STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017539	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE CARDINAL	1410 CARDINAL LANE GREEN BAY, WI 54313

(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 11/03/2025, Surveyors conducted a verification visit and 2 complaint investigations at Clarity Care Cardinal. On 11/07/2025, the Department received a new complaint which was added to this investigation. Additional information was gathered through 11/17/2025. All 3 complaints were substantiated, and as a result of the survey, 6 deficient practices were identified, including 2 repeat deficient practices. Under statutory provisions, a $200 revisit fee is being assessed for the follow-up licensing visit. Census: 5	{N 000}		
{N 158}	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	{N 158}		

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

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{N 158}	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure an investigation was completed when an allegation of caregiver misconduct was reported. The provider did not recognize the reported information as an allegation of caregiver misconduct and subsequently did not document any investigation procedures completed, did not report the allegation of caregiver misconduct to the Office of Caregiver Quality, did not interview the resident, and did not respond to the allegation with a written summary of the grievance with any findings, conclusions and any actions taken to the resident's legal representative, Power of Attorney (POA) X. This is a repeat deficient practice being cited a third time. See Statement of Deficiency (SOD) XG7Q11, dated 11/04/2024 and SOD XG7Q12, dated 06/09/2025. Findings Include: Allegations of Caregiver Misconduct and Provider Response On 11/03/2025 at 1:00 PM, Surveyor interviewed Division Administrator QQ and Team Lead EE. As a part of the verification visit, Division Administrator QQ and Team lead EE discussed requirements regarding recognizing and responding to an allegation of caregiver misconduct and investigation and reporting requirements. Administrator QQ and Team Lead EE discussed the allegations made during the previous survey regarding a caregiver taking away Resident 3's phone and call light so s/he could not call for help. Administrator QQ and	{N 158}		

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{N 158}	Continued From page 2 Team Lead EE both identified the report made to the provider referenced in SOD XG7Q12 were allegations of caregiver misconduct. Prior to exiting the facility on 11/03/2025, Division Administrator QQ and Team Lead EE stated they were aware of the regulatory requirements and stated they had no questions. On 11/03/2025, Surveyor reviewed Resident 3's record: Resident 3's record noted s/he was admitted to the facility on 03/05/2025 with diagnoses including major depressive disorder, anxiety disorder, insomnia, spastic diplegic cerebral palsy, hallucinations, and suicidal ideations. Resident 3 had a POA (POA X) and his/her Individual Service Plan (ISP) (undated, unsigned, last dated entry 03/10/2025) indicated s/he required full assistance with eating, was a choking risk, needed full assistance with mobility, was a fall risk, needed assistance with positioning, needed full assist with toileting, and transferred with a full body lift with 2 staff assisting. On 11/07/2025 at 1:56 PM, Surveyor interviewed POA X with Resident 3 joining the interview at 2:30 PM. POA X stated Resident 3 had an incident on 11/05/2025 at approximately 12:45 AM that resulted in the resident being sent to the hospital. POA X stated on 11/06/2025 Resident 3 told him/her on 11/05/2025 at 12:45 AM s/he had extensive abdominal pain and called Caregiver HH (who was working in the facility and available to reach via phone) for assistance calling 911. Resident 3 stated to POA X that Caregiver HH did not call 911, minimized the resident's pain by telling him/her that s/he should wait until morning, and then took Resident 3's phone away from	{N 158}		

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{N 158}	Continued From page 3	{N 158}		

him/her and placed it on a table where Resident 3 could not access it. Resident 3 alleged s/he had to use his/her electronic voice recognition virtual assistant (Alexa) to call 911 for help. (When Resident 3 joined the interview at 2:30 PM [s/he] confirmed [POA X's] recollection of when [s/he] reported the allegation to [POA X] on 11/06/2025.) POA X stated on 11/06/2025 s/he reported the allegation of caregiver misconduct to Division Administrator QQ, Regional Administrator GG, Team Lead EE, MCO RN JJ, and MCO Care Manager II. Surveyor reviewed an e-mail sent to Division Administrator QQ, Regional Administrator GG, Team Lead EE, MCO RN JJ, and MCO Care Manager II dated 11/06/2025 at 4:44 PM that noted:

" ... I was informed that [Resident 3's] phone was taken away from [him/her] and that [s/he] called 911 from [his/her] Alexa because [s/he] was in pain."

