| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525559 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Odd Fellow Home | 1229 S Jackson St<br>Green Bay, WI 54301 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not report allegations of abuse to the State Agency (SA) for 2 residents (R) (R1 and R8) of 2 sampled residents.R1 had a witnessed fall on 10/17/25. The facility determined abuse occurred. The facility's 5-day investigation was not submitted to the SA within the required timeframe.R8 reported that a Certified Nursing Assistant (CNA) was abusive to R8. The facility initiated a grievance form but did not report the allegation of abuse to the SA.Findings include: The facility's Patient Protection Program Freedom from Abuse, Neglect, and Exploitation policy, initiated 3/15/24, indicates the Nursing Home Administrator (NHA) or designee will report abuse to the State Agency per state and federal requirements .The facility will ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment .will be reported no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials (including the State Survey Agency) in accordance with state law through established procedures .The policy indicates follow-up investigative notes will be submitted via the Wisconsin (WI) Department of Health Services (DHS) Misconduct Incident Reporting System (MIRS) within 5 working days of the initial report. 1. On 11/18/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including diffuse large b-cell lymphoma, dysphagia, cognitive communication deficit, Huntington's disease, dementia, depression, retention of urine, dystonia, anxiety, and repeated falls. R1 had an activated Power of Attorney for Healthcare (POAHC) who assisted with medical decision making. R1's Minimum Data Set (MDS) assessment, dated 10/1/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderately impaired cognition.On 11/18/25, Surveyor reviewed a faciity-reported incident (FRI) that indicated R1 had a witnessed fall on 10/17/25. The Interdisciplinary Team (IDT) determined abuse had occurred based on Licensed Practical Nurse (LPN)-E's progress note of the incident. LPN-E was called to R1's room by CNA-F and discovered R1 on R1's knees in front of the bed facing the window. R1's pants were pulled down and R1 was defecating on bed linens. The initial report was submitted to the SA on 10/17/25. The 5-day investigation was due on 10/24/25 but was not submitted until 10/27/25.On 11/18/25 at approximately 12:30 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who acknowledged the due date for the 5-day investigation was 10/24/25. NHA-A indicated the report was not submitted on 10/24/25 because NHA-A was still waiting for an additional staff statement related to the incident. 2. On 11/18/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure (CHF), respiratory failure, bipolar disorder, falls, and osteoarthritis with pathological falls. R8 made R8's own healthcare decisions. R8's MDS assessment, dated 11/4/25, had a BIMS score of 15 out of 15 which indicated R8 had intact cognition. On 11/18/25, Surveyor reviewed a grievance provided by NHA-A that indicated R8 reported to staff on 10/24/25 that R8 was upset about cares during the PM/night (NOC) shift. R8 indicated a CNA man-handled R8 and flopped my legs and they are still tender. R8 also indicated the CNA was rude, just not kind after the CNA rolled R8 in bed and R8 stated R8 felt unsafe. The grievance findings indicated R8 had a prolonged hospital stay due to a change in condition and did not recall the incident when R8 returned to the facility. R8 stated R8 felt safe at the facility upon return. Staff were educated on taking time with residents and to follow-up when needed. The education was signed by Assistant Director of Nursing (ADON)-D on 11/7/25. The grievance form was signed by NHA-A on 11/17/25.On 11/18/25 at approximately 1:30 PM, Surveyor interviewed NHA-A who verified the allegation of abuse should have been reported to the SA. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not ensure allegations of abuse were thoroughly investigated for 2 residents (R) (R1 and R8) of 2 sampled residents.R1 fell on [DATE]. The facility determined abuse occurred. The allegation of abuse was not thoroughly investigated and inaccurate staff education was provided. R8 reported a Certified Nursing Assistant (CNA) was abusive to R8. The allegation of abuse was not thoroughly investigated.Findings include: The facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, indicates each resident's comprehensive person-centered care plan is consistent with the resident's right to .g. Receive the services and/or items included in the plan of care .The facility's Grievance Policy and Procedure, dated 3/18/24, indicates the resident has a right to voice grievances with respect to treatment or care that is or fails to be furnished .The facility will undertake prompt efforts to resolve any grievances residents may have .Alleged incidents of caregiver misconduct, allegations of abuse, neglect, and or misappropriation of resident property must be reported to a supervisor and the Administrator immediately. The facility's Patient Protection Program Freedom from Abuse, Neglect, and Exploitation policy, initiated 3/15/24, indicates that immediately upon receiving a report of alleged abuse, the Administrator or designee will coordinate delivery of appropriate medical and/or psychological care and attention to the involved resident. The designated personnel will begin the investigation immediately upon identification of alleged abuse. A root cause investigation and analysis will be completed including who was involved, the resident's statement, the resident's roommate's statement, involved staff and witness statements of events .Ensuring safety and well-being for the vulnerable individual, their roommate, and if applicable other residents with the potential to be affected. Procedures are in place to provide the resident with a safe, protected environment during the investigation, including removing the alleged perpetrator and employees accused of alleged abuse immediately from the resident's area pending the result of a thorough investigation. The facility will examine, assess, and