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 03/12/2024
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)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49010 Based on observation, staff and resident interview, and record review, the facility did not promote and facilitate resident self-determination for 6 Residents (R) (R1, R4, R10, R25, R27, and R39) of 6 residents. Staff did not allow R1, R4, R10, R25, R27 and R39 to make choices regarding their meals. Finding include: 1. R1 was admitted to the facility on [DATE] with diagnosis including dementia, anxiety, and malignant neoplasm of transverse colon. R1's Minimum Data Set (MDS) assessment, dated 1/24/24, contained a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R1 had moderate cognitive impairment. R1 had an activated power of attorney for healthcare (POAHC). R1's plan of care indicated R1 had a 2 gm (gram) (2000 mg (milligrams)) NA (sodium), CCHO (carbohydrate-controlled), mechanical soft diet with regular/thin liquids. R1's plan of care indicated R1 should consume adequate caloric intake and the nutrients should meet R1's metabolic needs. According to the lunch menu on 3/11/24, residents on a CCHO diet should receive 1 chicken breast, 4 ounces (oz) of broccoli, a 1/2 cup of buttered noodles, and a 1/2 square of devil's food pudding cake. A meal ticket on R1's tray indicated R1's diet was 2 gram sodium-mechanical soft and contained the following instructions: *Double Protein and Vegetable Portions; and *No beets or tacos or chicken. Per R1's meal ticket, R1's main meal was listed as: ground chicken breast, broccoli, garlic bread, devil's food pudding cake, buttered noodles, and low sodium soup with ground meat. On 3/11/24 at 12:43 PM, Cook (CK)-P and Regional Manager (RM)-N discussed R1's meal in front of Surveyor. Initially, CK-P stated R1 could have pasta and sauce without meat. RM-N stated R1 needed double protein. CK-P and RM-N then determined R1 should receive 2 grilled cheese sandwiches to replace the chicken from R1's meal. RM-N stated R1 needed 2 grilled cheese sandwiches instead of 1 because R1's diet order included double protein. For lunch on 3/11/24, R1 received 2 grilled cheese sandwiches, 4 oz. of broccoli, and 1 piece of devil's food pudding cake. R1 did not receive a double portion of vegetables, buttered noodles, soup, or garlic bread which were listed on R1's meal ticket. R1 was not asked what R1 wanted in place of the protein (chicken) on the menu and was not provided an adequate protein equivalent. (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

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 03/12/2024
NAME OF PROVIDER OR SUPPLIER Odd Fellow Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1229 S Jackson St Green Bay, WI 54301	

