STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017552	A. BUILDING: _____ B. WING _____	C 02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE WESTERN	825 FOREST AVE FOND DU LAC, WI 54935

(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
M 000	INITIAL COMMENTS On 02/08/2024, with information gathered through 02/20/2024, Surveyor conducted an abbreviated licensure survey and a complaint investigation at Clarity Care Western. The complaint was substantiated. Three deficiencies were identified. Census: 4	M 000		
M 448	88.07(2)(b)5 MONITORING HEALTH Monitoring resident health by observing and documenting changes in each resident's health and referring a resident to health care providers when necessary. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a monitoring program was in place regarding Resident 1's medical appointments. Findings include: On 10/24/2023, the Department received a concern that alleged resident medical appointments are not scheduled. On 02/08/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the home, 05/12/2022, with diagnoses including depressive disorder, anxiety disorder, autistic disorder, attention-deficit hyperactivity disorder, oppositional defiant disorder, and obsessive-compulsive disorder.	M 448		

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

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M 448	Continued From page 1 Resident 1's "Individual Service Plan," dated 09/14/2023, documented: "Medication Management: Medications are self-administered by resident with staff supervision." The ISP did not document any guidelines regarding who was responsible for scheduling his/her medical appointments. Resident 1's "Self-Supervision Evaluation and Waiver Request," dated 05/16/2022, documented: "Medications: Would medications during self-supervision periods be necessary? No; Does the person control his/her medication container(s)? No; Have the facility control the medication container(s)? Yes; Knows proper amount of medication? No" The waiver did not document any guidelines regarding who was responsible for scheduling his/her medical appointments. On 02/12/2024 at 3:09 PM, Surveyor interviewed Care Management Director (CMD) A. CMD A stated Resident 1 was his/her own person but agreed that Resident 1's ISP and Self-Supervision Evaluation did not identify who was responsible for his/her medical appointments. On 02/13/2024, at approximately at 8:15 AM, Surveyor interviewed Resident 1's Family Member (FM) F. FM F stated s/he had expressed concerns to the provider over Resident 1's missed medical appointments. The provider stated it was Resident 1's responsibility. FM F stated s/he had documentation from Resident 1's managed care organization (MCO) Care Manager (CM) C which stated that the provider was responsible for Resident 1's medical	M 448		

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M 448	Continued From page 2	M 448		

appointments and forwarded the following correspondence to Surveyor:
"[RN Care Manager G] emailed [FM F] and [CM C]: Just wanted to provide an update that I was able to talk to [Resident 1's] psych (psychiatrist). Provider [Psychiatrist E] ([s/he] prescribes [his/her] psych (psychotropic) Meds) I was able to explain to [him/her] that the multiple missed appointments were not [his/her] fault that ultimately ended with a discharge of [his/her] services. [Psychiatrist E] is willing to reinstate [Resident 1] and I have scheduled an appointment for [Resident 1] with [his/her] on 3/21/24 at 10AM. I have reached out supportive home care to see if they will be ready at that time to attend the appointment with [him/her]. It is of upmost importance that [s/he] attend this appointment as scheduled. If [s/he] is a no show- they will discharge [him/her] permanently. ..."

On 02/20/2024 at 10:10 AM, Surveyor interviewed Resident 1's managed care organization Care Manager (CM) C. CM C stated that the provider is responsible to ensure resident medical appointments are made, to ensure the resident has transportation, and to ensure the resident attends the appointment. CM C stated there were documented concerns that Resident 1 was missing appointments, which resulted in him/her being dropped by his/her providers. CM C provided surveyor with Resident 1's records which documented:

"12/19/2023 - AFH (adult family home) reports that [Resident 1] had a new patient appointment scheduled with [Doctor D] to establish with [him/her] as new PCP (primary care physician) on 12/14/23 but [Resident 1] missed that appointment. [Resident 1] reports that [s/he] was sleeping and did not want to get up, then states

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that [s/he] just forgot. AFH reports that [Resident 1] also has missed 4 psych appointments that have been scheduled, and current provider [Psychiatrist E] will no longer see due to no shows. AFH reports that they will attempt to find another psych provider so that [Resident 1] can continue his medication refills."

"01/05/2024 - AFH to schedule/arrange an appointment for [Resident 1] to get established with a new psych MD (medical doctor) as [his/her] current provider will no longer see [him/her] due to multiple no call no shows. [Resident 1] had an appointment scheduled to establish with a new PCP provider but he also did not attend that appointment.

"01/08/2024 - ... requests update on medical appointments that need to be scheduled. AFH was to look into alternate psych (psychiatrist) provider as current psych provider is no longer able to provide services due to no call no shows. AFH was also supposed to reschedule appointment for PCP as [Resident 1] also missed that scheduled appointment." ... also attempts to follow up on medical appointments in need of rescheduling/scheduling. [Resident 1]'s psych provider has recently advised that [s/he] will no longer be able to provide psych services to [Resident 1] for multiple no call no shows. AFH to contact other psych providers so that [Resident 1] has continuity of care. AFH to also reschedule appointment to establish with a PCP as [Resident 1] has also missed this appointment. ... provided update to AFH that [mom/father] does not wish to schedule [Resident 1's] medical appointments or accompany [him/her] to appointments, and that the AFH is responsible for this."