POA X stated s/he received an e-mailed response on 11/06/2025 from Division Administrator QQ noting the provider looked into who made the 911 call but no response regarding the allegation that Resident 3's phone had been taken away. POA X stated after the provider did not give a response to the allegation MCO Care Manager II reiterated the need for the provider to provide clarification by repeating the question to the provider in a follow-up e-mail dated 11/07/2025 at 7:30 AM:

"Just to confirm [Resident 3] called 911 or did the CBRF staff call? [Resident 3's] phone has never been taken away, correct?"

On 11/07/2025 at 1:57 PM, the provider again responded only to the allegation regarding who

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{N 158}	Continued From page 4 made the 911 call and did not address the allegation that the resident's phone had been taken away by the caregiver. On 11/13/2025 at 12:51 PM, Surveyor interviewed Division Administrator QQ. Division Administrator QQ stated s/he did not recognize POA X's e-mail communication on 11/06/2025, noting Resident 3 had to call 911 for help via his/her electronic virtual assistant device because his/her phone had been taken away by the caregiver, as an allegation of caregiver misconduct. During the interview on 11/03/2025 at 1:00 PM, Division Administrator QQ identified the report within SOD XG7Q12 that a caregiver took away Resident 3's phone, as an allegation of caregiver misconduct. Division Administrator QQ did not offer an explanation for the discrepancy as to why the provider did not recognize the report of a different caregiver taking away Resident 3's phone on 11/05/2025 was also an allegation of caregiver misconduct. Division Administrator QQ stated s/he saw Caregiver HH was at the provider's regional office on 11/07/2025 and stated s/he asked Caregiver HH what happened. Division Administrator QQ stated s/he did not document the interview as s/he did not believe an investigation was required. Division Administrator QQ stated s/he did not interview Resident 3, did not report the allegation of caregiver misconduct to OCQ, and did not provide Resident 3's legal representative POA X with a written summary of any actions taken, findings, or results. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0356 DHS 83.32(3)(l) Rights Of Residents: Least Restrictive Environment	{N 158}		

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N 196	Continued From page 5	N 196		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview, and record review, the licensee did not ensure all the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. Six deficient practices were identified with 2 repeat deficient practices (1 repeat deficient practice cited a third time,) and the licensee did not ensure the Department orders were followed. The provider is licensed to serve up to 5 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, developmentally disabled, emotionally disturbed/ mental illness and/ or traumatic brain injury. Findings include: Special Orders for Disseminating the Statement of Deficiency (SOD) On 08/22/2025, the provider was issued SOD #X67Q12 and was sent a letter of enforcement which included special orders for dissemination of the SOD: " ...SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF	N 196		

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N 196	Continued From page 6 THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Clarity Care Cardinal: ...2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., within 7 days of receipt of this notice, the licensee shall provide each resident's legal representative and case manager (if any) with a copy of Statement of Deficiency XG7Q12 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. Required evidence will be made available to the department representatives upon request." On 11/03/2025 at 10:40 AM, Surveyor interviewed Division Administrator (DA) Q. Surveyor reviewed the special orders within the letter of enforcement and asked for the provider to verify Residents 2, 3, 4, and 5's legal representatives were sent a copy of SOD X67Q12. DA Q was unable to provide verification that the resident's legal representatives had been sent a copy of the SOD as was required by the special orders. DA Q followed up by sending an e-mail on 11/04/2025 at 9:36 AM that contained forwarded e-mail communication between the Managed Care Organizations and the provider. The forward included an e-mail send on 09/08/2025 from MCO Provider Quality Specialist Z to Regional Administrator GG noting, "... Special Order #2 required all legal reps and case managers to be given a copy of the SOD ..." The forwarded e-mails indicated the MCOs had received a copy of SOD X67Q12 and both the MCOs and the provider were aware the resident's legal representatives required a copy to be sent, but	N 196		

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N 196	Continued From page 7 contained no evidence SOD X67Q12 had been sent to the resident's legal representatives. As of 11/05/2025, no additional information was received. On 11/06/2025 at 4:30 PM, Surveyor interviewed Resident 3's legal representative, Power of Attorney (POA) X. POA X stated SOD X67Q12 had not been sent to him/her. Special Orders for Caregiver Misconduct Training On 08/22/2025, the provider received a letter of enforcement with special orders including: "SPECIAL ORDERS Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Clarity Care Cardinal: 1 ... At a minimum, the licensee's corrective measures will include the development (or revision) of written procedures and staff training to address: ...Caregiver Misconduct: - A written procedure to address recognizing, investigating, documenting, and reporting allegations of abuse, neglect, misappropriation of property, and injuries of unknown origin. The procedure will address requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code chs. DHS 13 and 83. The procedure will incorporate steps to ensure that residents are protected while a determination on the matter of caregiver misconduct is pending during an investigation ... Training will be documented in personnel records and will include the date/duration of training, the signature/qualifications of the instructor, and an outline of course content ..."	N 196		