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 at 12:46 PM, Surveyor interviewed CK-P and indicated R1's meal ticket didn't include a grilled cheese sandwich. When asked how CK-P knew what R1 wanted, CK-P stated R1 didn't like chicken, tacos, or beef. CK-P indicated R1's meal ticket indicated R1 doesn't like beets, but should say beef. On 3/12/24 at 8:32 AM, Surveyor interviewed R1 who said staff don't ask R1 what R1 wants to eat. 2. R4 was admitted to the facility on [DATE] with diagnosis including stroke with right side paralysis, epilepsy, and dementia. R4's MDS assessment, dated 1/17/24, indicated R4 was rarely or never understood. R4 had an activated POAHC. R4's plan of care indicated R4 had a regular, pureed texture diet with regular/thin liquids. R4's plan of care indicated R4 should be offered double entrees at meals and indicated to give R4 as many choices as possible about care and activities. According to the lunch menu on 3/11/24, residents on pureed diets should receive a serving (#6 scoop) of pureed chicken pasta alfredo, a serving (#12 scoop) of pureed broccoli, a serving (# 20 scoop) of pureed garlic bread, and a serving (#12 scoop) of pureed devil's food pudding cake. Per R4' plan of care, R4 should have been offered a double portion of chicken alfredo. R4's meal ticket contained an instruction for double portions. Per R4's meal ticket, R4's main meal was listed as: pureed chicken pasta alfredo, pureed broccoli, pureed garlic bread, and pureed devil's food pudding cake. On 3/11/24 at 12:35 PM, Surveyor noted R4 received 1 scoop of pureed chicken, 1 scoop of mashed potatoes, 1 scoop of alfredo sauce, 1 scoop of pureed broccoli, and a container of pureed chocolate cake for lunch. R4 was not provided pureed pasta, pureed garlic bread, or double portions. Mashed potatoes were not on the menu or R1's meal ticket. On 3/11/24 at 12:35 PM, Surveyor interviewed CK-P who stated residents on pureed diets don't usually receive pasta. On 3/11/24 at 2:03 PM, Surveyor interviewed Registered Dietitian (RD)-V, RM-N, and Dietary Manager (DM)-O. DM-O stated the 4 residents on pureed diets do not fill out meal ticket slips indicating what they prefer for meals. DM-O stated R4 and another resident are nonverbal. When asked if nonverbal residents can read, DM-O stated, I don't know. DM-O verified R4 wasn't asked what R4 wanted and indicated R4 was delusional and would eat butterscotch pudding and oatmeal for every meal. DM-O stated R4's daughter wanted staff to give R4 mashed potatoes. When asked if R4's daughter was able to make choices on behalf of R4, DM-O was unsure. 3. R10 was admitted to the facility on [DATE] with diagnosis including Alzheimer's disease, stage two chronic kidney disease, and failure to thrive. R10's MDS assessment, dated 1/22/24, indicated R10 was rarely or never understood. R10 had an activated POAHC. R10's plan of care indicated R10 had a regular, pureed texture diet with regular/thin liquids. R10's plan of care indicated R10 should be offered double entrees at meals, should consume adequate caloric intake, and the intake of nutrients should meet R10's metabolic needs. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the lunch menu on 3/11/24, residents on pureed diets should receive a serving of pureed chicken pasta alfredo, a serving of pureed broccoli, a serving of pureed garlic bread, and a serving of pureed devil's food pudding cake. Per R10's plan of care, R10 should have been offered a double portion of chicken alfredo. R10's meal ticket contained an instruction for double entrees. Per R10's meal ticket, R10's main meal was listed as: pureed chicken pasta alfredo, pureed broccoli, pureed garlic bread, and pureed devil's food pudding cake. On 3/11/24 at 12:35 PM, Surveyor noted R10 received 1 scoop of pureed chicken, 1 scoop of mashed potatoes, 1 scoop of alfredo sauce, 1 scoop of pureed broccoli, and a container of pureed chocolate cake for lunch. R10 did not receive pureed pasta, pureed garlic bread, or a double entree. Mashed potatoes were not on the menu or on R10's meal ticket. On 3/11/24 at 12:35 PM, Surveyor interviewed CK-P who stated residents on pureed diets don't usually receive noodles. On 3/11/24 at 2:03 PM, Surveyor interviewed RD-V, RM-N, and DM-O. DM-O stated residents who receive pureed diets do not fill out meal ticket slips indicating what they prefer. When asked how staff know what the residents want, DM-O stated R10 loves oatmeal and sweets. 4. R25 was admitted to the facility on [DATE] with diagnosis including psychotic disorder with delusions, Parkinson's disease, and heart failure. R25's MDS assessment, dated 1/19/24, contained a BIMS score of 14 out of 15 which indicated R25 did not have impaired cognition. R25 had an activated POAHC. R25's plan of care indicated R25 had a regular, pureed texture diet with regular/thin liquids. R25's plan of care indicated R25 should consume adequate caloric intake and the intake of nutrients should meet R25's metabolic needs. R25 had a previous significant weight loss of 8% in three months on 10/23/23. According to the lunch menu on 3/11/24, residents on pureed diets should receive a serving of pureed chicken pasta alfredo, a serving of pureed broccoli, a serving of pureed garlic bread, and a serving of pureed devil's food pudding cake. Per R25's meal ticket, R25's main meal was listed as: pureed chicken pasta alfredo, pureed broccoli, pureed garlic bread, and pureed devil's food pudding cake. On 3/11/24 at 12:35 PM, Surveyor noted R25 received 1 scoop of pureed chicken, 1 scoop of mashed potatoes, 1 scoop of alfredo sauce, 1 scoop of pureed broccoli, and a container of pureed chocolate cake for lunch. R25 did not receive pureed pasta or pureed garlic bread. Mashed potatoes were not on the menu or on R25's meal ticket. On 3/11/24 at 12:35 PM, Surveyor interviewed CK-P who stated residents on pureed diets don't usually receive noodles. On 3/11/24 at 2:03 PM, Surveyor interviewed RD-V, RM-N, and DM-O. DM-O stated R25's meals depend on R25's moods and indicated R25 had Parkinson's disease with delusions. 5. R27 was admitted to the facility on [DATE] with diagnosis including Alzheimer's disease, stage 3 chronic kidney disease, and anemia. R27's MDS assessment, dated 1/3/24, indicated R27 was rarely or never understood. R27 had an activated POAHC. R27's plan of care indicated R27 had a regular, pureed texture diet with regular/thin liquids. R27's plan of care indicated R27 should consume adequate caloric intake and the intake of nutrients should meet R27's metabolic needs. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the lunch menu on 3/11/24, residents on pureed diets should receive a serving of pureed chicken pasta alfredo, a serving of pureed broccoli, a serving of pureed garlic bread, and a serving of pureed devil's food pudding cake. Per R27's meal ticket, R27's main meal was listed as: pureed chicken pasta alfredo, pureed broccoli, pureed garlic bread, pureed devil's food pudding cake. On 3/11/24 at 12:35 PM, Surveyor noted R27 received 1 scoop of pureed chicken, 1 scoop of mashed potatoes, 1 scoop of alfredo sauce, 1 scoop of pureed broccoli, and a container of pureed chocolate cake for lunch. R27 did not receive pureed pasta or pureed garlic bread. Mashed potatoes were not on the menu or on R27's meal ticket. On 3/11/24 at 2:03 PM, Surveyor interviewed RD-V, RM-N, and DM-O. DM-O indicated R27 was non-verbal and stated R27 eats everything. 6. R39 was admitted to the facility on [DATE] with diagnoses including transient cerebral ischemic attack, bipolar disorder, and epilepsy. R39's MDS assessment, dated 12/29/23, contained a BIMS score of 12 out of 15 which indicated R39 had moderately impaired cognition. R39 did not have an activated POAHC. R39 had an order for a regular diet with chopped meats and regular/thin liquids. R39's plan of care indicated R39 should consume adequate caloric intake and the intake of nutrients should meet R39's metabolic needs. R39's plan of care also indicated staff should offer substitutions if R39 was eating less than 50% of meals. According to the lunch menu on 3/11/24, residents on a regular diet should receive 6 oz. of chicken pasta alfredo, 4 oz. of broccoli, 1 piece of garlic bread, and 1 square of devil's food pudding cake. R39's meal ticket contained the following instructions: Grilled Cheese Sandwich; *No brats/peas/beets; and Extra fruit-No watermelon. Per R39's meal ticket, R39's main meal was listed as: chopped chicken pasta alfredo, broccoli, garlic bread, and devil's food pudding cake. Items listed under Always Available were: hamburger on bun, grilled cheese sandwich, chopped deli sandwich, macaroni and cheese, homemade soup, shredded garden salad, yogurt, cottage cheese, and fruit. Grilled cheese sandwich, cottage cheese, and fruit were highlighted in pink. Surveyor noted R39 received noodles and alfredo sauce for lunch. R39 did not receive chicken, garlic bread, and broccoli. R39 also did not receive a grilled cheese sandwich, cottage cheese, or fruit as highlighted on the meal ticket. On 3/11/24 at 12:44 PM, CK-P and RM-N discussed R39's meal in front of Surveyor. CK-P told RM-N that R39 doesn't eat broccoli or chicken. On 3/11/24 at 12:46 PM, Surveyor interviewed CK-P. When CK-P indicated CK-P decided to leave the chicken and broccoli off R39's tray, RM-N interjected and stated, You can't do that. When Surveyor asked if R39 filled out the highlighted meal ticket, CK-P stated CK-P filled out the slip and made the choices for R39. When Surveyor asked how CK-P knew what R39 wanted/liked, CK-P stated, Because that's what (R39) gets every day. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Odd Fellow Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1229 S Jackson St Green Bay, WI 54301	

