STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410083	A. BUILDING: _____ B. WING _____	C 09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE THIRD STREET HOUSE	225 THIRD ST NEENAH, WI 54956

(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 09/30/2024, Surveyor conducted a complaint investigation and an abbreviated survey at Clarity Care Third Street, a CBRF in Neenah. Two deficiencies were identified. The complaint was substantiated. Census: 5	N 000		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an individual service plan (ISP) was developed within 30 days of admission for 1 of 1 resident reviewed. Resident 1 admitted to the provider's facility on 08/01/2024 and did not have an ISP developed following admission as of 09/30/2024. The ISP on file did not include details regarding the care of Resident 1's colostomy.	N 386		

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

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N 386	Continued From page 1 Findings include: On 09/30/2024 at approximately 8:30 a.m., Surveyor observed Resident 1 in the facility's kitchen with a colostomy bag exposed. Surveyor observed a black binder clip, typically used for paper, was holding the colostomy bag closed. On 09/30/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 08/01/2024 with diagnoses including mild intellectual disability and psychiatric disorder. Resident 1's record included an individual service plan (ISP), dated 05/28/2024, greater than 2 months prior to his/her admission to the provider's facility. Surveyor noted the ISP stated Resident 1 required full assistance with colostomy cares, but did not include further details regarding colostomy changes, such as when or how often the colostomy bag was supposed to be changed. On 09/30/2024 at approximately 10:10 a.m., Surveyor asked Division Area Administrator B if Resident 1 had an ISP developed following his/her admission to the facility. Division Area Administrator B asked House Manager A if s/he had completed a new ISP for Resident 1 and/or if s/he had scheduled a care conference with Resident 1's care team. House Manager A replied, "No, but I will email them right now." Division Area Administrator B then explained to Surveyor that Resident 1 had transferred from an affiliated adult family home, so the ISP from the previous placement was being used. On 09/30/2024 at approximately 10:10 a.m., Surveyor interviewed House Manager A and	N 386		

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N 386	Continued From page 2 asked how caregivers were supposed to know how to care for Resident 1's colostomy bag, such as when to change the colostomy bag. House Manager A explained that s/he changed Resident 1's colostomy bag on Mondays and Fridays so other caregivers were only supposed to change the bag as needed. Surveyor asked if the provider had documentation regarding the care of Resident 1's colostomy. House Manager A replied, "No. It's all just verbal." Cross Reference: N0425 DHS 83.38(1)(a) Personal Care	N 386		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure 1 of 1 resident reviewed received all needed personal cares.	N 425		

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N 425	Continued From page 3 Resident 1 did not receive proper care of his/her colostomy bag. Findings include: On 09/30/2024, Surveyor conducted a complaint allegation alleging the provider did not properly care for a resident's colostomy. On 09/30/2024 at approximately 8:30 a.m., Surveyor observed Resident 1 in the facility's kitchen with his/her colostomy bag exposed. Surveyor observed a black binder clip, typically used for paper, was holding the colostomy bag closed. On 09/30/2024 at approximately 10:00 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 08/01/2024 with diagnoses including mild intellectual disability and psychiatric disorder. Resident 1's record included an individual service plan (ISP), dated 05/28/2024, that stated Resident 1 required full assistance with his/her colostomy cares. The record included progress notes that documented the following: - 08/07/2024: Resident 1 showed staff his/her wafer was falling off. Caregiver replaced the wafer. Resident 1 stated his/her skin was burning badly. - 08/17/2024: Colostomy bag changed twice today due to bowel movements. First time, Resident 1 had taken the clip off of the colostomy bag so his/her shirt had feces on it. Second time, Resident 1 was sitting in the living room and the clip had been removed so there was feces on the living room floor. - 08/31/2024: Changed Resident 1's bag because it was falling off and was unable to have a seal	N 425		

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N 425	Continued From page 4	N 425		

back in place.
- 09/10/2024: Changed Resident 1's bag today due to the seal having a hole by it.

On 09/30/2024 at approximately 10:10 a.m., Surveyor interviewed House Manager A regarding Resident 1's colostomy cares. Surveyor shared observation that Resident 1's colostomy bag was held closed with a binder clip. House Manager A replied, "Yeah, I saw that. It's an old bag." House Manager A stated Resident 1 admitted to the provider's facility with colostomy supplies, which included bags that required a clip to keep closed. House Manager A stated at some point the 2 clips Resident 1 had admitted with broke or were lost, so the provider used a binder clip or chip clip to keep the colostomy bag closed. Surveyor asked why new clips, intended for the colostomy bag, had not been obtained. House Manager A explained that Resident 1 had a clinic visit on 08/29/2024 and received new colostomy bags that staff were to cut to size for better skin integrity and the bags did not require a clip. House Manager A stated s/he wasn't sure why Resident 1 had an old bag on. House Manager A and Surveyor reviewed the provider's medication and supply closet, which showed the provider had an adequate supply of the colostomy bags ordered on 08/29/2024 that were better for Resident 1's skin integrity and did not require a clip. Surveyor asked how caregivers were supposed to know which supplies to use. House Manager A stated s/he had verbally told caregivers and that s/he was typically the one to change Resident 1's colostomy unless an "as needed" change was required.

On 09/30/2024 at approximately 11:00 a.m., Surveyor and Division Administrator B reviewed Resident 1's "Task Administration Record," which

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N 425	Continued From page 5 indicated Resident 1's colostomy had last been changed on 09/27/2024, indicating Resident 1 had been using a binder clip to keep his/her colostomy bag closed for 3 days. On 09/27/2024 at approximately 11:00 a.m., House Manager A stated s/he was going to change Resident 1's colostomy with a new bag and dispose of all the old bags that did not have a clip to keep closed. House Manager A estimated caregivers had been using a binder clip or chip clip for Resident 1's colostomy bag for approximately 1 week prior to his/her 08/29/2024 appointment and was unsure how often after the 08/29/2024 appointment. Cross Reference: N0386 DHS 83.35(3)(a) Comprehensive Individual Service Plan	N 425		