 was gripping the chair handles of his wheelchair as he was being pulled from behind. AA J did not face R28 from the front and address R28 explaining what she was doing. On 12/3/25 at 11:55 AM, Surveyor interviewed AA J and asked about pulling R28 backwards in his wheelchair and approaching from behind, not addressing R28 and explaining what was happening. Surveyor also informed AA J R28 had a startled look on his face and was gripping the chair handles of his wheelchair as he was being pulled from behind. AA J stated (AA J) should not be doing those things. AA J indicated she will be more aware of how she is approaching residents, transporting residents, and indicated she will approach from the front and explain what she's doing, push residents forward only. On 12/4/25 at 10:27 AM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and ANHA C (Assistant Nursing Home Administrator). Surveyor asked what the expectation is for staff approaching residents when transporting them in their wheelchair from one location to another. They all indicated residents should be approached from the front, staff should identify themselves and let them know what is going on and ask if it's ok before doing something. They indicated it is not respectful to pull someone from behind or approach from behind. Example 2R26 admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, major depressive disorder, vascular dementia, and anxiety disorder. R26's most recent MDS (Minimum Data Set) states R26's BIMS (Brief Interview for Mental Status) staff assessment indicated R26 has a memory problem and severely impaired cognitive skills. On 12/3/25 at 11:50 AM, Surveyor was in the dining room getting ready to observe the lunch meal service. There was a music program in the dining room that had just ended, and staff were transporting residents from where they were seated for the music to a dining table for lunch. Surveyor observed AA J (Activity Assistant) approach R26 from behind in the dining room and move R26 to a different table without warning. AA J did not face R26 from the front, did not address R26 and explain what she was doing. R26 had a startled look on his face as he was being moved and was gripping the chair handles of his wheelchair. R26 looked (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confused and disoriented. On 12/3/25 at 11:55 AM, Surveyor interviewed AA J and asked about moving R26 in his wheelchair, approaching from behind, not addressing R26 and explaining what was happening, pushing resident forward without warning. Surveyor also informed AA J R26 had a startled look on his face and was gripping the chair handles of his wheelchair as he was being moved to a different table. AA J stated (AA J) should not be doing those things. AA J indicated she will be more aware of how she is approaching residents, transporting residents, and indicated she will approach from the front and explain what she's doing first. On 12/4/25 at 10:27 AM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and ADON C (Assistant Director of Nursing). Surveyor asked what the expectation is for staff approaching residents when transporting them in their wheelchair from one location to another. They all indicated residents should be approached from the front, staff should identify themselves and let them know what is going on and ask if it's ok before doing something. They indicated it is not respectful to pull someone from behind or approach from behind. Example 3R49 admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease with late onset, dementia, osteoarthritis, and muscle weakness. R49's most recent MDS (Minimum Data Set) states R49 has a BIMS (Brief Interview for Mental Status) score of 4 out of 15, indicating R49's cognition is severely impaired. On 12/3/25 at 11:50 AM, Surveyor was in the dining room getting ready to observe the lunch meal service. There was a music program in the dining room that had just ended, and staff were transporting residents from where they were seated for the music to a dining table for lunch. Surveyor observed AA J (Activity Assistant) approach R49 from behind in the dining room and move R49 to a different table without warning. AA J did not face R49 from the front, did not address R49 and explain what she was doing. R49 had a startled look on her face as she was being moved and was gripping the chair handles of her wheelchair. R49 looked confused and disoriented. On 12/3/25 at 11:55 AM, Surveyor interviewed AA J and asked about moving R49 in her wheelchair, approaching from behind, not addressing R49 and explaining what was happening, pushing resident forward without warning. Surveyor also informed AA J R49 had a startled look on her face and was gripping the chair handles of her wheelchair as she was being moved to a different table. AA J stated (AA J) should not be doing those things. AA J indicated she will be more aware of how she is approaching residents, transporting residents, and indicated