STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008949	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE BERNARD ON HOFFMAN	898 E HOFFMAN RD ALLOUEZ, WI 54301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 08/06/2025, with additional information gathered through 08/19/2025, Surveyor investigated 2 complaints at Clarity Care Bernard on Hoffman. Two of 2 complaints were substantiated and 6 new deficiencies were identified. Census 2	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate injuries of an unknown source for 1 of 5 residents reviewed (Resident 1). Resident 1 had 4 occasions of bruising s/he could not explain. The 4 injuries of unknown source were not investigated. Findings Include: On 08/06/2025, at approximately 9:30AM, Surveyor reviewed Resident 1's Individual Service Plan (ISP), dated 07/28/2025. The ISP indicated Resident 1 was nonverbal and non-ambulatory. The ISP stated Resident 1 has body checks to identify bruising twice daily.	N 161		

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

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N 161	Continued From page 1 On 08/06/2025, Surveyor reviewed observation notes in Resident 1's record. Surveyor noted 3 entries by caregivers indicating Resident 1 had bruising. The entries were as follows: 5/28/2025: "There is a bruise on [his/her] left leg. 06/03/2025: " ...I pulled the covers back and noticed bruises on [his/her] right thighs ..." 07/29/2025: "[Resident 1] has bruise on [his/her] left arm on [his/her] wrist." On 08/06/2025, Surveyor reviewed Resident 1's incident reports. Surveyor noted an incident report dated 06/30/2025. The incident report noted Resident 1 had "a golf ball sized bruise to [his/her] right knee. Appears red and swollen." On 08/13/2025, at approximately 9:00AM, Surveyor interviewed Vice President of Operations A (VPO-A). VPOA confirmed there were no investigations for the identified occurrences of bruising.	N 161		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents received medications in the dosage and intervals	N 352		

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N 352	Continued From page 2 prescribed by a practitioner for 1 of 5 residents reviewed (Resident 1). Findings Include: On 07/24/2025, the department received a complaint alleging concerns with residents receiving medication. On 08/06/2025, Surveyor reviewed Resident 1's Individual Service Plan (ISP) dated 07/28/2025, and assessment dated 03/17/2025. The ISP and assessment identified Resident 1 required caregivers to administer his/her medication. On 08/06/2025, Surveyor reviewed Resident 1's July 2025 medication administration record (MAR). The MAR reflected an order dated 07/01/2025, for Lamotrigine (Lamictal) 25mg - take 2 tablets (50mg) three times daily for 14 days, beginning on 07/01/2025. Review of the MAR indicated the first dose was scheduled to be given at 8:00AM, the second dose at 2:00PM and the third dose at 8:00PM. Further review of the MAR revealed the first and third doses started as ordered on 07/01/2025, but the second dose was not started until 07/05/2025. Surveyor noted the second dose was shaded in gray. On 08/14/2025, Surveyor reviewed emergency department and hospital documentation dated 07/28/2025. According to the documentation, Resident 1 was admitted on 07/24/2025 due to dehydration and poor oral intake. On 07/25/2025, during the emergency room and hospital evaluations, the physician noted the following: " ...patient was referred to [physician] on 6/2/2025 with concerns for seizures marked by heavy snoring and foaming at the mouth that came in	N 352		

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N 352	Continued From page 3 spells with each episode lasting about a couple of minutes. At the time patient was started on Lamictal and then scheduled for continuous monitoring EEG that was performed on 07/11/2025. This confirmed activity in the left temporal lobe consistent with epilepsy. There was a question as to whether the patient was getting the Lamictal at home." On 08/19/2025, at approximately 2:30PM, Surveyor interviewed Vice President of Operations A (VPO-A). VPO-A explained if the boxes for administration initials shaded in gray, it typically means after the pharmacy entered the order into the electronic system, someone on the provider's end did not go in to verify and accept it. If the order was not verified and accepted, it would not be available for caregivers' providing administration. Additionally, if the order is not verified and accepted, it stays in the window and is not available on the MAR. VPO-A advised they are spending a lot of time at the home and the nurse is auditing the medication carts to identify any areas of concern that need to be addressed. VPO-A added they are hiring new program leads and will provide management training to ensure stability at the home. On 07/25/2025, the physician at the hospital noted the EEG conducted on 07/11/2025, detected activity in the left temporal lobe consistent with epilepsy and it was questioned if Resident 1 was receiving his/her prescribed Lamictal. Resident 1 was ordered to take 50mg of Lamictal three times daily beginning on 07/01/2025. The medication was not verified and accepted and not accessible on the MAR for administration. Resident 1 was not administered the second dose (2:00PM) until 07/05/2025, 4 days later.	N 352		