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N 196	Continued From page 8 On 11/03/2025, Surveyor conducted a verification visit and interviewed Division Administrator QQ at 10:30 AM. Surveyor requested the provider provide verification the provider reviewed and/or updated their policy on caregiver misconduct and provided retraining of caregiver misconduct to their staff. Division Administrator QQ stated s/he reached out to Human Resources (HR) H and no additional training had been provided to the staff regarding caregiver misconduct. During a meeting on 11/04/2025 at 1:00 PM, HR H stated the provider did not understand the enforcement letter special orders. HR H confirmed the provider did not reach out to the Department to clarify the special orders. HR H stated no training on caregiver misconduct was completed after the enforcement orders were received because the provider did not understand the orders included providing retraining to their staff. HR H stated they believed the initial misconduct training caregivers received during orientation or annual continuing education was sufficient. After review of enforcement compliance process, HR H acknowledged had the standard orientation or annual caregiver misconduct training been determined as sufficient, there would not have been an enforcement special order. The provider did not recognize the orientation and annual training had not been effective as evidenced by the repeat violations of investigation of caregiver misconduct and as a result the special orders were specified to ensure staff retraining would occur. As a result of not being in compliance with the laws governing a CBRF, 6 deficient practices were identified including 2 repeat deficient practices (1 repeat deficient practice cited a third	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 9 time,) and all containing cross references: N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect Based on record review and interview, the provider did not ensure an investigation was completed when an allegation of caregiver misconduct was reported. The provider did not recognize the reported information as an allegation of caregiver misconduct and subsequently did not document any investigation procedures completed, did not report the allegation of caregiver misconduct to the Office of Caregiver Quality, did not interview the resident, and did not respond to the allegation with a written summary of the grievance with any findings, conclusions and any actions taken to the resident's legal representative, Power of Attorney (POA) X. This is a repeat deficient practice being cited a third time. See Statement of Deficiency (SOD) XG7Q11, dated 11/04/2024 and SOD XG7Q12, dated 06/09/2025. N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws Based on observation, interview, and record review, the licensee did not ensure all the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. Six deficient practices were identified with 2 repeat violations, one in violation for the third time and the licensee did not ensure the enforcement orders were followed. N0203 DHS 83.14 (2)(h) Posting: License, Deficiencies, Revocations Based on observation, record review, and interview, the provider did not ensure a copy of	N 196		

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N 196	Continued From page 10 Statement of Deficiency (SOD) # X67Q12 (dated 06/09/2025) was posted for 90 days following receipt. N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication Based on observation, record review and interview, the provider did not ensure Resident 3 received all medication prescribed by their physician. Resident 3 missed 4 doses of 20 doses of antibiotic medication prescribed for a urinary tract infection. This is a repeat deficient practice. See Statement of Deficiency (SOD) XG7Q12, dated 06/09/2025. N0356 DHS 83.32(3)(l) Rights Of Residents: Least Restrictive Environment Based on observation, record review, and interview, the provider did not ensure Resident 3's right to least restrictive environment was upheld. A sign directing the resident when s/he was not to call for assistance during the overnight shift was found in Resident 3's room. N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs Based on observation, record review, and interview, the provider did not ensure adequate staff were present to meet 2 out of 5 residents' needs at all times. Resident 3 and Resident 5 were assessed to require the assistance of 2 staff for transferring while the provider had 1-2 staff working during the day and PM shifts and only 1 staff working overnight. Cross Reference: N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0203 DHS 83.14 (2)(h) Posting: License,	N 196		

