STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525559	A. BUILDING _____ B. WING _____	09/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure notification to the medical provider of a medication error for one of six sampled residents (R) (R2). R2 did not receive ordered bedtime insulin for five consecutive days following admission to the facility. R2's medical provider was not notified and consulted regarding the medication error involving R2. Findings include: 1. During a complaint investigation on 09/15/2020, the surveyor conducted a record review of R2. The surveyor noted R2 had orders for scheduled insulin at bedtime. R2 was diagnosed with [REDACTED]. R2 admitted to facility from acute care hospital on [DATE]. R2's hospital Discharge Summary dated 07/02/2020, contained orders for insulin administration including an order for [REDACTED]. Per R2's Medication Administration Record (MAR), R2 received the scheduled bedtime insulin at bedtime on the day of admission, 07/02/2020. R2's MAR indicated R2 did not receive the scheduled bedtime insulin on 07/03, 04, 05, 06, 07/2020 for a total of five doses. R2's MAR indicated R2 started receiving scheduled doses of bedtime insulin on 07/08/2020. The surveyor interviewed CEO/Nursing Home Administrator (NHA)-A on 09/15/2020 at 8:45 AM. NHA-A reported not being aware of R2 missing scheduled doses of medication. The surveyor interviewed registered nurse (RN)-D , who reported not being aware of a med error regarding R2's insulin. The surveyor and RN-D reviewed R2's MAR and noted the five days that the MAR indicated R2's bedtime insulin was not administered. At 9:50 AM on 09/15/2020, the surveyor interviewed NHA-A. NHA-A reported that R2's bedtime insulin order was transcribed as a one-time order on the day of admission. R2's bedtime insulin was administered on 07/02/2020 and then not administered for the next five days. NHA-A reported that a nurse noted the error and restarted the order for insulin however, did not report the error to anyone else. R2's bedtime insulin was restarted on 07/08/2020. R2's hospital Discharge Summary dated 07/02/2020, had a note dated 07/08/2020 by RN-G , next to the bedtime insulin order that read, not in computer. The order was restarted on 07/08/2020. On 09/15/2020 at 11:00 AM, the surveyor interviewed NHA-A who reported that there was no record of the provider being notified of the medication error involving R2's bedtime insulin when the error was discovered on 07/08/2020, that the error was not reported to facility leadership and not reported to R2's medical provider. NHA-A and NHA in Training-C indicated the medical provider should have been notified of the error. Facility policy titled, Medication Errors and Drug Reactions (not dated), directs staff, All medication errors and drug reactions must be promptly reported to the attending physician.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure that all alleged violations of abuse, neglect, or mistreatment were reported to the State Survey Agency (SA) for 6 Residents (R) (R7, R8, R9, R10, R11, and R12) of 6 sampled residents reviewed during review of the facility's grievance and complaint investigations. Surveyor reviewed the grievance and complaint file and noted concern related to alleged abuse, neglect, and mistreatment of [REDACTED]. Findings: The facility's Policy titled Abuse Policy and Procedure last reviewed on 1/8/2020 states: It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property. The facility's investigation process step 7 states: If the concern/incident constitutes as an allegation of a reportable event the Administrator, CEO, DON or designated Representative will immediately report the alleged incident to the DQA office .This should be reported no later than 2 hours after allegation is made, if events that cause the allegation involve abuse or result in serious bodily injury; if the events that cause the allegation does not involve abuse and does not result in serious bodily injury it should be reported no later than 24 hours to the Administrator of the facility the full in-depth investigation of the incident is to be completed and reported to the DQA office within five working days of the incident. The policy and procedure is in accordance with this Federal Regulation. On 6/16/2020, R7's POA-HC (Power of Attorney for Health Care) contacted the facility and stated R7 complained to POA-HC about being rushed at dinner and told to hurry up which lead to R7 biting R7's inside of cheek and was in pain. This allegation of mistreatments was not reported to the SA. On 7/1/2020, R8 reported to facility that two CNAs (Certified Nursing Assistants) were mistreating R8 and did not provide care in a timely manner. R8 overheard two CNA's making negative statements in the hallway prior to entering R8's room to discuss bathing. R8 felt those statements were directed at R8, but could not be certain. R8 felt one of the CNAs was expressing