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N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not re-assess residents after a change in needs and abilities occurred for 2 of 5 residents reviewed (Resident 2 and Resident 3). Resident 2 was not assessed after drinking a non-consumable substance and spraying a non-consumable substance into his/her mouth. Resident 3 was not assessed after s/he experienced 3 falls resulting in emergency room visits. Findings Include: On 07/25/2025, the department received a complaint alleging concerns about care needs not being provided. RESIDENT 2	N 381		

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N 381	Continued From page 5 On 08/06/2025, Surveyor reviewed Resident 2's Individual Support Plan (ISP), dated 03/04/2025. The ISP stated Resident 2, "functions as a [early stage of development]." The ISP also noted Resident 2 was ambulatory and nonverbal. On 08/06/2025, Surveyor reviewed Resident 2's observation notes. The observation notes on 05/05/2025, identified one instance of Resident 2 drinking hand sanitizer and one instance of spraying perfume into his/her mouth. The observation notes were as follows: 05/05/2025: "[Resident 2] swallowed 75% of hand sanitizer at 6:30am. Staff contacted program lead and lead informed staff to watch [Resident 2] for any side effects." 05/05/2025: "once staff was preparing breakfast [Resident 2] grabbed the perfume on the countertop and sprayed 2 times in [his/her] mouth." Further review of the record showed there was not medical intervention or notification of the physician. According to the Centers of Disease Control and Prevention (CDC), " ...hand sanitizers are safe when used as directed, but they can cause alcohol poisoning if a person swallows more than a couple of mouthfuls ..." Information was obtained on 08/06/2025 at 3:18PM, from https://www.cdc.gov/clean-hands/data-research/facts-stats/hand-sanitizer-facts.html. On 08/13/2025, at approximately 9:00AM, Surveyor interviewed Vice President of	N 381		

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N 381	Continued From page 6 Operations A (VPO-A) and Director of Residential Services B (DRS-B). VPO-A advised s/he would expect the staff to contact poison control and make the physician aware. VPO-A and DRS-B acknowledged Resident 2 had a history of drinking non-consumable liquids. VPO-A confirmed this was not assessed to add possible interventions to the ISP. RESIDENT 3 On 08/06/2025, Surveyor reviewed Resident 3's ISP dated, 02/03/2025. The ISP noted s/he had a diagnosis of epilepsy, required partial assistance with ambulation and was a fall risk. On 08/06/2025, Surveyor reviewed Resident 3's observation notes and managed care organization case notes. The notes showed instances of falls resulting in emergency room visits and injury. The notes were as follows: FALL ON 05/26/2025: Observation Note: 05/26/2025 - "Incident Report (Fall - Unwitnessed) created for [Resident 3]" MCO Case Notes: 05/27/2025: "Per ER (emergency room) report, member had a fall a couple of days ago and now was now [sic] having bilateral hand pain and bruising from that fall." 05/27/2025: "Per facility, patient had a fall a few days before, now has bruising on [his/her] hands and complains of hand pain ..." 05/28/2025: "Xray results reviewed further and shows closed nondisplaced fracture of [his/her]	N 381		

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N 381	Continued From page 7 right thumb and was told to return for splint placement ..." FALL ON 06/18/2025: Observation Note: 06/18/2025 - "Incident Report (ER Visit) created for [Resident 3]" 06/18/2025 - " ...resident was in need of some assistance with getting an object, which caused resident to fall down and hit head. Swelling the [sic] upper eyelid." MCO Case Notes: 06/19/2025: "Member presented to ER after a fall with head injury. CT was negative for fracture and hemorrhage. Discharged ..." 06/20/2025: " ...visited the emergency Room at [Hospital] for fall with hematoma to forehead ..." Note: The 06/19/2025 and 06/20/2025 MCO notes were referencing the fall from 06/18/2025. FALL ON 07/01/2025: MCO Case Notes: 07/03/2025: "Member was seen in the emergency room and was discharged the same day. [Emergency Room] on 07/01/2025." 07/03/2025: "[Resident 3] has a large, black and blue, and yellow bruise above [his/her] right eye which [s/he] and [Division Administrator C] reported was not from the last fall, but from the fall prior ..." 07/06/2025: " ...Member had a fall and hit [his/her] head. Member was sent to the ER for	N 381		

