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	05/07/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a Pre-admission Screening and Resident Review (PASRR) Level I Screen was submitted for a Level II Screen when a 30-day hospital exemption expired for 2 residents (R) (R56 and R49) of 18 sampled residents. R56 and R49 were identified on their PASRR Level I Screens as suspected of having a serious mental illness. The facility did not submit for PASRR Level II Screens when R56 and R49's 30-day hospital exemptions expired. Findings include: 1. On [DATE] Surveyor reviewed R56's medical record. R56 had a diagnosis of anxiety disorder and was prescribed Ativan (an anti-anxiety medication). R56's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R56 was not cognitively impaired. R56's medical record indicated R56 was screened for mental illness, developmental disabilities, and intellectual disabilities on [DATE] and granted a 30-day hospital exemption for a PASRR Level II Screen. R56's medical record did not indicate there was submission for a PASRR Level II Screen after R56's 30-day exemption expired. 2. On [DATE], Surveyor reviewed R49's medical record. R49 had diagnoses of insomnia, depression, and anxiety disorder. R49 was prescribed zolpidem tartrate (a sedative/hypnotic medication), Zoloft (an antidepressant medication) and oxazepam (a sedative medication used to treat anxiety). R49's MDS assessment, dated [DATE], had a BIMS score of 8 out of 15 which indicated R49 had moderate cognitive impairment. R49's medical record indicated R49 was screened for mental illness, developmental disabilities, and intellectual disabilities on [DATE] and granted a 30-day hospital exemption for a PASRR Level II Screen. R49's medical record did not indicate there was submission for a PASRR Level II Screen after R49's 30-day exemption expired. On [DATE] at 3:00 PM, Surveyor requested PASRR Level I and Level II Screens for R56 and R49 from Director of Nursing (DON)-B. On [DATE] at 11:06 AM, Surveyor reviewed R56's updated PASRR Level I Screen which was dated [DATE] and R49's updated PASRR Level I Screen which was dated [DATE]. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:02 PM, Surveyor interviewed Admissions Coordinator (AC)-D who confirmed AC-D was responsible for completing PASRRs for residents. AC-D indicated R56's PASRR Level I Screen was completed on [DATE] with a 30-day hospital exemption and should have been submitted for a Level II Screen when the 30-day exemption expired. AC-D verified R49's PASRR Level I Screen was completed on [DATE] with a 30-day hospital exemption and should have been submitted for a Level II Screen when the 30-day exemption expired.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure ongoing communication with the dialysis center or ensure ongoing monitoring of the fistula site for 1 resident (R) (R6) of 1 sampled resident. R6 received dialysis three times weekly. The facility did not ensure ongoing communication with the dialysis center or routinely monitor R6's fistula site. Findings include: The facility's Dialysis policy, revised 7/2018, indicates: There should be a pulse, buzzing, or thrill feeling in the fistula or graft. This is the blood rushing through the area. Check the fistula or graft daily. The facility's Hemodialysis Catheters-Access and Care of policy, revised 2023, indicates: Care of arteriovenous fistulas (AVFs) and arteriovenous grafts (AVGs) .Check patency of the site at regular intervals. Palpate the site to feel the thrill or use a stethoscope to hear the whoosh or bruit of blood flow through the access. From 5/5/25 to 5/7/25, Surveyor reviewed R6's medical record. R6 was admitted to the facility on [DATE] and had diagnoses including dementia, anxiety, end stage renal disease, dependence on renal dialysis, and type 2 diabetes mellitus with diabetic neuropathy. R6's Minimum Data Set (MDS) assessment, dated 3/20/25, had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R6 had moderate cognitive impairment. R6's care plan indicated R6 received hemodialysis three times weekly related to end stage renal disease. R6's care plan and Medication Administration Record (MAR) did not indicate the facility monitored R6 for bruit/thrill daily. In addition, R6's medical record contained only eight dialysis communication entries from 6/22/24 through 2/18/25. (The entries were dated: 2/18/25, 1/30/25, 1/21/25, 7/4/24, 6/29/24, 6/27/24, 6/25/24, and 6/22/24.) On 5/6/25 at 1:30 PM, Surveyor interviewed Licensed Practical Nurse (LPN)- E who confirmed monitoring for bruit/thrill was not on R6's MAR or Treatment Administration Record (TAR). LPN-E indicated bruit/thrill should be monitored each shift. On 5/6/25 at 10:26 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility's policy