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N 196	Continued From page 11 Deficiencies, Revocations N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0356 DHS 83.32(3)(l) Rights Of Residents: Least Restrictive Environment N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs	N 196		
N 203	83.14(2)(h) Posting: license, deficiencies, revocations The licensee shall post the CBRF license, any statement of deficiency, notice of revocation and any other notice of enforcement action in a public area that is visually and physically available. A statement of deficiency shall remain posted for 90 days following receipt. Notices of revocation and other notices of enforcement action shall remain posted until a final determination is made. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a copy of Statement of Deficiency (SOD) # X67Q12 (dated 06/09/2025) was posted for 90 days following receipt. Findings include: On 05/21/2025, a survey was conducted while the facility had a census of 4 residents (Residents 2, 3, 4, and 5.) On 08/22/2025, the provider was issued SOD #X67Q12 and was sent a letter of enforcement which included special orders for dissemination and posting the SOD: " ...SPECIAL ORDERS	N 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 203	Continued From page 12 Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Clarity Care Cardinal: ...POSTING OF NOTICES According to Wis. Admin. Code DHS §§ 83.13(3)(a) and 83.14(2)(h), each facility shall immediately upon receipt post next to its CBRF license, and in a public area that is visually and physically available, any citation/statement of deficiency, notice of revocation, notice of non-renewal, and any other notice of enforcement action. Citations and statements of deficiency shall remain posted for ninety (90) days following receipt ..." On 11/03/2025, (74 days after SOD X67Q12 and the associated enforcement order was issued to the provider,) Surveyor observed SOD X67Q12 was not posted in the facility as was required. On 11/03/2025 at 10:00 AM, Surveyor interviewed Team Lead EE. Team Lead EE stated s/he had been working at the facility for approximately 1 month, had no knowledge of the SOD, and had not seen it posted within the facility. On 11/03/2025 at 10:40 AM, Surveyor interviewed Division Administrator (DA) Q. DA Q looked around the facility and did not find SOD X67Q12 posted. DA Q acknowledged the requirement to have the SOD posted for 90 days was not met and could not state if the SOD had ever been posted, or why the SOD had not been posted. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures	N 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017539	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE CARDINAL	1410 CARDINAL LANE GREEN BAY, WI 54313

(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 203	Continued From page 13 Facility Complies With Laws	N 203		
{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 observation, record review and interview, the provider did not ensure Resident 3 received all medication prescribed by their physician. Resident 3 missed 4 doses of 20 doses of antibiotic medication prescribed for a urinary tract infection. This is a repeat deficient practice. See Statement of Deficiency (SOD) XG7Q12, dated 06/09/2025. Findings Include: On 11/03/2025, Surveyor reviewed Resident 3's medical record which noted Resident 3 had an Activated Power of Attorney for Health Care (POA X), was admitted to the facility on 03/05/2025 and had diagnoses including spastic diplegic cerebral palsy, personal history of urinary tract infections, neuromuscular dysfunction of bladder, carrier of Methicillin Resistant Staphylococcus Aureus (MRSA), and had a suprapubic catheter placed. Resident 3's Individual Service Plan (ISP) indicated Resident 3 needed full assist with toileting including catheter care. Resident 3's Medication Administration Record (MAR)	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017539	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

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{N 352}	Continued From page 14 indicated that Resident 3 started taking Bactrim DS 800/160mg 1 tablet twice daily for 10 days for a total of 20 doses starting on 10/25/2025. The Bactrim DS, an antibiotic, was for treatment of a urinary tract infection (UTI). On 11/03/2025 at 9:12 AM, Surveyor interviewed Resident 3 who stated s/he was given a 30-day notice and had to move because s/he needed too much care because s/he was getting too many UTIs. Resident 3 stated s/he was currently fighting a urinary tract infection and on an antibiotic. Surveyor observed the urinary catheter bag to contain approximately 700 ml of amber colored urine. Resident 3 indicated the overnight staff did not empty the catheter bag this morning. On 11/03/2025 at 9:45 AM, Surveyor interviewed Caregiver FF who stated the catheter bag would typically be emptied at the end of the night shift but could not confirm if the catheter bag had been emptied this morning. Caregiver FF stated a home health nursing service provided catheter changes, irrigation, and assessed the catheter 3 times per week. Caregiver FF stated Resident 3 completed an antibiotic regimen for UTI on 11/03/2025 with the morning (AM) dose. Caregiver FF provided Surveyor Resident 3's medications. Surveyor observed the antibiotic was bubble packed in separate packing while other medications combined into medication pouches for AM and bedtime (HS) doses. The AM medication pouch for 11/03/2025 had been administered and there were no extra medication pouches observed. Caregiver FF pointed to the 11/03/2025 date on the antibiotic bubble pack and stated 11/03/2025 was the last pill of the regimen and had been administered. Surveyor observed the AM dose and HS dose for 11/02/2025, the AM dose for 10/25/2025, and the HS dose for	{N 352}		