frustration by sighing when discussing R8's bathing schedule. R8 asked for assistance to the bathroom while the CNAs were in R8's room and was told R8 would need to wait and left the room. After R8 waited 45 minutes for the CNAs to return to the room to assist R8, R8 stated R8 had an accident and couldn't hold it anymore. After the two CNAs returned to R8's room they began cleaning up R8 and their responses lead R8 to feel blamed and embarrassed. This allegation of mistreatment was not reported to the SA. On 4/2/2020, R9 reported to an RN (Registered Nurse) R9 was concerned with the care R9 received the day of admission. The RN providing care to R9 told R9 I don't have time for this and walked out of R9's room after R9 questioned the RN on some medications the RN was about to administer to R9. R9 informed the RN that R9 was not supposed to take most of them. This allegation of abuse was not reported to the SA. On 6/4/2020, R10 reported to a social worker that R10 received wound care from an RN and CNA. The CNA had been rough with the toe wound and appeared insensitive to R10 stating R10 was in pain and continued to touch R10's toe. R10 requested not to have the same CNA provide cares for R10. This allegation of mistreatment was not reported to the SA. On 6/15/2020, R11 reported to a social worker that while R11 was being assisted off the toilet, R11 told the staff that the gait belt was not secure and that the staff member made an inappropriate comment. R11 no longer wants to work with that staff member. This allegation of mistreatment was not reported to the SA. On 4/27/2020, a CNA reported observing a CNA yell at and proceed to be rough with R12 while providing cares to R12. This allegation of mistreatment was not reported to the SA. On 9/15/2020 at 12:30 PM after Surveyor reviewed the facility grievance and complaint file, Surveyor asked NHA in Training-C for documentation supporting that the facility reported the six complaints to the SA. At 12:55 PM, NHA in Training-C stated We don't feel these were reportable to State Agency. The documented complaints involving R7, R8, R9, R10, R11, or R12 were not reported to the State Agency.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure residents (R) were free from significant medication errors for one (R2) of six sampled residents. R2 did not receive ordered bedtime insulin for five consecutive days

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) following admission to the facility. Findings include: During a complaint investigation on 09/15/2020, the surveyor conducted a record review of R2. The surveyor noted R2 had orders for scheduled insulin at bedtime. R2 was diagnosed with [REDACTED]. R2 admitted to facility from acute care hospital on [DATE] after falling at home. R2's hospital Discharge Summary dated 07/02/2020, contained orders for insulin administration including an order for [REDACTED]. Per R2's Medication Administration Record (MAR), R2 received the scheduled bedtime insulin at bedtime on the day of admission, 07/02/2020. R2's MAR indicated R2 did not receive the scheduled bedtime insulin on 07/03, 04, 05, 06, 07/2020 for a total of five doses. R2's MAR indicated R2 started receiving scheduled doses of bedtime insulin on 07/08/2020. The surveyor interviewed CEO/Nursing Home Administrator (NHA)-A on 09/15/2020 at 8:45 AM. NHA-A reported not being aware of R2 missing scheduled doses of medication. The surveyor interviewed registered nurse (RN)-D , who reported not being aware of a med error regarding R2's insulin. The surveyor and RN-D reviewed R2's MAR and noted the five days that the MAR indicated R2's bedtime insulin was not administered. At 9:50 AM on 09/15/2020, the surveyor interviewed NHA-A. NHA-A reported that R2's bedtime insulin order was transcribed as a one-time order on the day of admission. R2's bedtime insulin was administered on 07/02/2020 and then not administered for the next five days. NHA-A reported that a nurse noted the error and restarted the order for insulin however, did not report the error to anyone else. R2's bedtime insulin was restarted on 07/08/2020. A review of R2's medical record indicated R2's AM blood sugar levels (that would be impacted by the bedtime dose of insulin) were as follows: 07/03/2020 - 131 07/04/2020 - 190 07/05/2020 - 242 07/06/2020 - 263 07/07/2029 - 225 Following resumption of R2's bedtime insulin, R2's AM blood sugar levels were documented as follows: 07/09/2020 - 214 07/10/2020 - 110 07/11/2020 - 164 07/12/2020 - 133 07/13/2020 - 191 R2 did not receive scheduled bedtime insulin for five consecutive days following admission to facility. Insulin is vital in the treatment of [REDACTED]. R2's bedtime insulin was restarted on 07/08/2020 per R2's medical record however, the error was not reported to facility leadership and subsequently, the facility did not conduct an investigation into the error and develop corrective measures to prevent future similar medication errors.