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 at 2:03 PM, Surveyor interviewed RD-V, RM-N, and DM-O. When asked how staff know what residents want to eat if residents don't fill out a slip and staff don't ask them, DM-O stated, I don't know. I never thought of asking (them). When Surveyor asked if staff should decide what residents receive for meals if residents don't fill out a slip and staff don't ask them, RM-N stated residents should receive the full menu if they haven't chosen anything and their preferences don't indicate otherwise. RM-N stated the facility has plans to put a new system in place with the goal to ask residents each day what they want for the next day. When Surveyor asked RD-V, RM-N and DM-O if they felt residents' choices were being honored, RM-N stated, Nope.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47248 Based on staff and resident interview and record review, the facility did not make a prompt effort to resolve grievances for 5 Residents (R) (R210, R211, R28, R209 and R13) of 7 sampled residents. R210 reported to staff that R210 was missing numerous articles of clothing. The facility did not resolve the grievance in a timely manner. R211 reported to staff that R211 was missing a nightgown. The facility did not resolve the grievance in a timely manner. R209 reported to staff that R209 was missing numerous articles of clothing. The facility did not resolve the grievance in a timely manner. R28 reported to staff that R28 was missing bed linens. The facility did not resolve the grievance in a timely manner. R13 reported to staff that R13 was missing numerous articles of clothing. The facility did not resolve the grievance in a timely manner. The facility's grievance log contained missing clothing items or laundry concerns for 1 resident in September 2023, 1 resident in November 2023, and 2 residents in December 2023. The facility was unable to provide Surveyor with grievance investigation forms. Findings include: The facility's Grievance Policy and Procedure, reviewed 1/8/20, indicates: It is the intent of this policy to support each resident's right to voice grievances and concerns and to assure that after receiving a grievance, the facility actively seeks a resolution and keeps the resident and/or family member appropriately apprised of its progress toward a resolution .Procedure .6. The Grievance Officer needs to investigate the concern further to determine if it can be resolved and will complete the review within 2 business days of the grievance. If it involves another department, the department head should also be notified and work as a team to investigate and find a resolution to the problem. The Grievance Officer will ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, steps taken to investigate, a summary of pertinent findings or conclusions regarding resident concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issues . 10. A copy of all investigation will be kept in a file in the Social Service Office. Odd fell ow Home will maintain evidence demonstrating the resolution of complaints and grievances for the past three years . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/24 Surveyor reviewed the facility's grievance log and requested grievance investigation forms for missing laundry items on the log. Surveyor noted the grievance log contained missing clothing items or laundry concerns for 1 resident in September 2023, 1 resident in November 2023, and 2 residents in December of 2023, as well as 3 grievances in January of 2024 and 2 grievances in February of 2024. On 3/11/24 Surveyor received the following grievance investigation forms and noted the following: 1. R210 filed a grievance on 1/31/24 that indicated R210 was missing pants, underwear, a t-shirt and a night shirt. The investigation section of the form was blank and the findings section indicated staff could not find the items. The action taken section indicated staff will mark clothing before sending clothing to laundry. The grievance follow-up section contained the findings and indicated the person who voiced the concerns was satisfied. The form contained the name of the person who completed the form, but the completed date was blank. The notes section of form indicated the clothing was not found and a message was left on 2/5/24. The grievance form was signed by Social Worker (SW)-D on 2/5/24 and Assistant Nursing Home Administrator (ANHA)-C on 2/13/24. R210 was no longer a resident of the facility. 2. R211 filed grievance on 1/31/24 that indicated R211 was missing a night gown. The investigation section of the form was blank and the findings section indicated staff did not find the night gown after looking for weeks. The action taken section, the person completing form, and the completed date were blank. The grievance follow-up section contained the findings and indicated the person who voiced the concerns was satisfied with the findings. The notes section of form indicated the clothing was not found and there was an update on 2/2/24. The form was signed by SW-D on 2/2/24 and ANHA-C on 2/13/24. R211 was no longer a resident of the facility. 3. R28 filed a grievance (on a missing items form found in the facility's grievance file) on 2/27/24 that indicated R28 was missing a bottom sheet, a top sheet, and a pillowcase. The form indicated the items were last seen on 2/7/24 in R28's bedroom. R28's room was searched. Housekeeping staff and R28's family/Power of Attorney (POA) were notified. The resolution section indicated the items were not in laundry and the facility would reach out to a friend who did R28's laundry. The signatures lines for the Social Services Director and Administrator were blank. On 3/12/24 at 8:15 AM, Surveyor interviewed R28 who stated the missing items were not found or replaced and R28 was not satisfied with the resolution. 4. R209 filed a grievance on 1/31/24 that indicated R209 was missing a nightgown, a couple pair of pants, and a couple shirts. The investigation information was blank and the findings section indicated staff could not find the items. The action taken section indicated staff will be mark clothing before sending clothing to laundry. The findings were reported to R209 on 2/5/24 and the form indicated R209 was both satisfied and unsatisfied with the findings. The notes section indicated the items were still not found. The form was signed by SW-D on 2/6/24 and ANHA-C on 2/13/24. R209 was no longer a resident of the facility. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R13 filed a grievance on 2/27/24 that indicated R13 was missing a nightgown, a blouse, 2 winter caps, and a leather coin purse that did not contain money. The investigation information was blank and the findings section indicated the items were not found. The action taken section indicated staff would continue to look. The findings were reported to R13 on 3/1/24. The form indicated R13 was both satisfied and unsatisfied with the results. The notes section indicated R13 wanted the items back and staff continued to look for them. On 3/11/24, Regional Consultant (RC)-E indicated on the form that a black dress and floral gown were located in lost and found and were washed and returned to R13. The form was signed by SW-D on 3/6/24. The Administrator's signature line was blank. On 3/12/24 at 8:30 AM, Surveyor interviewed R13 who indicated there was no resolution for R13's missing items. R13 indicated some of the items were found yesterday (3/11/24). R13 indicated R13 would like all the missing items returned or would like reimbursement. On 3/11/24 at 8:41 AM, Surveyor interviewed Supervisor (SP)-F who indicated the laundry department has had lost resident items and stated in January of 2024, a process was implemented to have nursing staff put a newly admitted resident's name on a bag prior to the resident's clothing being sent to laundry to be washed so that laundry staff could label the clothing. SP-F stated laundry staff took lost and found items to residents recently to locate residents who were missing items. SP-F stated when residents inform staff of missing items, laundry staff begin looking for the items, and let staff know if the items are found in laundry. On 3/11/24 at 2:45 PM, Surveyor interviewed RC-E who indicated when residents submit grievances regarding laundry, laundry staff are notified. When Surveyor interviewed RC-E about recent grievances regarding laundry, RC-E stated since November 2023, the facility's laundry process was revamped and there were no complaints since December 2023. When Surveyor provided RC-E with grievance forms from January 2024 and February 2024, RC-E indicated RC-E was not aware of the grievances. On 3/11/24 at 2:55 PM, Surveyor interviewed SW-D who indicated the process for grievances regarding laundry is to alert laundry staff right away, check the resident's room, and if not found, follow-up with the resident. SW-D indicated the resident can be reimbursed while the facility continues to look for the items. Surveyor interviewed SW-D regarding the grievances filed by R210, R211, R28, R209 and R13. SW-D indicated the items were not found, reimbursement did not occur, and the facility is still looking for the items. SW-D indicated the facility looks for items for 5-7 days and indicated the grievance should be resolved at that time. On 3/11/24 at 3:45 PM, ANHA-C indicated to Surveyor that ANHA-C was looking for the grievance forms requested from Surveyor for grievances filed in September, October, November, and December 2023. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/12/24 at 9:30 AM, Surveyor interviewed ANHA-C who indicated the facility was continuing to look for R28's items, as well as the other residents' missing items. In regard to the facility's grievance policy that indicates grievances should be resolved within two days, ANHA-C indicated the time frame wasn't long enough for the facility to find the items and resolve the grievance. ANHA-C also indicated the facility could offer reimbursement. ANHA-C provided a document from SP-F that was titled Steps Taken to Locate Items and listed the following: Check label, look in to be labeled bin, check in resident room, check soiled linens and clean linen closet, 2/5/24 followed up with Certified Nursing staff, reminder to have personal clothing sent down to laundry to be labeled. When Surveyor indicated the process prior to 2/5/24 (on the 1/31/24 grievances) indicated nursing staff will mark clothing before sending clothing to laundry, ANHA-C indicated laundry staff just completed a lost and found look through to find lost clothing for residents. ANHA-C indicated laundry staff looked through all unclaimed laundry and indicated missing clothing or lost items continue to occur. ANHA-C also confirmed the facility did not have grievance forms for the requested grievances in September, October, November, and December 2023. ANHA-C stated ANHA-C thought the previous administrator threw away the grievance forms after a complaint survey was conducted in September 2023 and confirmed the facility did not maintain a copy of the grievances and resolutions per the facility's policy.