she will approach from the front and explain what she's doing first. On 12/4/25 at 10:27 AM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and ADON C (Assistant Director of Nursing). Surveyor asked what the expectation is for staff approaching residents when transporting them in their wheelchair from one location to another. They all indicated residents should be approached from the front, staff should identify themselves and let them know what is going on and ask if it's ok before doing something. They indicated it is not respectful to pull someone from behind or approach from behind. Example 4R16 admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder, anxiety disorder, unspecified mood affective disorder, and cognitive communication deficit. R16's most recent MDS (Minimum Data Set) states R16 has a BIMS (Brief Interview for Mental Status) score of 9 out of 15, indicating R16's cognition is moderately impaired. On 12/3/25 at 11:50 AM, Surveyor was in the dining room getting ready to observe the lunch meal service. There was a music program in the dining room that had just ended, and staff were transporting residents from where they were seated for the music to a dining table for lunch. Surveyor observed AA J (Activity Assistant) approach R16 from behind in the dining room and move R16 to a different table without warning. AA J did not face R16 from the front, did not address R16 and explain what she was doing. R16 looked startled, confused and disoriented as she was being moved. On 12/3/25 at 11:55 AM, Surveyor interviewed AA J and asked about moving R16 in her wheelchair, approaching from behind, not addressing R16 and explaining what was happening, pushing resident forward without warning. Surveyor also informed AA J R16 had a confused look on her face as she was being moved to a different table. AA J stated AA J should not be doing those things. AA J indicated she will be more aware of how she is approaching residents, transporting residents, and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated she will approach from the front and explain what she's doing first. On 12/4/25 at 10:27 AM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and ADON C (Assistant Director of Nursing). Surveyor asked what the expectation is for staff approaching residents when transporting them in their wheelchair from one location to another. They all indicated residents should be approached from the front, staff should identify themselves and let them know what is going on and ask if it's ok before doing something. They indicated it is not respectful to pull someone from behind or approach from behind. Example 5R25 admitted to the facility on [DATE] with diagnoses including chronic kidney disease, major depressive disorder, unspecified dementia, and Alzheimer's Disease. R25's most recent MDS (Minimum Data Set) states R25 has a BIMS (Brief Interview for Mental Status) score of 4 out of 15, indicating R25's cognition is severely impaired. On 12/3/25 at 11:50 AM, Surveyor was in the dining room getting ready to observe the lunch meal service. There was a music program in the dining room that had just ended, and staff were transporting residents from where they were seated for the music to a dining table for lunch. Surveyor observed LPN H (Licensed Practical Nurse) approach R25 from behind in the dining room and move R25 to a different table without warning. LPN H did not face R25 from the front, did not address R25 and explain what she was doing. R25 looked confused and disoriented as she was being moved, had a startled look on her face. On 12/4/25 at 10:27 AM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and ADON C (Assistant Director of Nursing). Surveyor asked what the expectation is for staff approaching residents when transporting them in their wheelchair from one location to another. They all indicated residents should be approached from the front, staff should identify themselves and let them know what is going on and ask if it's ok before doing something. They indicated it is not respectful to pull someone from behind or approach from behind. Example 6R62 admitted to the facility on [DATE] with diagnoses including unspecified dementia, major depressive disorder, cognitive communication deficit, and adjustment disorder with anxiety. R62's most recent MDS (Minimum Data Set) states R62 has a BIMS (Brief Interview for Mental Status) score of 1 out of 15, indicating R62's cognition is severely impaired. On 12/3/25 at 11:50 AM, Surveyor was in the dining room getting ready to observe the lunch meal service. There was a music program in the dining room that had just ended, and staff were transporting residents from where they were seated for the music to a dining table for lunch. Surveyor observed LPN H (Licensed Practical Nurse) approach R62 from behind in the dining room and move R62 to a different table without warning. LPN H did not face R62 from the front, did not address R62 and explain what she was doing. R62 had a startled look on her face and looked confused and disoriented. On 12/4/25 at 10:27 AM, Surveyor interviewed NHA A (Nursing Home Administrator), DON B (Director of Nursing), and ADON C (Assistant Director of Nursing). Surveyor asked what the expectation is for staff approaching residents when transporting them in their wheelchair from one location to another. They all indicated residents should be approached from the front, staff should identify themselves and let them know what is going on and ask if it's ok before doing something. They indicated it is not respectful to pull someone from behind or approach from behind.