should be followed along with the physician's orders. On 5/6/25 at 2:15 PM, Surveyor requested R6's aftercare visit instructions related to a fistulagram (an X-ray procedure used to evaluate dialysis access). DON-B provided Surveyor with a radiology pre-procedure note, not the aftercare visit instructions for care of the fistula. On 5/7/25 at 11:15 AM, Surveyor interviewed DON-B who indicated bruit/thrill is managed by the dialysis center. Surveyor requested the last visit sheet from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 11:44 AM, Surveyor interviewed Registered Nurse (RN)-F about communication with the dialysis center. RN-F was not sure what information was sent with R6 but assumed R6's weight and vital signs were sent. RN-F was unsure if the facility received a report from the dialysis center upon R6's return. On 5/7/25 at 12:02 PM, Surveyor interviewed Unit Coordinator (UC)-G who indicated R6 should be sent to each dialysis appointment with an envelope containing a face sheet, appointment sheet, and medication list. UC-G indicated weights and vital signs are not normally sent with residents. UC-G indicated the dialysis center calls or faxes the facility if new orders are given. UC-G indicated appointment sheets are scanned in residents' medical records. On 5/7/25 at 12:20 PM, Surveyor interviewed Dialysis RN (DRN)-H who indicated the facility does not send anything with R6. When Surveyor indicated staff said an envelope with a face sheet, appointment sheet, and medication sheet are sent to each dialysis appointment, DRN-H indicated the dialysis center does not receive that information and they do not have a communication binder for R6. DRN-H indicated if the dialysis center issues new orders, the dialysis center calls or faxes the facility. When Surveyor asked if bruit/thrill should be monitored daily, DRN-H indicated that is the facility's decision, but it should be done daily and especially before and after dialysis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, staff interview, and record review, the facility did not ensure the accurate administration of medication for 1 resident (R) (R13) of 4 residents observed during medication administration During the AM medication pass on 5/5/25, R13 received Senna-Plus instead of Senna. Findings include: The facility's Administrating Medications policy, dated 2001, indicates: .4. Medication are administered in accordance with prescriber orders .10. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. On 5/5/25 at 9:20 AM, Surveyor observed Registered Nurse (RN)-F administer R13's medication. One of the medications administered was Senna-Plus (which is a mixture of sennosides (a stimulant laxative) and docusate sodium (a stool softener)). On 5/6/25 at 8:00 AM, Surveyor reviewed R13's Medication Administration Record (MAR) which indicated R13 should have received Senna 8.6 milligrams (mg) daily for constipation. Surveyor noted RN-F administered Senna-Plus to R13 instead of Senna. On 5/6/25 at 10:26 AM and 11:17 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated medication should be administered per the order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure medications for 8 residents (R) (R13, R30, R26, R46, R14, R263, R20, and R0) in 1 of 2 medication carts were labeled and/or dated appropriately. In addition, the facility did not ensure expired treatment supplies were removed from storage in 1 of 4 medication storage areas and did not ensure medication was stored appropriately. Medication was left unattended on top of the medication cart. A medication storage area contained undated and expired resident and stock medications and medical supplies. A medication cart contained unlabeled, undated, and expired resident and stock medications. Findings include: The facility's Administering Medications policy, dated 2001, indicates: The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. The facility's Medication Labeling and Storage policy, dated 2001, indicates: .3. If the facility has discontinued, outdated, or deteriorated medication or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying the items .4. Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. The facility's Ophthalmic Medications policy, dated 6/2021, indicates: If the manufacturer states a specific expiration date upon opening this date should be used to determine when to discard the eye preparation. If a manufacturer is unable to provide an expiration date once the medication is open, current standards of practice generally recommend discarding the eye drop after 28 days because sterility cannot be guaranteed beyond that point. On [DATE] at 8:43 AM, Surveyor observed License Practical Nurse (LPN)-O during medication administration and noted a Med Pass 2.0 supplement on the medication cart did not contain an open date. LPN-O verified the container of Med Pass should have been dated when opened. On [DATE] at 9:01 AM, Surveyor observed medication on top of a medication cart in the hallway. When Registered Nurse (RN)-F returned to the cart, RN-F stated RN-F supposed Surveyor wrote RN-F up for leaving medications on the cart. Surveyor confirmed with RN-F that medication should not be left unattended on the cart when RN-F is in a resident's room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:20 AM, Surveyor noted R13's Arnuity Ellipta inhaler (commonly used to manage asthma) did not contain an open date. A pharmacy label indicated the inhaler expired 42 days after opening. Surveyor also noted R13's Lantus insulin (a long-acting insulin used to manage blood sugar levels) did not contain an open date. On [DATE] at 8:45 AM, Surveyor observed the medication storage room and noted the following: ~ Twenty BD Vacutainer Luer-Lok access devices with expiration dates of [DATE] ~ Sixteen Cardinal Health lubricating jelly 0.11 ounce (oz) packets with expiration dates of [DATE] ~ One purple vial blood tube with an expiration date of [DATE] ~ Two red top tubes with expiration dates of [DATE] ~ Nine light blue top tubes with expiration dates of [DATE] ~ One Sol-Care Luer Lock safety syringe 3 milliliter/without needle with an expiration date of [DATE] ~ One 22 gauge x 1 inch in BD Insyte Autoguard needle with an expiration date of [DATE] ~ One bottle of zinc 50 milligrams (mg) with an expiration of 4/2025 ~ An open and undated package of DuoNeb vials for R30 ~ Five bottles of Air Power guaifenesin expectorant 200 mg for R26 with expiration dates of [DATE], [DATE], [DATE], [DATE], and [DATE] ~ One bottle of Medline Remedy Phytoplex skin repair cream with an expiration date of 3/2023 ~ One 19 oz container of fiber powder with an expiration date of 4/2025 ~ One female urinary specimen kit with an expiration date of [DATE] ~ One Dri-[NAME] hearing aid dehumidifier with an expiration date of [DATE] On [DATE] at 9:41 AM, Surveyor interviewed LPN-O who verified the above items were expired. On [DATE] at 12:18 PM, Surveyor observed a medication cart and noted the following: ~ An open, unlabeled, and undated Symbicort inhaler for R26 ~ Open and undated bottles of fluticasone prop nasal spray for R46, R14, R13, and R263 ~ A bottle of Artificial Tears for R26 with an open date of [DATE] ~ An open and undated bottle of Artificial Tears for R14 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~ A bottle of Artificial Tears for R13 with an open date of [DATE] ~ A bottle of Bausch and Lomb Muro 128 5% eye drops for R26 with an expiration date of [DATE] ~ An open and undated bottle of Rocklatan eye drops for R14 ~ A bottle of Assure Prism control solution with an expiration date of [DATE] ~ An open and undated bottle of ProSource ~ An open and undated bottle of Deep Sea nasal spray for R14 ~ An open and undated albuterol inhaler for R13 ~ An open and undated package of DuoNebs for R20 with one remaining vial ~ An open and undated package of DuoNebs for R0 with six vials in the bottom of the box and four vials in open foil ~ An open and undated bottle of hydrogen peroxide 3% USP 10 volume On [DATE] at 1:04 PM, Surveyor interviewed LPN-E who verified the above items were unlabeled, undated, and/or expired. On [DATE] at 10:26 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated medications such as eye drops, inhalers, and nebulizer packets should be dated when opened. Regarding eye drop and inhaler expiration dates, DON-B provided Surveyor with expiration sheets. DON-B confirmed expired items should be disposed of. DON-B stated the facility does audits and indicated staff should check dates before use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. R39's medical record indicated R39 had chronic diabetic wounds. On 5/5/25 at 10:40 AM, Surveyor observed 3 staff (2 therapy staff and one CNA) transfer R39 without wearing PPE. R39's room did not contain a sign on or near the door that indicated R39 was on EBP. On 5/6/25 at 8:15 AM, Surveyor noted an EBP sign was on R39's door. On 5/6/26 at 10:26 AM, Surveyor interviewed DON-B who indicated PPE should be worn during high-contact cares such as hygiene, dressing, linen changes, and cares involving open areas and and body fluids for residents who are on EBP. DON-B indicated residents with wounds should be on EBP and confirmed R39 should be on EBP. On 5/6/25 at 1:07 PM, Surveyor observed CNA-R assist R39 to the restroom without PPE. When Surveyor asked CNA-R if PPE was required, CNA-R indicated no because R39 did not have any open wounds. Surveyor then interviewed CNA-T who indicated PPE should be worn if toileting or transferring a resident on EBP. On 5/6/25 at 2:30 PM, Surveyor observed DON-B and Medical Doctor (MD)-S complete wound care for R39. DON-B and MD-S donned gowns and gloves. During the observation, Surveyor noted DON-B and MD-S kneeled on the floor without a barrier. When wound care was finished, Surveyor interviewed DON-B who confirmed there should have been a barrier on the floor. MD-S and DON-B indicated R39's wounds were present upon admission. DON-B confirmed R39 should have been on EBP since R39 was admitted on [DATE]. 