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47248 Based on staff interview and record review, the facility did not ensure their abuse policy was implemented for 1 of 8 employees reviewed for background checks. Certified Nursing Assistant (CNA)-J's background check information did not contain an out-of-state criminal or caregiver background check. Findings include: The facility's Patient Protection Program: Freedom from Abuse, Neglect, and Exploitation document indicates: Screening components: .It is the policy of this facility to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check .Employee screening and training: Before new employees are permitted to work with residents, references provided by the prospective employee will be verified as well as appropriate board registrations and certifications regarding the prospective employee's background. The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law .A criminal background check will be conducted on all prospective employees as provided by the facility's policy on criminal background checks. A significant finding on the background check will result in denied employment consistent with the criminal background check policy in accordance with state and federal regulation On 3/10/24, Surveyor requested a staff list from Nursing Home Administrator (NHA)-A. On 3/11/24, Surveyor reviewed the staff list and requested background check information for eight staff, including CNA-J's background check and CNA registry information from Assistant Nursing Home Administrator (ANHA)-C. On 3/12/24, Surveyor reviewed CNA-J's background check information and noted CNA-J was hired by the facility on 11/7/23 and had a caregiver background check completed on 10/27/23. Surveyor noted CNA-J's caregiver background check indicated CNA-J lived outside the state of Wisconsin within the last 3 years. Surveyor reviewed the background check information provided by the ANHA-C and noted out-of-state criminal and caregiver background checks were not included. On 3/12/24 at 10:17 AM, Surveyor requested an out-of-state criminal and caregiver background check for CNA-J from NHA-A. On 3/12/24 at 2:56 PM, NHA-A indicated to Surveyor that the facility did not complete out-of-state criminal or caregiver background checks for CNA-J and did not have information to provide to Surveyor.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47248 Based on staff interview and record review, the facility did not ensure 3 Residents (R) (R204, R36, and R19) of 4 residents reviewed for hospitalization s received a written notice of transfer, including the reason for the transfer, location of the transfer, appeal rights, and contact information for the State Long-Term Care Ombudsman. In addition, the facility did not notify the Ombudsman of the transfers. R204 was transferred to the hospital on 2/27/24. R204 was not provided a written transfer notice and the Ombudsmen was not notified of the transfer. R36 was transferred to the hospital on 11/21/23 and 11/27/23. R36 was not provided written transfer notices and the Ombudsmen was not notified of the transfers. R19 was transferred to the hospital on 12/12/23 and 2/27/24. R19 was not provided written transfer notices and the Ombudsmen was not notified of the transfers. Findings include: The facility's Transfer or Discharge Documentation document, revised 12/2016 indicates: When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider .When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: a. The basis for the transfer and discharge. b. That an appropriate notice was provided to the resident and/or legal representative .i. Other as appropriate and necessary . 1. On 3/11/24, Surveyor reviewed R204's medical record. R204 was transferred to the hospital on 2/27/24 due to a low blood sugar level. R204's medical record did not indicate R204 received a written transfer notice or that the Ombudsman was notified. R204 did not have an activated power of attorney for healthcare (POAHC). On 3/11/24 at 4:00 PM, Surveyor requested a copy of the written transfer notice provided to R204 and a copy of the Ombudsman notification. On 3/12/24 at 9:20 AM, Assistant Nursing Home Administrator (ANHA)-C confirmed a written transfer notice was not provided to R204. Surveyor reviewed the facility's February 2024 Ombudsman transfer notification and noted the Ombudman was not notified of R204's transfer on 2/27/24. 32768 2. On 3/11/24, Surveyor reviewed R36's medical record. R36 was transferred to the hospital on 11/21/23 due to acute kidney injury and on 11/27/23 due to low blood pressure, headache and dizziness. Surveyor noted R36's medical record did not indicate R36 was provided a written transfer notice for either transfer or that the Ombudsman was notified of the transfers. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 11:21 AM, Surveyor requested a copy of the written transfer notices provided to R36 and notification to the Ombudsman of R36's transfers. On 3/12/24 at 12:29 PM, ANHA-C confirmed written transfer notices were not provided to R36. On 3/11/24 at 12:41 PM Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A expects nurses to use the facility's transfer form when a resident is transferred to the hospital. On 3/11/24 Surveyor reviewed the facility's Ombudsman transfer notifications for November 2023 and noted the Ombudsman was not notified of R36's transfers on 11/21/23 and 11/27/23. 45942 3. On 3/11/24, Surveyor reviewed R19's medical record. R19 was transferred to the hospital on 12/12/23 due to right sided weakness and on 2/27/24 due to a fall with a head injury. Surveyor noted R19's medical record did not indicate R19 (who did not have an activated POAHC) was provided written transfer notices or that the Ombudsman was notified of the transfers. On 3/12/24 at 11:21 AM, Surveyor requested a copy of the written transfer notices provided to R19 and notification to the Ombudsman of R19's transfers. On 3/12/24 at 12:29 PM, ANHA-C confirmed written transfer notices were not provided to R19. On 3/11/24 at 12:41 PM, Surveyor interviewed NHA-A who indicated NHA-A expects nurses to use the facility's transfer form when a resident is transferred to the hospital. On 3/11/24 at 1:03 PM, Surveyor reviewed the facility's Ombudsman transfer notifications for December 2023 and February 2024 and noted the Ombudsman was not notified of R19's transfers on 12/12/23 and 2/27/24.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 47248 Based on staff interview and record review, the facility did not ensure 3 Residents (R) (R204, R36 and R19) of 4 residents reviewed for hospitalization s received written information of the duration of the facility's bed hold policy, the reserve bed payment policy, and the right to return to the facility. R204 was transferred to the hospital on 2/27/24 and was not provided a copy of the facility's bed hold policy. R36 was transferred to the hospital on 11/21/23 and 11/27/23 and was not provided copies of the facility's bed hold policy. R19 was transferred to the hospital on 12/12/23 and 2/27/23 and was not provided copies of the facility's bed hold policy. Findings include: The facility's Bed-Holds and Returns policy, revised 3/2022, indicates: Resident and/or representative are informed (in writing) of the facility and state (if applicable) bed hold policies .1. All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization s or therapeutic leave). Residents are provided written information about these policies at least twice: well in advance of any transfer (e.g., in the admission packet) and at the time of transfer (or, if the transfer was an emergency, within 24 hours). The facility's Bed Hold Notification document indicates: Bed hold occurs when an individual is transferred to the hospital for medical care or when an individual is on therapeutic leave .Medical Assistance will pay for a resident's bed to be held for up to 15 days when they are admitted to the hospital. After the 15th day, the resident or family will be asked if they wish to continue to hold the bed using private funds .The resident or family has the option to hold the bed indefinitely. The bed will be held at the bedhold rate .Surveyor noted the Bed Hold Notification form listed the 2022 rate for semi-private, private, and enhanced private rooms. Surveyor also noted an area on the form that indicated if the resident wanted to hold the bed or decline a bed hold contained a signature line and date for the resident or resident's representative to sign. 1. On 3/11/24, Surveyor reviewed R204's medical record. R204 was transferred to the hospital on 2/27/24 due to a low blood glucose reading. R204's medical record did not indicate a copy of the bed hold policy was provided to R204 (who did not have an activated power of attorney for healthcare (POAHC)). On 3/12/24 at 9:20 AM, Assistant Nursing Home Administrator (ANHA)-C confirmed R204 was not provided with the facility's bed hold policy when R204 was transferred to the hospital. 32768 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 3/11/24, Surveyor reviewed R36's medical record. R36 was transferred to the hospital on 11/21/23 due to acute kidney injury and on 11/27/23 due to low blood pressure, headache and dizziness. Surveyor noted R36's medical record did not indicate a copy of the bed hold policy was provided to R36. On 3/12/24, Surveyor requested a copy of the facility's bed hold policy that was provided to R36 for the transfers on 11/21/23 and 11/27/23. On 3/12/24 at 12:29 PM, ANHA-C confirmed the bed hold policy was not provided to R36 for either transfer. ANHA-C indicted that a nursing note was completed, but not a written bed hold. On 3/11/24 at 12:41 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated NHA-A expects nurses to provide a copy of the facility's bed hold policy when a resident is transferred to the hospital 45942 4. On 3/11/24, Surveyor reviewed R19's medical record. R19 was transferred to the hospital on 12/12/23 due to right sided weakness and on 2/27/24 due to a fall with a head injury. Surveyor noted R19's medical record did not indicate a copy of the bed hold policy was provided to R19 (who did not have an activated POAHC). On 3/12/24 at 11:21 AM, Surveyor requested a copy of the bed hold policy that was provided to R19 for the transfers on 12/12/23 and 2/27/24. On 3/12/24 at 12:29 PM, ANHA-C confirmed the bed hold policy was not provided to R19 for either transfer. On 3/11/24 at 12:41 PM, Surveyor interviewed NHA-A who indicated NHA-A expects nurses to provide a copy of the facility's bed hold policy and transfer form when a resident is transferred to the hospital.