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N 381	Continued From page 8 evaluation. Head CTs and left arm x-ray were negative ..." On 08/13/2025, at approximately 9:00AM, Surveyor interviewed VPO-A and DRS-B. VPO-A reported s/he was not aware of the falls and notifications should have been made so there could be discussion. VPO-A advised they have 2 nurses on staff that could have responded. DRS-B reported Resident 3 has seizures and if falls are occurring it should be addressed. On 05/26/2025, Resident 3 had a fall resulting in and emergency room visit. The fall resulted in a closed fracture of the right thumb. Twenty-four days later, Resident 3 experienced another fall resulting in an emergency room visit. The second fall resulted in a hematoma on the forehead. Fourteen days later, Resident 3 experienced a 3rd fall resulting in an emergency room visit due to hitting his/her head. Resident 3 was not reassessed after the falls to determine interventions to prevent additional falls. Cross Reference Y3244 DHS 50.09(L) Care Cross Reference N0435 DHS 83.38(1)(k) Transportation	N 381		
N 435	83.38(1)(k) Transportation. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Transportation. The CBRF shall provide or arrange for transportation when needed for	N 435		

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N 435	Continued From page 9 medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on interview and record review the provider did not ensure residents were taken to medical appointments to monitor the health of residents for 1 of 5 residents reviewed (Resident 3). Findings Include: RESIDENT 3 On 08/06/2025, Surveyor reviewed Resident 3's Individual Service Plan (ISP) dated, 02/03/2025. The ISP noted Resident 3 had a diagnosis of epilepsy and uses a wheelchair for ambulation. The ISP identified the provider was responsible for transportation. On 08/07/2025, Surveyor interviewed Managed Care Organization Case Manager F (CM-F). CM-F confirmed s/he is the case manager for Resident 3. CM-F reported Resident 3 has missed many medical appointments and it is concerning. CM-F advised Resident 3 has missed neurology, dental, vision appointments and a colon screening. CM-F reported appointments are either not scheduled, rescheduled due to transportation, or scheduled appointments were missed. CM-F advised more information would be found in the registered	N 435		

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N 435	Continued From page 10 nurse case manager's notes. On 08/12/2025, Surveyor reviewed Resident 3's Managed Care Organization registered nurse (RN) case notes. The notes identified the following concerning missed appointments: Wheelchair Fitting Appointment 06/05/2025: "PCP did order PT and a wheelchair through [DME Provider]. 07/29/2025: [S/he] stated [s/he] was supposed to go today at 2pm to have a wheelchair evaluation/fitting done, but there are no staff there that can drive the van ..." Orthopedic Appointment 05/27/2025: "Per ER (emergency room) report, member had a fall a couple of days ago and now was now [sic] having bilateral hand pain and bruising from that fall. 05/28/2025: "Xray results reviewed further and shows closed nondisplaced fracture of [his/her] right thumb and was told to return for splint placement ..." 06/17/2025: " ...the ortho appointment is tomorrow and will let RN know the outcome afterwards." 07/11/2025: "Member now has orthopedic follow up appointment scheduled for July 23." 07/28/2025: [Division Administrator C] ... Ortho [Orthopedic Appointment] follow up was rescheduled for 8/4 (08/04/2025) related to not having transportation."	N 435		

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N 435	Continued From page 11 Other Appointments 06/25/2025: " ...CM (case manager) asked bout Colon Screen appt, orthopedics appt., neurology appt., Vision appt, dental appt. and mammogram appt. [Division Administrator C] stated all need to be scheduled but neurology ..." 07/03/2025: " ...Most follow up for Resident 3 at this time is catching up on medical appts." 08/01/2025: "CM (case manager) completed paper work [sic] related to [Resident 3] missing so many appts. CM completed follow up related to [Resident 3] missing a neurology, vision, mammogram, dental, and PCP (primary care physician) appt. (appointment) to assess possible activation of [his/her] POAHC (power of attorney of healthcare) ..." On 08/13/2025, at approximately 9:00AM, Surveyor interviewed Vice President of Operations A (VPO-A) and Director of Residential Services B (DRS-B). DRS-B reported there were issues with transportation at the home. DRS-B further clarified there was a caregiver that was not trained on how to operate the wheelchair van, and another caregiver did not have a driver's license. DRS-B advised a lead from another home provided wheelchair van training form the home's caregivers. VPO-A and DRS-B confirmed they need to make up a lot of appointments. DRS-B stated they received a list of the needed appointments from the case manager and are currently scheduling. N0381 DHS 83.35(3)(a) Pre-Admission And Ongoing Assessments Y3244 DHS 50.09(L) Care	N 435		