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure the resident environment remains as free of accidents/hazards as is possible for 1 of 1 sampled resident (R12) and 1 of 1 supplemental resident (R5) reviewed for accidents/hazards.Surveyor observed R12 sitting in his motorized wheelchair in his room while the chair was plugged into the electrical outlet and charging. The motorized wheelchair has a lithium battery.R12's care plan indicates he can have substances such as beer and cigarettes on the premises and they will be held by nursing staff in a locked area. R12's Nurse Notes indicate R5 entered R12's room and took a beer with him when he exited. While on survey, Surveyor observed R12 to have four 30-packs of beer in his room unsupervised and unattended. Evidenced by:Example 1:R12 admitted to the facility on [DATE] with diagnoses, including alcohol use, alcohol dependence, cocaine use, and nicotine dependence.On 12/3/25 at 4:09 PM, Surveyor observed R12 in his room sitting in his motorized wheelchair while the wheelchair was plugged into the outlet charging. (It is important to note the motorized chair unit contained a lithium battery.)On 12/3/25 at 4:10 PM, CNA M (Certified Nursing Assistant) indicated R12 should not be charging his wheelchair in his room, but that is where it is usually charged. On 12/3/25 at 4:12 PM, LPN F (Licensed Practical Nurse) stated, I do not know for sure where we charge them. I'm not sure if it is ok to charge in his room. We used to charge chairs at the end of the hallway. On 12/3/25 4:17 PM, Surveyor asked CNA M if she would unplug the chair or get someone to unplug the chair due to the risk of the lithium battery exploding. CNA M indicated she would unplug chair and remove the cord. On 12/3/25 at 4:25 PM, DON B (Director of Nursing) and NHA A (Nursing Home Administrator) indicated motorized wheelchairs should not be charging in residents' rooms with residents present. Example 2:R12 admitted to the facility on [DATE] with diagnoses, including alcohol use, alcohol dependence, cocaine use, and nicotine dependence.R12's Comprehensive Care Plan, includes in part: initiated 10/3/25, revised 11/7/25, target date 12/12/25. R12 has a history of substance abuse. R12 is drinking alcohol products daily and consuming THC gummies occasionally. R12 voluntarily agreed to allow facility to keep alcohol products and THC gummies locked in med room to monitor resident consumption as it relates to administration of narcotics. R12's Nurse Notes, dated 10/27/25, include: R12 reported to writer that R5 had come to his room to ask for a cigarette and then took one of his beers off his bedside table. Writer offered to go close R12's bedroom door, R12 stated No, if we could just keep an eye on R5, if seen walking by or around his room. Incident reported to NHA A (Nursing Home Administrator), R12 agreed to have his case of beer removed from room and locked up but refused to allow writer to remove three cans of beer that was sitting on his bedside table, (NHA A) notified, no further issues.On 12/1/25 at 11:27 AM, Surveyor observed 2 full 30-packs of [NAME] Light in R12's room and another 30-pack with a few cans missing. R12 indicated he drinks the beer every day and he gets it from the gas station. R12 indicated he had trouble with one resident coming in his room and helping himself and had one resident enter his room and take a beer. On 12/2/25 at 3:29 PM, during an interview Activity Therapy Director N indicated R12 keeps his beer in his room, because he will not allow staff to lock it up. Activity Therapy Director N indicated she in not aware of a time when another resident gained access to R12's beer. On 12/3/25 at 4:10 PM, Surveyor observed R12 have another unopened 30 pack of beer in his room on the floor near his bedside table. R12 indicated he just bought the 30 pack of beer today at the gas station and is stocking up for the big snowstorm that is coming. On 12/4/25 at 2:10 PM, DON B (Director of Nursing), ANHA C (Assistant Nursing Home Administrator), and NHA A (Nursing Home Administrator) indicated staff have tried to lock R12's beer up and he gets loud and curses at them. Surveyor asked if the facility has offered to lock it up in R12's room? NHA A indicated they have not, but they could do that as he is in a private room and there is an extra closet.