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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** 32768 Based on observation, resident and staff interview, and record review, the facility did not ensure each resident received adequate supervision and assistive devices, did not ensure fall assessments were completed, and did not ensure interventions to prevent falls were implemented for 2 Residents (R) (R12 and R19) of 18 sampled residents. On 3/11/24, staff used a lift with defective brakes and a defective sling to transfer R12. Staff did not appropriately assess R19 following a fall with head injury on 2/26/24. In addition, the facility did not update R19's care plan with interventions to prevent future falls. Findings include: The facility's Safety and Supervision of Residents policy, dated 12/2007, indicates: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Resident Risks and Environmental hazards: Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: b. Safe lifting and movement of residents. c. Falls . The EZ Way Smart Stand Operator's Instructions indicate: The only time you should lock the wheels of the EZ Way Smart Stand when in use is when you are raising or lowering the patient during ambulation. To operate the EZ Way Smart Stand follow the steps .Pre Operation check: Before operating the unit, complete a maintenance safety check for loose nuts and bolts and damaged parts. Also ensure the harness is not ripped, frayed, or showing signs of wear. 1. On 3/10/24 at 10:15 AM, Surveyor was approached by Certified Nursing Assistant (CNA)-G who showed Surveyor an EZ stand sling with a broken clip on a shelf near the C wing nurses' station. Surveyor noted the black plastic clip that went into the receiving end had one intact prong and one broken prong. CNA-G indicated CNA-G only worked occasionally at the facility but believed other staff used the sling to transfer R17 that morning. CNA-G stated CNA-G previously told staff 5 times that the sling was broken and should be removed from the unit. When Surveyor asked if CNA-G informed Nursing Home Administrator (NHA)-A or Director of Nursing (DON)-B, CNA-G indicated CNA-G told a few full time staff and a nurse. CNA-G indicated CNA-G pulled the sling from the unit and handed it to a full time staff, but the sling came back. CNA-G also indicated CNA-G wrote a note on the sling that indicated the sling was broken; however, staff continued to use the sling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/24 at 1:42 PM, Surveyor observed CNA-H transfer R12 via EZ stand lift. CNA-H opened the lift's legs and put the lift under R12. CNA-H indicated CNA-H would usually engage the brakes, but the brakes on the lift didn't work. CNA-H then lifted R12 from the wheelchair and transferred R12 to R12's recliner. When Surveyor asked CNA-H if the other EZ stand lift had working brakes, CNA-H indicated the brakes on the other lift worked, but the lift was in use so CNA-H had to use the lift with the broken brakes. CNA-H indicated the facility only had 2 EZ stand lifts. When Surveyor asked CNA-H if management was aware that the lift's brakes didn't work, CNA-H indicated CNA-H was not sure. Surveyor also noted the sling CNA-H used to transfer R12 contained a broken prong on the waist strap. On 3/12/24 at 11:23 AM, Surveyor interviewed NHA-A who verified the sling and EZ stand lift were used to transfer residents on the C Wing. NHA-A verified staff should not have used the lift and stated the sling should have been removed from the unit. 45942 2. The facility's Falls and Fall Risk Managing policy, revised 12/2007, indicates: Based on previous evaluations and current data, 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 .Prioritizing Approaches: 1. The staff with the input of the Attending Physician will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions .4. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant .6. In conjunction with the Attending Physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. The facility's Assessing Falls and Their Causes policy, revised 10/2010, indicates: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall .1) After a fall: a. If a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries .f. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. g. An incident report must be completed for resident falls. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing no later than 24 hours after the fall occurs .Documentation: When a resident falls, the following information should be recorded in the resident's medical record .2. Assessment data. 3. Interventions, first aid, or treatment administered .5. Completion of a falls risk assessment. 6. Appropriate interventions taken to prevent future falls .Reporting: .2. Report other information in accordance with the facility policy and professional standards of practice. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Neurological Assessment, revised 10/2010, indicates: The purpose of this procedure is to provide guidelines for a neurological assessment .2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. General Guidelines: 1. Neurological assessments are indicated: .b. following an unwitnessed fall; c. following a fall or other accident/injury involving head trauma; 2. When assessing neurological status, always include frequent vital signs .Steps in the Procedure: .3. Perform neurological checks with the frequency as ordered or per falls protocol. 4. Determine resident's orientation to time, place and person. 5. Take temperature, pulse, respirations, blood pressure .7. Check pupil reaction .8. Determine motor ability: a. Have resident move all extremities; b. Ask resident to squeeze your fingers. Note strength bilaterally, c. Have resident plantar and dorsiflex. Note strength bilaterally. Ask resident if he/she has any numbness or tingling in legs/feet/toes and document accordingly. 9. Determine sensation in extremities .Documentation: The following information should be recorded in the resident's medical record: 1) The date and time the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason why and the intervention taken. 6. The signature and title of the person recording the data . From 3/10/24 to 3/12/24, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular accident (stroke) affecting the right dominant side, repeated falls, and difficulty in walking. R19's Minimum Data Set (MDS) assessment, dated 2/23/24, contained a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R19 had moderately impaired cognition. R19 had a fall with head injury during the night shift on 2/26/24 when R19 reached for a remote control and fell out of bed. R19 was sent to the Emergency Department (ED) and returned to the facility several hours later on 2/27/24. A progress note, dated 2/27/24 at 1:32 AM, indicated a raised edge mattress and low bed position would be implemented following R19's fall. On 3/11/24 at 10:48 AM, Surveyor interviewed CNA-M who indicated a new fall intervention for R19 was to check on R19 more often. The intervention was not included in R19's plan of care. On 3/11/24 at 1:35 PM, Surveyor noted R19's bed did not have a raised edge. Surveyor interviewed R19 who confirmed R19's bed did not have a raised edge and stated staff only check on R19 when R19 activates R19's call light. On 3/11/24 at 1:51 PM, Surveyor reviewed the Interdisciplinary Team's (IDT) review of R19's fall on 2/26/24 and noted the IDT still agreed with the current intervention (continue to monitor). On 3/11/24 at 2:33 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-K who indicated R19's fall interventions included a mat by the bed and a noodle on one side of the bed. Surveyor noted neither of the interventions were included in R19's plan of care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/24 at 2:42 PM, Surveyor interviewed LPN-K regarding R19's new interventions post fall. LPN-K indicated R19's new fall interventions included Velcro on R19's remote control; however, LPN-K was unsure if the intervention was in R19's care plan. When Surveyor asked LPN-K if R19's care plan was revised, LPN-K reviewed R19's care plan and confirmed R19's care plan was not revised or updated and did not contain R19's new fall interventions. On 3/11/24 at 2:47 PM, Surveyor interviewed LPN-L regarding fall interventions implemented after R19's fall on 2/26/24. LPN-L stated there were no new interventions after R19's fall. LPN-L indicated neurochecks should have been completed every 15 minutes x 4, every 30 minutes x 4, every hour x 4 and every shift x 72 hours. At 2:53 PM, LPN-L confirmed R19's bed did not have a raised edge. On 3/11/24 at 3:03 PM, Surveyor interviewed Director of Nursing (DON)-B regarding the interventions implemented after R19's fall on 2/26/24. DON-B indicated Velcro was put under R19's television remote to prevent the remote from falling which was the root cause of R19's fall. DON-B indicated Velcro, a reacher and clip (call light) interventions were on the Point Click Care (PCC) (computerized medical record) dashboard. Per DON-B, the dashboard could only be accessed by administration and nurses. DON-B confirmed the interventions were not contained in area that CNAs could access. DON-B agreed CNAs should be able to access new fall interventions and verified R19's care plan should have been updated with the new interventions. DON-B verified neurochecks were not completed under R19's PCC assessment tab, but stated R19's progress notes indicated neurochecks were completed and within normal limits. On 3/12/24 at 10:57 AM, Surveyor interviewed DON-B who reviewed R19's neurochecks for the 2/26/24 fall and verified the neurochecks were not completed. DON-B indicated although nursing notes indicated neurochecks were completed, DON-B expects staff to complete neurochecks using the neurocheck form under the assessment tab in PCC. DON-B agreed neurochecks should be completed every 15 minutes x 4, every 30 minutes x 4, every hour x 4 and every shift x 72 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45942 Based on observation, staff and resident interview, and record review, the facility did not ensure 1 Resident (R) (R34) of 1 resident received the necessary care and services for respiratory therapy. The facility provided R34 with respiratory therapy via CPAP (continuous positive airway pressure) without a physician's order. In addition, R34's need for and use of CPAP therapy was not care planned for assessment, evaluation, or monitoring. Findings include: The facility's CPAP Therapy policy, revised 10/2010, indicates: Purpose: 1) To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. 2) To improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea (OSA), or restrictive/obstructive lung disease .apnea .Preparation: .3) Review the physician's orders .Document the following in the resident's medical record: 1) General assessment prior to procedure; 2) Time CPAP was started and duration of the therapy; 3) Mode and settings for the CPAP; .5) How the resident tolerated the procedure; and 6) Oxygen saturation during therapy . The facility's Respiratory Therapy-Prevention of Infection policy, revised 4/2012, indicates: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment . Preparation: 1) Review the resident's care plan to assess for any special circumstances or precautions related to the resident .General Guideline: 1) Distilled water used in respiratory therapy must be dated and initiated when opened and discarded after 24 hours; 2) Condensate in the breathing circuits must be drained back into waste bottles, which must be marked with resident's name, and emptied into the toilet or hopper at the end of every shift. Condensate should be considered infectious. Condensate should never be drained back into the breathing circuit or cascade .Steps in the Procedure: .4) Check water levels of refillable humidifier units daily .If the water level falls below the fill line .e) Change the reservoir every 48 hours . From the website: https://www.sleepfoundation.org/cpap/how-to-clean-a-cpap-machine: Continuous positive airway pressure (CPAP) machines are a standard treatment for sleep apnea, a serious breathing disorder. While they are an effective way to treat sleep apnea, CPAP machines do require frequent care and cleaning. Given that the mask, tubing, and other components are breathed into and deliver air throughout the night, their cleanliness can be a serious health concern. Daily cleaning removes dangerous microbes, mold, dust, and debris to ensure your CPAP treatment makes you feel better and not worse. While daily cleaning may seem overwhelming, it is a relatively quick process that is easy to integrate into your daily schedule. Manufacturers and experts tend to recommend daily cleaning of your CPAP machine's components, and users should commit to weekly cleaning at a minimum. On 3/10/24, Surveyor reviewed R34's medical record. R34 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA), dementia, weakness, and anxiety. R34's Minimum Data Set (MDS) assessment, dated 12/20/23, contained a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R34 had moderate cognitive impairment. R34's medical record indicated R34 had an activated Power of Attorney (POA). (continued on next page)