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N 483	83.43(2)(b) Clean, comfortable mattress and pad. Bedroom furnishings. If a resident does not provide the resident ' s own bedroom furnishings, the CBRF shall provide all of the following: A clean, comfortable mattress covered with a mattress pad and when necessary, waterproof covering. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure residents had waterproof covering when necessary for 1 of 5 residents reviewed (Resident 2). On 08/12/2025, the department received an allegation regarding hygiene concerns. Findings Include: On 08/06/2025, Surveyor reviewed Resident 2's Individual Support Plan (ISP), dated 03/04/2025. The ISP stated Resident 2, had a diagnosis of urinary incontinence. The ISP further noted Resident 2 pull up briefs and a disposable chuck pad on his/her bed. On 08/06/2025, at 9:31AM, Surveyor observed Resident 2's bed. Surveyor noted Resident 2's mattress had a large yellowish stain resembling urinary incontinence. Surveyor observed the mattress did not have a waterproof covering to prevent urinary incontinence contamination. On 08/13/2025, at approximately 9:00AM, Surveyor interviewed Vice President of Operations A (VPO-A) and Director of Residential Services B (DRS-B). VPO-A and DRS-B acknowledged the findings and advised Resident	N 483		

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N 483	Continued From page 13 2 was discharging today (08/13/2025).	N 483		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on interviews, record reviews and observations, the provider did not ensure residents received care within in the capacity of the facility for 3 of 5 residents reviewed (Resident 1, Resident 4 and Resident 5). Resident 1's ISP identified weights were to be taken monthly. On 07/24/2025, Resident 1 was admitted to the hospital for dehydration and poor oral intake. Resident 1 was removed from the home and protectively placed. Resident 4's ISP identified s/he was to receive	Y3244		

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showers on Mondays, Wednesdays and Fridays. Resident 4 was only provided bed baths and was found to have concerns with skin integrity including the scalp. Resident 4 was removed from the home and protectively placed.

Resident 5's wheelchair broke in April 2025. The provider loaned Resident 5 an unused wheelchair from the home. The loaned wheelchair's right brake did not work causing Resident 5 to sustain a fall when transferring. The fall resulted in a quarter sized bruise on the right eye

Findings Include:

On 07/25/2025, the department received a complaint alleging concerns with care.

RESIDENT 1

On 08/06/2025, Surveyor reviewed Resident 1's assessment dated, 03/17/2025. The assessment identified the following:

Communication: [Resident 1] can verbalize when [s/he] is happy, [s/he] will laugh, stick [his/her] tongue out & blow spit noises ..."

Eating: " ...Full Assistance ... [Resident 1] can feed [his/herself] simple finger foods with help if placed in [his/her] right hand ... Beverage consistency: regular use a hospital cup with a lid & straw."

Weights: [Resident 1] is now in a wheel chair [sic] and the care team is requesting monthly weight checks. If there is a weight concern this may change."

Oral Health: "[Resident 1] has [his/her] own teeth

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Y3244	Continued From page 15 ... [Resident 1] has a mouth wash that is to be used with a toothette. Staff is to dip the toothette in the mouth wash & swap [sic] it around in [his/her] mouth." WEIGHTS On 08/06/2025, at 10:21AM, Surveyor asked to review Resident 1's weights. Division Administrator D (DA-D) advised s/he searched the electronic record and did not find any documented weights for Resident 1. DA-D reported s/he did not know why the weights were not completed. On 08/13/2025, at approximately 9:00AM, Surveyor interviewed Vice President of Operations A (VPO-A). VPO-A advised a portable wheelchair scale was purchased for Resident 1 to be weighed, but did not know why the weights did not occur. HOSPITAL ADMISSION On 08/07/2025, at 2:22PM, Surveyor interviewed the Guardian for Resident 1, Guardian E. Guardian E reported s/he and other family members visited Resident 1 at the home a few days prior to being sent to the emergency room on 07/24/2025. One of the family members fed Resident 1 some chocolate. Guardian E stated after a couple of pieces of the chocolate, Resident 1 appeared very thirsty. Guardian E asked the caregiver for a cup of water. The caregiver brought a cup of water, approximately 12-16 ounces, and s/he "drank and drank." Resident 1 still appeared thirsty, and Guardian E got another 12-16 ounces and Resident 1 drank it all. Guardian E explained a few days after visiting, Resident 1 was sent to the emergency room.	Y3244		