3. On 5/5/25 at 8:43 AM, Surveyor observed RN-F administer medication to R25 who was on EBP. R25 complained of pain in the right fifth toe. RN-F removed R25's sock and assessed R25's right fifth toe without gloves or a gown. When RN-F left R25's room, RN-F confirmed R25 was on EBP for a right ankle infection in the hardware. When Surveyor asked if RN-F should have donned gloves and a gown prior to touching R25's right foot, RN-F indicated PPE was only needed when toileting R25 due to something in R25's urine. 4. On 5/5/25 at 9:01 AM, Surveyor observed RN-F attempt to obtain R4's blood pressure with a vitals machine which was not successful. RN-F then attempted to obtain R4's blood pressure with a wrist cuff from the mediation cart which was also not sucsessful. RN-F then obtained a manual cuff and stethoscope from the medication cart and successfully obtained R4's blood pressure. RN-F then put the wrist and manual cuffs and stethoscope back in the medication cart without sanitizing them and did not sanitize the vitals machine. On 5/5/25 at 9:19 AM, Surveyor interviewed RN-F after RN-F finished administering medication to R4 and had moved on to the next resident. When Surveyor asked if the blood pressure cuffs and stethoscope should have been sanitized, RN-F indicated they should have been but did not sanitize them. Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection. This practice had the potential to affect more than 4 of the 59 residents residing in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Seven staff who tested positive for COVID-19 and two staff with gastrointestinal (GI) symptoms returned to work earlier than recommended by the Centers for Disease Control and Prevention (CDC) and/or the Wisconsin Department of Health Services (DHS) whose guidelines the facility followed. R39 had chronic diabetic wounds that were present upon admission and was put not on enhanced barrier precautions (EBP) until 5/6/25. Staff did not did not wear the appropriate PPE during cares and knelt on the floor without a barrier during wound care. R25 was on EBP. Staff did not ensure proper personal protective equipment (PPE) was worn when assessing R25's toe. Staff did not ensure a vitals machine, blood pressure equipment, and a stethoscope were sanitized after use for R4 Findings include: The CDC webpage COVID-19, last updated on 3/18/24, contains an article titled Interim Guidance for Managing Healthcare Personnel (HCP) with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 that indicates: The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work . HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: ~ At least 7 days have passed since symptoms first appear if a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and ~ At least 24 hours have passed since the last fever without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved. Either NAAT (molecular) or antigen testing may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later Per the Wisconsin DHS website, last updated 3/18/25, webpage titled Preventing and Controlling Respiratory Illness Outbreaks in Long-Term Care Facilities and Other Health Care Settings .Long Term Care Facilities are strongly encouraged to maintain and update a line list during an acute respiratory illness (ARI) outbreak to organize case information .DHS recommends facilities continue to share them with public health as part of shared outbreak response . The Wisconsin DHS online booklet Prevention and Control of Acute Gastroenteritis Outbreaks in Wisconsin Long-Term Care Facilities, dated 12/2017, indicates: .A staff illness policy should be developed and implemented, and all employees should be educated about the policy. The policy should clearly outline staff responsibilities for when and how to inform management of illness .and should outline the policy for returning to work (48 hours after signs and symptoms subside) .Staff should exclude themselves from resident care and food service duties at the onset of symptoms, including nausea, vomiting, abdominal pain, and/or diarrhea. Such exclusions shall remain in effect until the employee is asymptomatic and free of diarrhea and vomiting for 48 hours . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Enhanced Barrier Precautions Policy, dated 1/2025, indicates: The purpose of this policy is to reduce the transmission of multidrug-resistant organisms (MDROs) and other infectious agents within the facility by implementing enhanced barrier precautions (EBPs) for residents at increased risk for infection or colonization .Infection control practices requiring the use of persona protective equipment (PPE) during certain high-contact resident care activities, even when standard isolation precautions are not indicated. High-Contact Resident Care Activities: activities involving potential exposure to infectious agents, including dressing, bathing/showering, transferring, providing hygiene (toileting), changing lines, device care or use, and wound care .EBP must be implemented for residents known or suspected to be colonized or infected with MDROs or those at risk for such colonization (e.g., residents with indwelling devices, open wounds, or recent hospitalizations). 2 .Healthcare personnel (HCP) must wear gloves and gowns during high-contact care activities .5 .Place signage outside residents' rooms to indicate the implementation of EBPs and the required PPE for care .7 .High-touch surfaces and equipment in residents' care areas should be cleaned . 1. On 5/6/25 at approximately 9:45 AM, Surveyor reviewed staff infection line lists from December 2024 through May 2025. The line list header titles included: staff name, illness type, illness start date, positive test date, symptoms, unit last worked, COVID retest date (48 hours prior to return), and return to work date. Surveyor noted staff with COVID-19 completed 1 retest prior to returning to work. The December 2025 staff infection line list indicated 7 staff tested positive for COVID-19 and 6 staff returned to work prior to the CDC recommendations: ~ Certified Nursing Assistant (CNA)-I had COVID-19 with a first symptom date of 12/22/24. CNA-I was retested on [DATE] and returned to work on 12/30/24. ~ Registered Nurse (RN)-J had COVID-19 with a first symptom date of 12/20/24. RN-J was retested on [DATE] and returned to work on 12/27/24. ~ CNA-K had COVID-19 with a first symptom date of 12/22/24. CNA-K was retested on [DATE] and returned to work on 12/29/24. ~ CNA-L had COVID-19 with a first symptom date of 12/21/24. CNA-L was retested on [DATE] and returned to work on 12/31/24. ~ CNA-M had COVID-19 with a first symptom date of 12/30/24. CNA-M was retested on [DATE] and returned to work on 1/7/25. ~ CNA-N had COVID-19 with a first symptom date of 12/30/24. CNA-N was retested on [DATE] and returned to work on 1/9/25. The January 2025 staff infection line list indicated 1 staff had GI symptoms of nausea, vomiting, and diarrhea and returned to work prior to DHS recommendations of 48 hours from the last GI symptom: ~ RN-P had GI illness with a first symptom date of 1/15/25 and returned to work on 1/17/25. (The line list did not indicate the date of RN-P's last symptom.) (continued on next page)

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	05/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2025 staff infection line list indicated 1 staff tested positive for COVID-19 and returned to work prior to the CDC recommendations: ~ Hospitality Aide (HA)-Q had COVID-19 with a first symptom date of 3/8/25. HA-Q was retested on [DATE] and returned to work on 3/14/25. The April 2025 staff infection line list indicated 1 staff had GI symptoms of vomiting and returned to work prior to DHS recommendations of 48 hours from the last GI symptom: ~ CNA-R had GI illness with a first symptom date of 4/13/25 and returned to work on 4/16/25. (The line list did not indicated the date of CNA-R's last symptom.) On 5/7/25 at 12:03 PM, Surveyor interviewed Infection Preventionist (IP)-C, Director of Nursing (DON)-B, and Nursing Home Administrator (NHA)-A and reviewed the staff line list concerns. DON-B stated the staff infection line list return-to-work dates were not correct as listed. NHA-A stated the facility's previous IP was still learning the role and left unexpectedly; therefore, the previous IP's documentation was incorrect. DON-B indicated DON-B would provide time clock punches for staff with COVID-19 to verify if the previous IP's documentation was correct for return-to-work dates. When Surveyor asked about the facility's return-to-work policy for staff with GI illness, IP-C indicated staff with GI illness can return to work 48 hours after the last GI symptom. DON-B indicated the facility does not have a GI policy that includes criteria for return to work and stated the facility follows the CDC and WI DHS guidelines. When Surveyor asked where the facility documents staffs' last GI symptom in order to determine when staff should return to work, no response was provided. DON-B indicated DON-B would also provide time clock punches for