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 03/12/2024
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During multiple observations from 3/10/24 through 3/12/24, Surveyor observed a CPAP machine on R34's bedside table. The machine's tubing was not labeled with a date to indicate when it was last changed. On 3/10/24 at 12:52 PM, Surveyor interviewed R34 who indicated R34 did not always use the CPAP machine because not all staff were educated on the CPAP mask/machine. Surveyor reviewed R34's physician orders and noted R34 did not have an order for CPAP therapy. On 3/11/24 at 3:36 PM, Surveyor reviewed R34's plan of care which did not mention R34's need for CPAP therapy and did not contain a cleaning schedule. On 3/12/24 at 11:03 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R34 received CPAP therapy. DON-B verified R34 did not have a physician's order for CPAP therapy or a care plan that addressed the use of CPAP therapy and how and when the equipment should be cleaned. DON-B verified R1's care plan should contain reference to R34's need for CPAP therapy. DON-B also indicated R34's CPAP tubing should be labeled with a date/time to indicate when the tubing was last changed to help aid with infection prevention.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40342 Based on staff interview and record review, the facility did not ensure monitoring of a high risk medication was provided for 1 Resident (R250) of 5 residents reviewed for unnecessary medication. R250 had physician orders for short-acting and long-acting insulin (used to treat high blood sugar). R250's plan of care did not contain interventions to monitor R250 for signs and symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Findings include: On 3/12/24, Surveyor reviewed R250's medical record. R250 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (a disease in which blood sugar levels are too high). R250's medical record contained the following physician orders: ~ Humalog Injection Solution 100 unit/ml (units per milliliter) (Insulin Lispro) (short-acting insulin) Inject as per sliding scale: if 120-149 = 2 units; 150-199 = 4 units; 200-249 = 6 units; 250-299 = 8 units; 300-349 = 10 units 350 or more *12 units & call MD (Medical Doctor), subcutaneously (under the skin) one time a day for diabetes .Prime 2 units before each dose. Glucose <70 hypoglycemia treatment, 70-119 *No corrective insulin. ~ Lantus Subcutaneous Solution 100 unit/ml (Insulin Glargine) (long-acting insulin) Inject 25 unit subcutaneously at bedtime for diabetes ~ Lantus Subcutaneous Solution 100 unit/ml (Insulin Glargine) Inject 30 unit subcutaneously one time a day for diabetes R250's plan of care did not contain interventions that alerted staff to monitor R250 for signs and symptoms of hypoglycemia or hyperglycemia. On 3/12/24 at 1:20 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R250's comprehensive care plan was not yet completed and staff were working off of R250's baseline care plan. DON-B verified the need to monitor for signs and symptoms of hypoglycemia and hyperglycemia was not addressed on R250's baseline care plan.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 49010 Based on observation and staff interview, the facility did not ensure garbage and refuse were properly disposed of in outside garbage receptacles. This practice had the potential to affect all 50 residents residing in the facility. On 3/10/24, the lids on 3 outside refuse dumpsters were open and there was garbage on the ground. Findings include: During an initial kitchen tour on 3/10/24 at 10:13 AM, Surveyor and Dietary Manager (DM)-O observed 3 outside refuse dumpsters with open lids. Surveyor and DM-O observed a bag of garbage on the ground behind the middle dumpster and scattered pieces of paper on the ground around the 3 dumpsters. On 3/10/24 at 10:14 AM, Surveyor interviewed DM-O who indicated the lids were most likely open for ease of use, but should be shut to keep rodents out. DM-O went between the dumpsters and looked at the bag of garbage on the ground. DM-O stated the garbage was CNA (Certified Nursing Staff) stuff and left the bag of garbage on the ground behind the dumpster.