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Y3244	Continued From page 16 Guardian E stated Resident 1 was admitted to the hospital and given an IV for hydration. Guardian E later received a call from the MCO informing him/her Resident 1 was also found to be malnourished. Guardian E reported Resident 1 stayed in the hospital for 3 days. A couple of days after returning to the home, the MCO case manager informed Guardian E Resident 1 was being sent back to the ER due to looking gray. Guardian E explained during the ER visit Resident 1 was found to be slightly dehydrated but was not admitted. On 08/07/2025, Surveyor reviewed the managed care organization's (MCO) registered nurse's (RN) case management notes. The notes were as follows: 07/28/2024 at 9:24AM: "RN spoke with [Guardian E] via phone. Member is in ICU (intensive care unit) with acute metabolic encephalopathy. Per guardian, this was caused by severe dehydration however RN waiting for MD (medical doctor) confirmation ..." 07/28/2025 at 12:08PM: "RN spoke with [nurse] from hospital. [Nurse] reports member is being discharged today with transport on their way. [Nurse] reported that member was treated for dehydration and malnutrition which are resolved also causing heart rate to return to normal. RN spoke with [Division Administrator C] and had lengthy discussion regarding severity of situation ... RN spoke with [Guardian E] ...[Guardian E] is upset and concerned for his [Family Member's] care ... it is also agreed that IDT (interdisciplinary team) will look for alterative placement ..." 08/01/2025 at 4:35PM: " ...Member's skin appeared gray and discolored. RN reported all of	Y3244		

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Y3244	Continued From page 17 this to [Division Administrator C] and highly suggested for member to be examined by MD." 08/04/2025 at 09:36AM: "RN updated by [Guardian E]. Member was evaluated by ER (emergency room) MD. Per [Guardian E], MD stated that member was slightly dehydrated however ok to return home." 08/05/2025 at 9:36AM: "On 8/04/2025 APS (Adult Protective Services) removed member from home due to unsafe environment. Team and guardian updated." On 08/14/2025, Surveyor reviewed emergency department (ED) and hospital documentation. Resident 1 was taken to the emergency room on 07/24/2025 and was admitted to the hospital. Resident 1 discharged from the hospital on 07/28/2025. The hospital documentation identified the following: History of Present Illness: " ...presenting to the emergency department with altered level of consciousness. Poor appetite for the past several days. Sleeping more frequently ..." Emergency Department (ED) Course - Medical Decision-Making: "patient evaluated and treated in the emergency department for acute metabolic encephalopathy. Hyperchloremic, with a serum chloride of 115. Suggestive of dehydration ... admit the patient for additional testing and treatment ... Patient will be admitted to a medical unit in guarded condition." ED Provider Diagnosis: "Hypernatremia (Primary)" and "Acute metabolic encephalopathy"	Y3244		

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Y3244	Continued From page 18 Physical Examination: "Appearance: [S/he] is underweight ..." Assessment/Plan: "1. ACUTE METABOLIC ENCEPHALOPATHY Suspected to be due to severe dehydration and hypernatremia ..." "2. FAILURE TO THRIVE WITH ACUTE BYPERNATREMIA From poor oral intake of both food and water over the last few days leading to hypernatremia and metabolic encephalopathy." "3. BRADYCARDIA ...Patient will remain on telemetry for close monitoring ..." Cleveland Clinic defined metabolic encephalopathy as follows: "Metabolic encephalopathy is a brain dysfunction caused by an underlying condition. Many possible conditions can cause metabolic encephalopathy, but these mainly target your metabolism. Your metabolism is the chemical process that converts the things you eat and drink into energy. Brain dysfunction can affect your mood, thinking and memory or cause a loss of consciousness (coma) ... Acute metabolic encephalopathy happens due to a lack of vitamins, oxygen or glucose (sugar) within your body." Information was obtained on 08/14/2025 at 3:05PM at: https://my.clevelandclinic.org/health/diseases/metabolic-encephalopathy. Yale Medicine defines hypernatremia as follows: "Hypernatremia is a medical condition characterized by an abnormally high concentration of sodium in the blood, which can result from dehydration, excessive sodium intake, or an underlying medical condition. It can lead to	Y3244		

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various symptoms and complications if not properly managed."