staff with GI symptoms to determine when they returned since the line list might be incorrect. On 5/7/25 at approximately 2:00 PM, DON-B provided staff time punches and new staff infection line lists for December 2024 through May 2025. The new line lists correlated with the time punches; however, they did not provide the dates of last symptoms. On 5/7/25 at 2:52 PM, Surveyor interviewed DON-B who verified staff with COVID-19 completed one COVID-19 antigen test 48 hours prior to returning to work. The CDC COVID HCP return-to-work guidelines indicated 2 antigen tests should be completed prior to returning to work, if both antigen tests are negative staff can return after day 7 since the start of symptoms but if 1 of the 2 tests is positive, staff cannot return until after day 10. Since the facility did not follow the guidelines for the completion of 2 tests prior to returning to work, staff were not able to return until after day 10.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not implement their antibiotic stewardship program to ensure the accurate use of antibiotics for 3 residents (R) (R19, R122, and R264) of 6 sampled residents. R19 did not meet McGeer's criteria for a urinary tract infection (UTI) but received antibiotic therapy. The physician was not asked if the antibiotic should have been continued when R19 did not meet the criteria for a UTI. R122 did not meet McGeer's criteria for a skin and soft tissue infection (SSTI) but received antibiotic therapy. The physician was not asked if the antibiotic should have been continued when R122 did not meet the criteria for an SSTI. R264 did not meet McGeer's criteria for a respiratory tract infection (RTI) but received antibiotic therapy. The physician was not asked if the antibiotic should have been continued when R264 did not meet the criteria for an RTI. Findings include: The facility's Antibiotic Stewardship policy, revised 12/2016, indicates: .11. When a culture and sensitivity (C&S) is ordered, lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued . The facility's Antibiotic Stewardship-Orders for Antibiotics policy, revised 12/2016, indicates: .3. Appropriate indications for use of antibiotics include: a. criteria met for clinical definition of active infection or suspected sepsis; and b. pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending) . 1. From 5/5/25 to 5/7/25, Surveyor reviewed R19's medical record. R19 was admitted to the facility on [DATE] and had diagnoses including abscess of abdominal wall, anemia, malignant neoplasm of endometrium, methicillin- resistant Staphylococcus aureus (MRSA) infection, and fibromyalgia. R19's Minimum Data Set (MDS) assessment, dated 3/10/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R19 had intact cognition. R19's medical record included McGeer's criteria for a UTI that indicated the date of infection was 12/10/24. The form indicated R19 met the criteria for a UTI without an indwelling catheter. Upon review of R19's culture, it was noted the culture grew 50,000 organisms per milliliter which did not meet McGeer's criteria of more than 100,000 organisms per milliliter. R19 took nitrofurantoin (an antibiotic medication) for 5 days. The facility did not update the physician that R19 did not meet the criteria for infection and antibiotic use. On 5/7/25 at 2:23 PM, Surveyor interviewed Director of Nursing (DON)-B and Infection Preventionist (IP)-C who did not comment when Surveyor asked if R19 met McGeer's infection criteria and if the physician was notified. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. From 5/5/25 to 5725, Surveyor reviewed R122's medical record. R122 was admitted to the facility on [DATE] and had diagnoses including malignant neoplasm of duodenum, bacterial infection, and stage 2 pressure ulcer of the sacral region. R122's MDS assessment, dated 4/30/25, had a BIMS score of 14 out of 15 which indicated R122 had intact cognition. R122's medical record included a McGeer's SSTI criteria form that indicated the date of infection was 5/2/25. The form indicated R122 met the criteria for infection, however, only 2 of 4 required new or increasing signs or symptoms were identified which indicated R122 did not meet infection criteria. Surveyor also noted R122 was not on the May 2025 resident infection line list. R122 received cephalexin (an antibiotic medication) twice daily for 10 days from 5/2/25 to 5/11/25. The facility did not update the physician that R122 did not meet the criteria for infection. On 5/6/25 at 12:05 PM, Surveyor interviewed IP-C who indicated R122 must have been forgotten on the resident infection line list. IP-C agreed R122 did not meet the criteria for infection based on the fact that R122 had only 2 of 4 required new or increasing signs or symptoms. On 5/7/25 at 11:30 AM, DON-B indicated resident infection line lists are not filled out until the end of each month when they are brought to Quality Assurance Performance Improvement (QAPI) meetings and are reviewed. On 5/7/25 at 1:39 PM, IP-C provided Surveyor with a revised McGeer SSTI infection criteria form and indicated R122 did meet McGeer's criteria. Surveyor reviewed the updated McGeer SSTI criteria form and noted R122 met 3 of 4 required criteria but still did not meet all criteria for infection. 