STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525559	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odd Fellow Home	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)
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, staff interview, record review, and policy review, the facility did not ensure fall interventions were in place for 1 resident (R) (R1) of 4 sampled residents.R1 was assessed to be at high risk for falls and had a history of falls. R1's care plan contained interventions for fifteen-minute safety checks and grip strips on the floor near R1's bed. The interventions were not consistently implemented. Findings include: The facility's Falls and Fall Risk, Managing policy, dated March 2018, indicates: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors: .2. Resident conditions that may contribute to the risk of falls include: .c. delirium and other cognitive impairment; .e. lower extremity weakness; f. functional impairments; .k. incontinence 3. Medical factors that contribute to the risk of falls include: .d. neurological disorders; and e. balance and gait disorders, etc. Resident-Centered Approaches to Managing Falls and Fall Risk: .5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable .Monitoring Subsequent Falls and Fall Risk: .3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. R1's Resident Profile indicated R1 was admitted to the facility on [DATE] and received Hospice services effective 8/5/25. R1 had diagnoses of muscle weakness, unsteadiness on feet, unspecified intellectual disabilities, unspecified dementia (a decline in cognitive function), unspecified convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement), cognitive communication deficit, and repeated falls. A Significant Change in Status Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/5/25, contained a Staff Assessment of Mental Status that indicated R1's cognitive skills for daily decision making were severely impaired (never/rarely made decisions). The MDS assessment also indicated R1 demonstrated inattention and disorganized thinking and R1's behavior, care rejection, and wandering were worse than the prior assessment (admission MDS, dated [DATE]). The MDS review period indicated R1 required substantial/maximal assistance for functional mobility, was always incontinent of bladder, and had two or more falls since the Admission/Entry Assessment (dated 7/3/25) with no injury and one fall with injury. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan, initiated 7/1/25, indicated R1 was at high risk for falls related to confusion, deconditioning, weakness, and frequent falls. Interventions included: Fifteen-minute safety checks while sleeping (initiated 7/23/25); Grip strips to floor near bed (initiated 8/7/25); R1 needs to be evaluated for and supplied appropriate adaptive equipment or devices as needed. Re-evaluate and as needed for continued appropriateness and to ensure least restrictive device or restraint (initiated 7/1/25). A Fall Risk Evaluation, dated 8/2/25, contained a score of 18 which indicated R1 was at high risk for falls. The evaluation indicated prevention protocol should be initiated immediately and documented on the care plan. A Safety Check log (15-minute safety checks), indicated 15-minute safety checks were not completed between 4:30 PM and 7:45 PM on 9/7/25. R1 had an unwitnessed fall in R1's room on 9/7/25 at 7:45 PM. An Incident Report, dated 9/7/25 at 7:45 PM, indicated the incident location was R1's room. A nursing description of the incident indicated R1 was discovered face down on the floor in front of R1's Broda chair and had lacerations on the top of the head. During an observation on 10/6/25 at 10:21 AM, R1's room did not have grip strips (or a fall mat, rubber flooring, or rubber treads) at the bedside to provide traction and reduce slips or falls. R1 was not present in the room. During a continued observation outside R1's room, R1 was seated in a Broda chair (specialized therapeutic wheelchair) with poor posture. It appeared that R1's body had moved forward and down in the chair from an upright position. The Assistant Activities Director (AAD) wheeled R1 through the 300 hallway and called down the hall that someone might want to help (R1). (R1) is sliding down and needs help. During an observation and attempted interview on 10/7/25 at 5:27 PM, R1 was in bed on R1's back and could not participate in a meaningful interview. R1 provided eye contact when R1's name was spoken. During an interview on 10/6/25 at 1:46 PM, the Director of Nursing (DON) stated R1 required stand-by assistance (SBA) with ambulation during rehab. The DON stated R1 had a decline in physical functioning, increased dependence for activities of daily living (ADLs), and multiple witnessed falls after R1 transferred to the long-term care (LTC) unit. The DON said R1 tripped over R1's feet because R1's shoes did not fit. R1's Guardian was asked to bring better fitting shoes. Grippy socks were implemented for safety. During an interview on 10/8/25 at 10:56 AM, Licensed Practical Nurse (LPN)1 stated R1 moved around in a wheelchair, was compulsive, had no safety awareness, and would get up from a seated position. R1 did not follow verbal redirection. LPN1 said LPN1 assisted staff after R1 sustained a fall from a wheelchair in R1's room. During an interview on 10/8/25 at 3:41 PM, the DON stated R1 was impulsive, unaware of R1's limitations, and 15-minute safety checks were implemented from 8/12/25 to 9/14/25. The DON said the facility did not use fall mats and occasionally put residents on 1:1 supervision if requested by a nurse. The DON confirmed non-skid strips were not placed beside R1's bed when R1 changed rooms on 8/18/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/25 at 4:00 PM, the Assistant Director of Nursing (ADON) stated the purpose of 15-minute checks is to ensure R1's safety by having staff visually monitor R1 at regular intervals to prevent falls, including early intervention to assess R1's mood, behavior, and environment. The ADON said 15-minute checks were completed at times but not listed as a care plan intervention because the Certified Nurse Aides (CNAs) did whatever they wanted. The ADON indicated staff were re-educated on how to complete 15-minute safety checks.