Information obtained on 8/14/2025 at 3:44PM at: https://www.yalemedicine.org/clinical-keywords/hypernatremia.

Mayo Clinic defines bradycardia as follows: "Bradycardia (brad-e-KAHR-dee-uh) is a slow heart rate. The hearts of adults at rest usually beat between 60 and 100 times a minute. If you have bradycardia, your heart beats fewer than 60 times a minute. Bradycardia can be a serious problem if the heart rate is very slow and the heart can't pump enough oxygen-rich blood to the body. If this happens, you may feel dizzy, very tired or weak, and short of breath..."

Information obtained on 08/14/2025 at 4:02PM at: https://www.mayoclinic.org/diseases-conditions/bradycardia/symptoms-causes/syc-20355474

On 08/06/2025, at 10:21AM, Division Administrator D (DA-D) reported after Resident 1's return from the hospital on 07/28/2025, s/he implemented a hydration program for Resident 1.

On 08/06/2025, Surveyor reviewed Resident 1's updated assessment dated, 07/28/2025. The assessment included the addition of the hydration program. The hydration program stated, "Resident 1 also drinks out of a hospital cup with a lid & straw ...Staff will offer [Resident 1] fluids 6 times per day ..."

On 08/06/2025, Surveyor reviewed Resident 1's Care History from 07/31/2025 through 08/06/2025. The care history noted documentation of hydration program occurred from 07/31/2025 through 08/03/2025. Review of

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the care history documented Resident 1 was not offered fluids 6 times per day. The care history noted the following liquid amounts:

07/31/2025 at 9:26PM - 10 ounces (offered once)
08/02/2025 at12:44PM - 10 ounces, 6:41PM - 8 ounces and 8:35PM - 8 ounces (offered 3 times)
08/03/2025 at 2:53PM - 3 ounces (offered once)
Note: APS removed Resident 1 from the home on 08/04/2025.

ORAL CARE

On 08/06/2025, Surveyor reviewed Resident 1's July and August 2025 Medication Administration Record (MAR). The MAR identified Resident 1 required the use of Listerine Antiseptic 20mL in mouth/throat twice daily. The key on the MAR indicated "SNP" was documented on the MAR when the supply is not present. Review of the MAR showed several days when the Listerine was not used due to the "supply not present." The dates were as follows:

07/01/2025 through 07/14/2025
07/16/2025 through 07/24/2025
07/29/2025 through 08/01/2025
08/03/2025

On 08/13/2025, at approximately 9:00AM, Surveyor interviewed Vice President of Operations A (VPO-A) regarding Resident 1's hospital admission, weights and oral care. VOP-A explained s/he has found there were concerns in the home regarding the previous Director of Residential Services and Division Administrator as well as high staffing turnover. VPO-A reported s/he and Director of Residential Services B (DRS-B) are managing the home to ensure there is more follow through with staff training and

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turnover. Additionally, the nurse is auditing the medication carts to identify any areas of concern that need to be addressed. VPO-A added they are hiring new program leads and will provide management training to ensure stability at the home.

Resident 1's assessment dated 03/17/2025, specified s/he is nonverbal, required full assistance with eating, oral care and required monthly weights. On 07/24/2025 through 07/28/2025, Resident 1 was admitted to the hospital due to dehydration and malnutrition. The provider did not have documentation for weights in the months leading up to the hospitalization. Additionally, Resident 1 did not receive assistance with mouthwash for oral hygiene due to the supplies not being present. On 08/05/2025, Resident 1 was removed from the home and protectively placed.

RESIDENT 4

On 08/06/2025, Surveyor reviewed Resident 4's Individual Support Plan (ISP), dated 04/10/2025. The ISP specified the following:

Diagnosis: Quadriplegia and traumatic brain injury locked in syndrome.
Ambulation: Resident 4 uses a wheelchair with specialized strap to keep his/her head up.
Transfers: Resident 4 uses an electric Hoyer lift with assistance of one staff.
Bathing: Resident 4 requires full assistance with bathing. " ...[Resident 4] takes a shower Mon (Monday), Wed (Wednesday), and Fri (Friday) ... Staff will bring [Resident 4's] shower chair into [his/her] room, Staff will then get [Resident 4] undressed in bed, put the hoyer sling under [him/her] and will transfer [him/her] with the hoyer

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lift into [his/her] shower chair. Staff will place a towel or blanket over [him/her] and will wheel [him/her] into the shower room. Staff will wash [Resident 4] head to toe ..."