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	525616	A. Building B. Wing	12/04/2025

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

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents with an indwelling catheter received the appropriate care and services to prevent a urinary tract infection (UTI) for 1 of 3 residents (R28) reviewed for catheters.Surveyor observed R28's indwelling urinary catheter bag to be resting in direct contact with the floor.Evidenced by:Facility policy, titled Catheter Care, implemented 2/1/25, includes: privacy bags will be available and catheter drainage bags will be covered at all times while in use. (It is important to note the policy does not give information on whether it is ok for the catheter bag to be in direct contact with the facility floor.)R28 admitted to the facility on [DATE] with diagnoses, including retention of urine and encounter for attention to other artificial openings of urinary tract.R28's Video Visit Note, dated 10/28/25, includes Recurrent complicated E.coli urinary tract infection in the setting of chronic foley indwelling catheter. The patient is seen today by video visit.was seen last 3 months ago on 7/9/25 for his recurrent complicated E.coli urinary tract infection in the setting of chronic indwelling foley catheter.(It is important to note R28 has a history of urinary tract infections.)On 12/2/25 at 9:48 AM, Surveyor observed R28 in the dining room and his catheter bag, including the spout, was in direct contact with the floor.On 12/2/25 at 9:52 AM, Surveyor and ANHA C (Assistant Nursing Home Administrator) observed R28's catheter to have no dignity bag around it and to be in direct contact with the floor. ANHA C indicated catheter bags, should not be in contact with the floor.On 12/4/25 at 9:30 AM, RN/IP G (Registered Nurse/Infection Preventionist) indicated R28 has a history of urinary tract infections with sepsis and his catheter bag or spout should not be in direct contact with the floor.On 12/4/25 at 10:15 AM, DON B (Director of Nursing), NHA A (Nursing Home Administrator), and ANHA C indicated catheter bags should have dignity covers on them and should not be in direct contact with the floor.

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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 interview and record review, the facility did not ensure pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, this affected 1 of 16 sampled residents (R1). R1 did not receive his ordered nephrocaps (vitamin specific to renal (kidney) support) for several days in November. This is evidenced by: The Facilities Policy and Procedure entitled Medication Administration dated 2/28/25 that does not speak to omitted medications. R1 is a long-term resident of the facility. R1 has the following diagnoses: end stage renal disease, type 1 diabetes mellitus, and dependence on renal dialysis. R1's Physician Orders:Neprhocaps capsule 1 mg (milligram) (B Complex-C-Folic Acid) Give 1 capsule by mouth one time a day for supplement. R1's MAR (Medication Administration Record):Nephrocaps have 10 documented for the following dates- 11/7/25, 11/9/25, 11/10/25, 11/11/25, 11/27/25, and 11/28/25. R1's Nurses Notes:No notes for 11/7/25, 11/10/25, 11/11/25, or 11/27/25. Note on 11/9/25 documents the following- medication unavailable per pharmacy will deliver 11/10/25. Note on 11/28/25 documents the following- medication unavailable per pharmacy will deliver 11/30/25. It is important to note that there is no further documentation following up that the medication is not available. On 12/2/25 at 9:01 AM, Surveyor interviewed R1. Surveyor asked R1 if he receives his medications timely, R1 said he is waiting on a pill he takes after dialysis. Surveyor asked R1 if he knew what the medication was, R1 said my vitamin. Surveyor asked R1 how long he hasn't had it, R1 replied not for a week. On 12/4/25 at 1:17 PM, Surveyor interviewed LPN H (Licensed Practical Nurse). Surveyor asked LPN H what does 10 mean if on MAR, LPN H explained it means there should be a Nurses Note written about the medication. Surveyor asked LPN H if it is marked 10 should there be a nurses note, LPN H stated yes. On 12/4/25 at 2:09 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect R1 to receive his nephrocaps as ordered, DON B said yes. Surveyor asked DON B would you expect there to be a nurses note if the staff is documenting 10 on MAR, DON B stated absolutely. R1 did not receive his nephrocaps per physician orders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 1 of 5 Residents (R2) observed for medication administration, 1 of 1 Residents (R3) observation of wound care, and 1 of 1 observation of equipment disinfection.APNP D (Advance Practice Nurse Practitioner) had breaches in infection control when APNP D did not perform hand hygiene after removal of R3's wound dressings.RN E (Registered Nurse) had a breach in infection control after performing an INR (International Normalized Ratio-a test to determine how long it takes for blood to clot) when RN E did not disinfect the machine prior to bringing the machine out to the nurse's station.LPN F (Licensed Practical Nurse) had breaches in infection control during medication administration when LPN F set clean equipment on R2's bed linens, placed R2's used insulin pen into a clean supply kit, and used bare hands to remove a used needle from R2's insulin pen. Evidenced by:The facility's Infection Prevention and Control Program policy, dated 2/25/25, states, in part: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Definitions: Staff includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility. 