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 32768 Based on observation, staff interview, and record review, the facility did not establish and maintain an infection prevention and control program based on current standards of practice, designed to provide a safe environment and to help prevent the development and transmission of communicable disease and infection. This practice had the potential to affect all 50 residents residing in the facility. The facility did not have a system for preventing the growth and spread of Legionella in the facility's water system. The facility's Water Management Plan (WMP) was not based on current standards of practice and did not: Describe the building's water system using text and an accurate flow diagram of the system; Include an assessment of the facility's water system to identify all locations where Legionella could grow and spread; Maintain acceptable ranges of control limits (temperature ranges) and corrective actions when control limits are not met; Include a process to confirm the WMP is being implemented and is effective. Findings include: The 7/6/18 revised Centers for Medicaid & Medicare Services (CMS) Quality, Safety and Oversight Letter 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD) contains the following information: Facilities must have water management plans and documentation that, at a minimum, ensure each facility: -Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g., Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility's water system. -Develops and implements a water management program that considers the ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) industry standard and the CDC (Centers for Disease Control and Prevention) toolkit. -Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions taken when control limits are not maintained. The 6/24/21 CDC Toolkit titled Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings identifies the key elements of a water management program for healthcare facilities that include: 1. Establish a water management program team. 2. Describe the building water system using text and flow diagrams. 3. Identify areas where Legionella could grow and spread. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