interview the resident and other residents potentially affected as soon as possible to determine any injury and identify any immediate clinical interventions.1. On 11/18/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including diffuse large b-cell lymphoma, dysphagia, cognitive communication deficit, Huntington's disease, dementia, depression, retention of urine, dystonia, anxiety, and repeated falls. R1 had an activated Power of Attorney for Healthcare (POAHC) who assisted with medical decision making. R1's Minimum Data Set (MDS) assessment, dated 10/1/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderately impaired cognition.On 11/18/25, Surveyor reviewed a faciity-reported incident (FRI) that indicated R1 had a witnessed fall on 10/17/25. The Interdisciplinary Team (IDT) determined abuse had occurred based on Licensed Practical Nurse (LPN)-E's progress note of the incident. LPN-E was called to R1's room by CNA-F and discovered R1 on R1's knees in front of the bed facing the window. R1's pants were pulled down and R1 was defecating on bed linens. The investigation did not contain statements from CNA-F or LPN-E. The facility provided abuse education to staff on 10/21/25. Upon review of the signatures, Surveyor noted 39 of 172 employees, including agency employees, signed the education. Surveyor reviewed an event summary that indicated LPN-E provided education to CNA-F after the fall, including gait belt and proper footwear use and indicated further transfers should be completed with the assistance of 2 staff or the assistance of 1 staff with a second staff as a standby assist; however, R1's care plan indicated R1 required a sit-to-stand lift for transfers at the time of the fall. Nursing Home Administrator (NHA)-A provided a care plan with a revision date of 10/23/25 (which was after the incident) that indicated R1 transferred via pivot transfer with a front-wheeled walker with the assistance of 2 staff. On 11/18/25 at 11:49 AM, Surveyor interviewed NHA-A who verified R1's care plan at the time of the fall indicated R1 should have been transferred with a sit-to-stand lift and that LPN-E's education to CNA-F did not accurately reflect the correct transfer technique for R1. NHA-A indicated NHA-A did not feel lack of following the care plan was the primary cause of R1's witnessed fall. 2. On 11/18/25, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including congestive heart failure (CHF), respiratory failure, bipolar disorder disorder, falls, and osteoarthritis with pathological falls. R8's MDS assessment, dated 11/4/25, had a BIMS score of 15 out of 15 which indicated R8 had intact cognition. Surveyor reviewed the facility's grievance file and noted R8 filed a grievance on 10/24/25 that indicated R8 was upset about PM/night shift cares. R8 indicated an unnamed CNA man-handled R8 and flopped my legs |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not ensure administration of medication in accordance with physician orders for 1 resident (R) (R2) of 1 sampled residentR2's AM and PM medications were administered late on multiple occasions. Findings include:The facility's Administration of Medication policy, dated April 2019, indicates: .Medications are administered in a safe and timely manner, and as prescribed .3. Staffing schedules are arranged to ensure medications are administered without unnecessary interruptions. 4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). On 11/18/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including osteomyelitis left ankle non-healing wound, epilepsy, peripheral vascular disease (PVD), depression, and osteoarthritis. R2's most recent Minimum Data Set (MDS) assessment, dated 11/11/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R2 had intact cognition. The MDS assessment also indicated R2 required assistance with activities of daily living (ADLs). R2 was R2's own decision maker.On 11/18/25 at 9:06 AM Surveyor interviewed R2 who stated R2's medications were late most days, including R2's epilepsy medications. R2 indicated R2 had not yet received R2's AM medications. On 11/18/25 at 9:26 AM, Surveyor observed Registered Nurse (RN)-C administer medications to residents. Surveyor interviewed RN-C who indicated RN-C was running late with medication pass and was going to administer R2's medications next. RN-C indicated R2 prefers to receive medication at 8:30 AM, however, RN-C was running late. RN-C verified R2's medications were scheduled for 8:00 AM and indicated staff can administer medication up to an hour before or after the scheduled time. RN-C confirmed that R2 has expressed concerns about receiving medications late.Surveyor reviewed R2's Medication Administration Record (MAR) which indicated R2's medications were administered late 8 times from 10/29/25 to 11/18/25.R2 was scheduled to receive the following medications at 8:00 AM: multivitamin 1 tablet; aspirin 81 mg 1 tablet; vitamin D 25 micrograms (mcg) 2 tablets; probiotic 1 capsule twice daily; levetiracetam (an antiepileptic medication) 1,000 mg 2.5 tablets twice daily; amlodipine 5 mg 1 tablet daily, gabapentin 400 mg 3 capsules 3 times daily; clopidogrel 75 mg 1 tablet daily; and meropenem intravenous solution reconstituted 2 grams (gm) 1 dose intravenously (IV) every 8 hours. R2's MAR indicated the medications were administered late on the following dates: ~ 10/31/25 - administered at 9:30 AM~ 11/1/25 - administered at 10:03 AM~ 11/6/25 - administered at 10:06 AM~ 11/11/25 - administered at 9:26 AM~ 11/14/25 - administered at 9:10 AM~ 11/15/25 - administered at 9:11 AM~ 11/18/25 - administered at 9:26 AM R2 was scheduled to receive the following medications at 8:00 PM: mirtazapine 15 mg 1 tablet at bedtime; levetiracetam 1,000 mg 2.5 tablets twice daily; probiotic 1 capsule twice daily; gabpentin 400 mg 3 capsules 3 times daily; atorvastatin 20 mg 1 tablet at bedtime; and topiramate 25 mg 1 tablet at bedtime.R2's MAR indicated the medications were administered late on the following date:~ 10/29/25 - administered at 11:04 PMOn 11/18/25 at 11:25 AM, Surveyor interviewed Nusing Home Administrator (NHA)-A who indicated nurses have an hour before or after the prescribed time to administer medications to residents. |