On 08/06/2025, at approximately 8:00AM, Surveyor interviewed Caregiver G regarding transfers and showers for Resident 4. Caregiver G reported Resident 4 uses a hoyer lift and shower chair with assistance of one staff. Caregiver G explained it was difficult to put Resident 4 in the shower chair with one staff so Resident 4 received bed baths instead of a full shower.

On 08/07/2025, Surveyor interviewed Resident 4's guardian, Guardian H. Guardian H reported Resident 4 was not receiving showers because the caregivers at the home complained the wheelchair was too big. Guardian H advised since caregivers were having difficulty getting Resident 4 to the shower, they began only providing bed baths.

On 08/06/2025, Surveyor reviewed the Managed Care Organizations case management notes for Resident 4. The notes specified the following:

07/22/2024: " ...case manager then went to [Resident 4's] room to see [him/her]. [Resident 4] was half dressed and in bed, but [his/her] hair was greasy, [his/her] scalp was flakey, and [his/her] face looked like it hadn't been cleaned ... When questioned about showers, the staff there stated that [Resident 4] get's [sic] bed baths due to the difficulty maneuvering [his/her] wheelchair out of [his/her] room and into the bathroom ..."

07/25/2025: " ... [Resident 4's] appearance was a little better than the other day ... [his/her] hair

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wasn't as greasy, but there was still a lot of flaking on [his/her] face and scalp. [Resident 4's] fingernails were also very long. Staff also mentioned that it is difficult to get [him/her] into the shower based on the layout of the hallway, home and bathroom ... Case manager explained the concerns about [Resident 4's] showering and fingernails. The regional administrator stated that it's been difficult with limited staff ... [s/he] was going to make sure that [Resident 4's] fingernails were cut and was going to try to make sure that [Resident 4] had a proper shower ..."

07/29/2025: " ...Case manager visited and saw that [Resident 4's] appearance in regards to concerns, has not changed. [His/her] fingernails are still very long, [his/her] hair is still greasy and [his//her] scalp is flaky. Staff said that [s/he] hasn't been out of [his/her] bed in 5 days because there are not enough staff to lift [him/her] into her wheelchair. [S/he] also hasn't had a proper shower in a while, but does continue to get bed baths ..."

08/01/2025: "RN (registered nurse) had face to face visit with member in the home ... Member's hair was excessively grease [sic] and had not been brushed and nails extremely long. Member's face was greasy with bright red blotches all over [his/her] face with some of them being crusty ..."

08/04/2025: "[Resident 4] has been removed from the Clarity Care home Bernard and protectively placed at a skilled nursing home ..."

08/05/2025: "Writer visited member today for a pop in visit at [skilled nursing facility] ... Was informed [Resident 4] was going to be seen by wound care today regarding skin conditions and

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Y3244	Continued From page 24 wound on foot ..." On 08/07/2025, Surveyor reviewed Resident 4's June and July 2025 Task Administration Record (TAR). The June 2025 TAR reflected Resident 4 received bed baths from 06/01/2025 through 06/30/2025 except for 06/14/2025 and 06/19/2025. A full shower was documented on 06/14/2025 and nothing was documented for 06/19/2025. Review of the July 2025 TAR reflected Resident 4 received bed baths from 07/01/2025 through 07/31/2025, except 07/12/2025 and 07/25/2025. There was nothing documented for 07/12/2025 and only "lotion applied" was documented on 07/25/2025. On 08/13/2025, at approximately 9:00AM, Surveyor interviewed VPO-A and DRS-B. VPO-A advised Resident 4 was admitted while the former Division Administrator was overseeing the home. VPO-A explained the complication getting Resident 4 into the shower was because of the setup of the home. VPO-A reported the home has two bathrooms. One of the two bathrooms had a roll-in shower. The roll-in shower was located on side of the house opposite of Resident 4's room. Additionally, turning the corners in the hallways with the shower chair made it difficult for caregivers to navigate. VPO-A reported they tried to swap rooms with another resident so Resident 4's path was more direct, but that resident's guardian declined. VPO-A further explained they were trying to make it work at the home until other arrangements could be made. VPO-A stated they purchased a portable tub so Resident 4's hair and scalp could be washed and there was an expectation of a full shower at least once a week. VPO-A advised Resident 4 discharged	Y3244		

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before the portable tub could be delivered.