4. Describe where control measures should be applied and how to monitor them.

5. Establish ways to intervene when control limits are not met.

6. Make sure the program is running as designed and is effective.

7. Document and communicate all the activities.

The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings located at https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html#anchor_72633 contains the following information: This document concisely describes a core set of infection prevention and control practices that are required in all healthcare settings, regardless of the type of healthcare provided. The practices were selected from among existing CDC recommendations and are the subset that represent fundamental standards of care that are not expected to change based on emerging evidence or to be regularly altered by changes in technology or practices and are applicable across the continuum of healthcare settings .

Core Practice Category 4. Performance Monitoring and Feedback notes:

1. Identify and monitor adherence to infection prevention practices and infection control requirements.

2. Provide prompt, regular feedback on adherence and related outcomes to healthcare personnel and facility leadership.

3. Train performance monitoring personnel and use standardized tools and definitions.

4. Monitor the incidence of infections that may be related to care provided at the facility and act on the data and use information collected through surveillance to detect transmission of infectious agents in the facility.

The facility's undated Water Management Program to Reduce Legionella Growth and Spread indicates: Purpose: To monitor and manage the water system at Odd fell ow Home to reduce the risk of the growth and spread of Legionella.

On 3/12/24 at 1:02 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated the Maintenance Director was responsible for the WMP. NHA-A indicated the information given to Surveyor was the only information available for the WMP. NHA-A verified the facility did not have a Facility Assessment to identify sources for the growth of Legionella. NHA-A also verified the facility did not have a process or flow diagram to identify Legionella in the facility.