

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
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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 07/22/2026
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)		
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. Based on observation, interview, and record review, the facility did not ensure 1 resident (R) (R15) of 3 sampled residents was appropriately supervised to prevent accidents and abuse. R15 wandered in the facility and into residents' rooms uninvited. On 7/6/26, R15 wandered into R4's room, looked through their personal belongings, and hit them on the arm. R15's care plan did not contain appropriate interventions and levels of supervision to prevent future occurrences. Findings include: The facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, indicates: .The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .Care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan includes measurable objectives and timeframes .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .and reflects currently recognized standards of practice for problem areas and conditions .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making .When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.Assessments of residents are ongoing and care plans are revised as information about the residents and their condition changes .The IDT reviews and updates the care plan .when the desired outcome is not met . On 7/20/26, Surveyor reviewed R15's medical record. R15 had a diagnosis of dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 6/16/26, stated R15 had a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severely impaired cognition. On 7/20/26 at 9:15 AM, Surveyor observed R15 self-propel a wheelchair in the hallway. On 7/20/26 at 9:40 AM, Surveyor interviewed R48 who had stop sign on their door frame. R48 stated the resident rolling in the hallway (and pointed to R15) comes into their room all the time even when the door is closed and brings the stop sign into the room with them. R48 stated R15 goes through their personal items and drawers. R48 recently accepted the stop sign to deter R15 from entering their room uninvited. R48 stated they call staff or push R15's wheelchair out of the room if staff do not come in time. R48 stated the stop sign does nothing and staff know R15 enters their room because they have to frequently remove them from the room. (R48's medical record indicated they had diagnoses including cognitive communication deficit, depression, other specified disorders of the brain, and severely impaired cognition.) On 7/20/26 at 11:58 AM, Surveyor interviewed R4 who stated R15 often wanders into their room and wanders into a lot of peoples' rooms uninvited. R4 stated R15 entered their room and smacked them on the arm when they told R15 to leave as they were rummaging through all my stuff. R4 stated the facility put a stop sign on their bedroom door, however, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525559 If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R15 continues to enter their room uninvited. R4 stated the stop sign does not deter R15 from entering and said R15 comes into the room carrying the stop sign. R4 stated staff do redirect R15, however, they continue to enter their room. On 7/20/26, Surveyor reviewed R4's medical record. R4 had diagnoses including post-traumatic stress disorder (PTSD) and major depressive disorder. A Quarterly MDS assessment, dated 6/16/26, stated R4 had a BIMS score of 15 out of 15, indicating intact cognition. A progress note, dated 7/7/26, indicated R4 was sitting in a chair when R15 entered their room and started picking through personal items on their table. When R4 asked R15 to stop, R15 struck their on the left arm. R4 and R15 were separated and assessed for injuries. Nursing Home Administrator (NHA-A) was notified. A progress note, dated 7/8/26, indicated Social Services staff spoke with R4 following the incident. R4 stated they felt frightened and anxious and were concerned R15 would return to their room. They discussed placing a stop sign at the entrance of the room as a non-restrictive intervention to deter unwanted entry. R4 was encouraged to let staff know if there were further concerns or if R15 entered their room. On 7/20/26 12:16 PM, Surveyor observed Certified Nursing Assistant (CNA)-U assist R15 who was behind the nurses' station. CNA-U transported R15 to the common area and left. On 7/20/26 at 12:45 PM, Surveyor interviewed CNA-U who verified they found R15 in the nurses' station by themselves and stated R15 should not be behind the nurses' station alone. CNA-U stated staff get busy and R15 wanders, including into other residents' rooms. CNA-U stated R15 is redirected easily and does not have behaviors. CNA-U verified R15 likes to have a doll and stated staff redirect R15 and document when they wander. Staff also give R15 a snack and sit with them at times. CNA-U confirmed R15 can self-propel a wheelchair. CNA-U indicated R15's behavioral interventions are for staff to redirect, distract, or sit with them. On 7/21/26 at 11:59 AM, Surveyor interviewed NHA-A who stated they had not completed audits to determine if the stop signs on R4 and R48's doors deterred R15 from entering their rooms. NHA-A stated they knew the stop signs worked. NHA-A was not aware that R15 continued to enter R4 and R48's rooms and confirmed the stop sign was not sufficient to provide supervision and deter potential accidents or abuse.		