Resident 4's ISP noted s/he was non-ambulatory and required assistance with showers. The ISP specified Resident 4 was to receive full showers on Mondays, Wednesdays and Fridays with full assistance. Interviews with caregivers, VPO-A and DRS-B revealed the set up of the house in relation to Resident 4's room posed barriers to meet Resident 4's showering needs. In place of full showers, Resident 4 received bed baths for 57 of 61 days resulting in greasy hair and flakey skin and scalp. Resident 4 was removed from the home and protectively placed in a skilled nursing facility.

RESIDENT 5

On 08/06/2025, Surveyor reviewed Resident 5's ISP dated 02/03/2025. The ISP noted Resident 5 used a wheelchair and was identified as a fall risk.

On 08/06/2025, at 8:43AM, Surveyor interviewed Resident 5. Resident 5 informed Surveyor his/her wheelchair has been broken for a long time, and s/he is borrowing one from the home. Resident 5 advised the right brake on the borrowed chair needs fixed. Resident 5 reported s/he experienced a fall when transferring because the brake did not work. Resident 5 stated, "the wheelchair rolled away." Resident 5 clarified, the chair ended up too far away and s/he missed it. Resident 5 reported s/he hit [his/her] head causing a large bump above his/her eye and s/he had to go to the emergency room. Resident 5 further stated s/he does not understand why his/her original wheelchair is not fixed.

On 08/06/2025, at 8:43AM, Surveyor observed

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CLARITY CARE BERNARD ON HOFFMAN	898 E HOFFMAN RD ALLOUEZ, WI 54301

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Y3244	Continued From page 26	Y3244		

the wheelchair Resident 5 was using. Resident 5 put the wheelchair in the locked position on both wheels and was still able to roll the chair back and forth. Surveyor observed right brake touched the wheel, but did stop the wheel from moving.

On 08/06/2025, Surveyor reviewed Resident 5's incident report dated 07/21/2025. The incident noted Resident 5 experienced an unwitnessed fall. The incident report identified Resident 5 was transferring from the bed to his/her wheelchair. The wheelchair was too far away, and Resident 5 missed the wheelchair. The incident report noted Resident 5 had a quarter sized bruise by the right eye and was taken to the emergency room.

On 08/07/2025, Surveyor interviewed Guardian J, Resident 5's guardian. Guardian J confirmed Resident 5's chair was broken and stated, "[Resident 5's] wheelchair has been broken for months." Guardian J advised the facility had an extra wheelchair in the garage and that is what Resident 5 has been using. Guardian J reported Resident 5 had a fall while transferring because, "only one brake works." Guardian J expressed it is important for Resident 5 to have a "heavy-duty" wheelchair because s/he is very shaky and presses down firmly on the arms of the chair when transferring for stability. Guardian J explained if the brakes do not work s/he could have another fall.

On 08/14/2025, at 1:31PM, Surveyor interviewed Managed Care Organization Case Manager I. Case Manager I stated in April 2025, the manager of the home informed him/her Resident 5's wheelchair was broken. Case Manager I reported the durable medical equipment (DME) provider's contact information was given to the manager at that time. Case Manager I explained s/he tried to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0008949	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE BERNARD ON HOFFMAN	898 E HOFFMAN RD ALLOUEZ, WI 54301

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Y3244	Continued From page 27 follow up on the wheelchair concern for months with no response. In the interim, the facility provided Resident 5 with a loaner chair from the home. Case Manager I confirmed s/he recently observed Resident 5's personal wheelchair was still broken. Case Manager I advised s/he has gotten the MCO's rehabilitation specialist involved to help find a solution. Case Manager I confirmed s/he was aware Resident 5 has experienced a fall since using the other wheelchair. On 08/18/2025 2:42PM, Surveyor received correspondence from DRS-B stating a virtual meeting was set up with the DME provider for 08/18/2025 at 3:15PM. Resident 5's ISP identified s/he was non-ambulatory and was at risk for falls. Resident 5's personal wheelchair broke, and s/he was provided with an unused wheelchair from the home. The wheelchair's right brake was not functioning appropriately as it did not prevent the wheel from moving when in the locked position. Resident 5 experienced a fall resulting in a quarter sized bruise on the right eye. N0381 DHS 83.35(3)(a) Pre-Admission And Ongoing Assessments N0431 DHS 83.38(1)(g) Health Monitoring	Y3244		