"01/10/2024 - AFH has rescheduled [Resident

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M 448	Continued From page 4 1's] PCP appointment with [Doctor D] for May 17th at 1pm to establish with a new PCP. AFH also reports that they have contacted [Psychiatrist E's] office that the provider stated that [Resident 1] can call the office and complete the intake questions over the phone. AFH also reports that they will assist [Resident 1] with this process. Once the intake is complete- an appointment can be scheduled. [MCO] requests that AFH provide [MCO] an update when the intake process is complete and when the appointment date/time is established." "02/07/2024 - [MCO] received return telephone call from [RN (registered nurse)] with [Psychiatrist E's] office. [MCO] explained to [RN] that current AFH did not provide update to [MCO] related to missed appointments and was not advised of current psych provider discontinuing services related to no calls until last month. [RN] reports that the letter was sent out in November 2023 advising of the discontinuation. [MCO] asks if [RN] could talk to [Psychiatrist E] and provide update on new move plan as well as SHC services in place for medical appointments and if she would reconsider keeping [Resident 1] as a patient. [MCO] was advised by the AFH that [Psychiatrist E] would continue to provide refills for [him/her] until [s/he] was able to establish with another provider. [RN] states that [Psychiatrist E] will not prescribe any more medications and that the last refill was the last. Plan/Intervention: [RN] will talk to [Psychiatrist E] tomorrow and inquire if [s/he] is willing to keep [Resident 1] as a patient and will call [MCO] back. ... [RN] spoke to [Psychiatrist E] and explained the situation, and [s/he] is willing to continue to reinstate [Resident 1] as a patient."	M 448		

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M 556	Continued From page 5	M 556		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the right to freedom of choice for 4 of 4 residents in the home. The provider locked the refrigerators, freezers, and cupboards with a lock that required a key, to limit resident access to food. Findings include: On 10/24/2023, the Department received a concern alleging resident food is locked up and resident's do not have access. On 02/08/2024, at approximately 5:15 PM, Surveyor toured the home. Surveyor observed the refrigerator, freezer, and cupboard doors with engaged locks. Surveyor asked Caregiver B to explain why the food was locked up, limiting access to residents. Caregiver B stated Resident 1 would eat all the food, so the food was locked up.	M 556		

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M 556	Continued From page 6 On 02/08/2024, at approximately 5:30 PM, Surveyor observed Resident 1 engage in conversation with Caregiver B. Resident 1 was in the process of packing up his/her room as s/he was moving to an independent apartment the next day. Resident 1 repeated, "I cannot wait to have my own place." On 02/08/2024, at approximately 5:45 PM, Surveyor interviewed Caregiver B. Caregiver B confirmed that Resident 1 was moving to his/her own place and the food was locked up because Caregiver B did not have impulse control over food. On 02/08/2024, Surveyor reviewed Resident 1's record. Resident 1's "Individual Service Plan (ISP)," dated 09/14/2023, documented: "Meal Preparation: Resident requires community to prepare meal." "Eating: Monitor for overeating. Resident requires staff monitoring and/or reminders and cues to complete eating tasks. Member will eat way too much food if not watched. Staff will monitor intake." Resident 1's ISP did not document that resident had restricted access to the refrigerator and freezer. On 02/12/2024, Surveyor reviewed the Department records for a restrictive measure waiver. Surveyor did not locate evidence that the provider submitted a request to lock the home's refrigerator, freezer, and cupboard doors. On 02/12/2024 at 1:46 PM, Surveyor emailed Care Management Director A and asked if the	M 556		

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M 556	Continued From page 7 provider had submitted a restrictive measure waiver. Care Management Director A stated s/he would have the locks removed.	M 556		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the home was a safe environment and that 4 of 4 residents were safeguarded from environmental hazards as toxic chemicals were not securely stored. Findings include: The licensee can serve up to 4 residents within the client groups of physically disabled, advanced aged, and developmentally disabled. On 02/08/2024, at approximately 5:40 PM, Surveyor toured the home and observed the following cleaning compounds unsecure in the kitchen sink vanity:	M 570		

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M 570	Continued From page 8 -23 ounce bottle of dishwasher rinse aid -18 ounce bottle of cooktop cleaner -16 ounce spray can of oven cleaner -19 ounce spray can of oven & grill cleaner -24 ounce bottle of disinfectant toilet bowel cleaner - clinging gel -96 pack container of dishwasher pods - fresh scent -62 pack container of dishwasher pods - fresh scent On 02/12/2024 at 1:46 PM, Surveyor emailed Care Management Director A and explained that the cleaning supplies in the home were not secured. Care Management Director A stated s/he would address the concern with staff.	M 570		