

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Odd Fellow Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1229 S Jackson St 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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361</p> <p>Based on staff interview and record review, the facility did not ensure an allegation of abuse was thoroughly investigated for 2 residents (R) (R5 and R6) of 13 sampled residents.</p> <p>The facility did not report a resident-to-resident altercation between R5 and R6 to the State Agency (SA) in a timely manner because staff did not report the incident timely to administration. The facility could not provide proof of education for the staff who were working when the resident-to-resident altercation occurred.</p> <p>Findings include:</p> <p>The facility's Patient Protection Program Freedom from Abuse, Neglect, and Exploitation policy, dated 3/2025, indicates: The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, and mistreatment: Take appropriate corrective action, because of investigation findings . Internal Reporting. A. Employees must always report any abuse or suspicion of abuse immediately to the Administrator or Abuse Coordinator Designee. External Reporting: Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency.</p> <p>On 10/7/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including degeneration of nervous system due to alcohol, weakness, and cognitive communication deficit. R5's Minimum Data Set (MDS) assessment, dated 9/9/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. R5 was R5's own decision maker.</p> <p>On 10/7/24, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] with diagnoses including dementia with other behavioral disturbance. R6's MDS assessment, dated 7/5/24, indicated R6 was severely cognitively impaired. R6 had an activated decision maker.</p> <p>On 10/7/24, Surveyor reviewed a facility-reported incident (FRI) that indicated on the 7/19/24 PM shift, R5's roommate called staff into R5's room and said there was an incident between R5 and R6. R5 reported to staff that R6 yelled and rammed R6's wheelchair into R5 while R5 was in the activity room watching TV. R5 also reported that staff removed R6 from the activity room. R5 could not recall the name of the staff or the time of the incident. Staff immediately reported R5's allegation to a nurse; however, the nurse did not notify administration of the incident. The nurse filled out a grievance form and left a message for the Social Worker regarding the incident.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525559
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Surveyor reviewed the facility's investigation which indicated staff were aware of the incident on the 7/19/24 (Friday) PM shift; however, administration did not become aware of the incident until 7/22/24 (Monday). An investigation was initiated and the incident was reported to the SA on 7/22/24 which was beyond the 24 hour reporting requirement. The investigation indicated the facility was not able to determine which staff intervened to remove R6 from the activity room during the incident. Surveyor reviewed education, dated 7/23/24 to 7/25/24, related to reporting incidents to administration in a timely manner. Surveyor reviewed the education sign-in sheets and compared the sign-in sheets to the PM shift schedule on 7/19/24. Surveyor noted Certified Nursing Assistant (CNA-D), CNA-E, and Hospitality Aid (HA-F) were not on the sign in-sheets but had worked on 7/19/24.</p> <p>The facility indicated additional abuse training, including reporting requirements, was completed on 8/26/24 and 8/27/24; however, Surveyor could not locate CNA-D, CNA-E, or HA-F's names.</p> <p>On 10/7/24 at 2:17 PM, Surveyor interviewed Nursing Home Administrator (NHA)-C who could not provide proof that education was completed for CNA-D, CNA-E, and HA-F. NHA-C confirmed education should have been completed since CNA-D, CNA-E, and HA-F were working when the incident occurred.</p>		