3. From 5/5/25 to 5/7/25, Surveyor reviewed R264's medical record. R264 was admitted to the facility on [DATE] and had diagnoses including unspecified injury of head, chronic obstructive pulmonary disease, and atherosclerotic heart disease. R264's MDS assessment, dated 2/19/25, had a BIMS score of 13 out of 15 which indicated R264 had intact cognition. R264's medical record included a McGeer's common cold symptoms or pharyngitis criteria under the RTI topic that did not document any signs or symptoms but contained sinus infection handwritten. The form did not indicate if the criteria for infection was met. R264 was prescribed amoxicillin (an antibiotic medication) for 10 days. R264's physician was not notified that R264 did not have any cold symptoms or signs of pharyngitis and did nor meet the criteria for infection. On 5/7/25 at 2:18 PM, Surveyor interviewed DON-B and IP-C who did not comment when Surveyor asked about R264's use of an antibiotic without signs or symptoms of infection or follow-up with the physician.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on staff interview and record review, the facility did not ensure the Infection Preventionist (IP) completed specialized training in infection prevention and control. This had the potential to affect all 59 residents residing in the facility. IP-C and Director of Nursing (DON)-B shared infection prevention duties for the facility since of March 2025. IP-C did not complete specialized training and DON-B had not begun specialized training. Nursing Home Administrator (NHA)-A indicated a permanent IP was hired and had started infection prevention and control training on 5/5/25. Findings include: Centers for Medicare & Medicaid Services (CMS) Memo QSO-22-19-NH, revised 6/29/22, indicates: In 2016, CMS overhauled the Requirements for Participation for Long-Term Care (LTC) facilities which was implemented in three phases: .Phase 3 (11/28/19) .regulations which require nursing homes to have an Infection Preventionist who has specialized training onsite at least part-time to effectively oversee the facility's infection prevention and control program. The facility did not have an infection prevention and control policy that outlined the facility's infection prevention and control program, provided a description of the Infection Preventionist's training requirements, or identified the number of hours or time needed for infection prevention and control in the facility. On 5/6/25 at 9:32 AM, Surveyor interviewed NHA-A, DON-B, and IP-C who all indicated the previous IP left the facility unexpectedly in March of 2025. A new IP was hired but was on leave until 5/5/25 when the new IP started training. NHA-A indicated the new IP was completing the Centers for Disease Control and Prevention (CDC) IP training this week and wound care training next week. NHA-A indicated IP-C was asked to fill the IP role and complete wound nurse rounds until the new IP completed training. NHA-A indicated IP-C started duties in March of 2025 and worked 1-2 days per week and DON-B assisted with IP duties. IP-C indicated IP-C started the CDC IP training modules but had not completed them. DON-B did not have IP training and was not currently completing IP training. Surveyor was provided with IP-C's progress in the CDC training program which included 24 modules of training. Surveyor noted IP-C completed 10 modules with the last module completed on 3/26/25. On 5/6/25 at approximately 9:45 AM, Surveyor reviewed staff infection line lists from December 2024 through May 2025. Surveyor identified 8 instances where staff returned to work prior to the CDC recommendations for staff with COVID-19 illness. Surveyor identified 2 instances where staff returned to work early after gastrointestinal (GI) illness symptoms of nausea, vomiting and/or diarrhea. (See F880 for further information.) On 5/7/25 at 11:30 AM, Surveyor interviewed NHA-A, DON-B, and IP-C regarding antibiotic therapy concerns for 3 residents. (See F881 for further information.) DON-B indicated the facility does not currently have a trained IP that can train the new IP so there are gaps in the process. On 5/8/25 at approximately 1:30 PM, Surveyor reviewed the Facility Assessment which did not specify the number of hours or time needed for the IP position.