2. All staff are responsible for following all policies and procedures related to the program.4. Standard Precautions: a. All staff assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. d. Licensed staff shall adhere to safe injection and medication administration practices. 10. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.The facility's Hand Hygiene policy, dated 2/2025, states, in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (applying) gloves, and immediately after removing gloves.The facility's Clean Dressing Change policy, dated 2/28/25, states, in part: .9. Loosen the tape and remove the existing dressing. 10. Remove gloves. 11. Wash hands and put on clean gloves. 12. Cleanse the wound. 14. Wash hands and put on clean gloves.Example 1On 12/3/25 at 8:39 AM, Surveyor observed APNP D (Advanced Practice Nurse Practitioner) perform wound care for wounds to R3's coccyx and abdominal fold. APNP D removed the coccyx dressing and removed gloves. APNP D picked up a new pair of gloves and moved the clean dressing supplies. APNP D then set down the gloves and cleansed hands. APNP D removed the abdominal dressing, cleansed the wound, and applied ointment to the wound while wearing the same pair of gloves. APNP D then removed her gloves and cleansed hands. Surveyor asked APNP D when hand hygiene is required with a dressing change. APNP D stated any time you remove gloves. Surveyor asked if hand hygiene is needed after glove removal and prior to touching any additional supplies. APNP D stated yes.Example 2On 12/3/25 at 4:04 PM, Surveyor observed RN E walking down the hall wearing gloves and carrying an INR machine. RN E set the INR machine on multiple surfaces of the nurse's station. Surveyor observed a test strip in the machine. Surveyor asked if a test had been performed. RN E stated yes. Surveyor asked if the used test strip was still in the machine. RN E stated yes, I have to take a photo of the display before I take the strip out of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	machine. Surveyor asked if the machine is considered contaminated after exposure to blood for the test. RN E stated yes, I should have disinfected the machine and cleansed my hands before leaving the resident's room.Example 3On 12/3/25 at 4:15 PM, Surveyor observed LPN F during medication administration. LPN F prepared R2's insulin and took the insulin pen along with a supply kit to the resident's bedside. LPN F set the supply kit on the bed next to the resident. After administering the insulin, LPN F placed the used insulin pen into a cup containing a vial of blood glucose test strips in the supply kit. LPN F removed gloves and cleansed hands, then picked up the supply kit and took it to the medication cart at the nurse's station. LPN F set the supply kit onto the medication cart. With bare hands, LPN F took the insulin pen from the kit and removed the used needle from the insulin pen with bare hands. Surveyor asked if the insulin pen is considered contaminated after administering insulin. LPN F stated yes. Surveyor asked if contaminated items should be placed into the supply kit with clean supplies. LPN F stated no. Surveyor asked if a contaminated needle should be removed from the insulin pen with bare hands. LPN F stated no. Surveyor asked if the supply kit should be placed directly onto the resident's bed linens. LPN F stated no, there should be a barrier to prevent cross-contamination.On 12/4/25 at 9:43 AM, Surveyor interviewed RN/IP G (Registered Nurse / Infection Preventionist) and asked about hand hygiene with wound care. RN/IP G stated it is to be done prior to the task, after removal of dressing, after cleaning, and after the dressing application. RN/IP G stated she would expect hand hygiene after removal of gloves prior to touching any supplies. Surveyor asked about infection control with insulin administration. RN/IP G stated the supply kit should not be brought into the resident room, setting it on the bed is a cross-contamination. RN/IP G stated that a used pen should not be placed into the supply kit / touching clean supplies and gloves are to be worn by staff when removing a used needle from an insulin pen. Surveyor asked about infection control following an INR test. RN/IP G stated the machine with a used test strip should not be brought out of a resident's room. It is to be disinfected in the resident's room, at point of service. RN/IP G stated when both the machine and the staff member's hands are clean, the machine is to be brought out of the resident's room and put away.