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{N 352}	Continued From page 15 10/30/2025 were still in the bubble pack. Caregiver FF was not certain why the doses were in the bubble pack and stated the Team Lead (TL) EE would know. On 11/03/2025 at 10:15 AM, Surveyor interviewed TL EE who stated s/he was not aware the 2 doses on 11/02/2025 were not administered. TL EE stated the dose on 10/25/2025 was not administered because the dose arrived after the time of administration. TL EE stated s/he was aware the dose on 10/30/2025 was not administered. TL EE stated s/he called the pharmacy about not administering the dose on 10/25/2025 and was told to continue doses as scheduled. TL EE stated Resident 3's physician was not aware 4 doses of antibiotic were not administered to Resident 3. TL EE stated s/he was going to call and update Resident 3's physician on 11/03/2025 that Resident 3 did not take 4 of the 20 doses of antibiotic ordered. TL EE stated s/he understood risk of further development of MRSA concerns by not ensuring all doses were administered and the physician not being alerted that not all of the ordered doses were administered. On 11/06/2025 at 4:30 PM, Surveyor interviewed POA X who stated Resident 3 had a history of UTIs and one UTI was so bad that Resident 3 became nonverbal and ended up on hospice. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws	{N 352}		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env	N 356		

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N 356	Continued From page 16 In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure Resident 3's right to least restrictive environment was upheld. A sign directing the resident when s/he was not to call for assistance during the overnight shift was found in Resident 3's room. The provider is licensed to serve up to 5 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, developmentally disabled, emotionally disturbed/ mental illness and/ or traumatic brain injury. Findings include: On 11/03/2025, Surveyor reviewed Resident 3's records: Resident 3's record noted s/he was admitted to the facility on 03/05/2025 with diagnoses including major depressive disorder, anxiety disorder, insomnia, spastic diplegic cerebral palsy, hallucinations, and suicidal ideations. Resident 3 had an Activated Power of Attorney for Health Care (POA) X and his/her Individual Service Plan (ISP) (undated, unsigned, last dated entry 03/10/2025) indicated s/he required full assistance with eating, was a choking risk,	N 356		

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N 356	Continued From page 17 needed full assistance with mobility, was a fall risk, needed assistance with positioning, needed full assist with toileting, and transferred with a full body lift with 2 staff assisting. During a previous survey (SOD X67Q12, dated 06/09/2025) it was discovered Resident 3's rights were violated when a caregiver took away his/her call light and phone overnight so the resident could not ask for assistance. Resident 3 was already prescribed nightly medication for general anxiety disorder, and the survey uncovered exacerbation of the resident's anxiety due to the caregiver's misconduct and the mental and emotional effect the neglect had on Resident 3's sense of security and trust that s/he could receive assistance when needed during the night. On 11/03/2025 at 11:30 AM, Surveyor interviewed Team Lead EE. Team Lead EE stated the facility was usually staffed with 1-2 caregivers from 6:00 AM through 9:00 PM and then with 1 caregiver from 9:00 PM to 6:00 AM. Team Lead EE stated Resident 3 called the house phone or used his/her voice to call out when s/he needed caregiver assistance. On 11/03/2025 at 9:12 AM, Surveyor interviewed Resident 3 who stated s/he was given a 30-day notice and had to move because s/he needed too much care because s/he was getting too many urinary tract infections (UTI). Resident 3 stated staff told him/her that s/he called too often for assistance, especially at night. Resident 3 stated s/he did not use a call light because it went around his/her neck and felt like it was choking him/her. Resident 3 indicated to a sign on the wall next to door that posted expectations for when Resident 3 was allowed to call for assistance during the overnight shift.	N 356		

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CLARITY CARE CARDINAL	1410 CARDINAL LANE GREEN BAY, WI 54313

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N 356	Continued From page 18 Resident 3 was interviewed again at 12:30 PM. After discussing receiving a 30-day involuntary discharge notice, Resident 3 became emotional and tearful when discussing how s/he was told s/he is "too much work to take care of" and calls too frequently at night. On 11/03/2025 at 9:15 AM, Surveyor observed a sign in Resident 3's room that indicated continued restrictions were being placed on Resident 3's rights: "WHEN TO CALL BETWEEN 11:00 PM- 5:00 AM Call Only for an Emergency: You are hurt have fallen or can't move safely in your wheelchair. You have chest pain, trouble breathing, or feel you might pass out. There is a fire, smoke, or power outage that affects safety. Your medical equipment (oxygen, feeding tubes, etc.) has stopped working. You see or hear something that makes you feel unsafe or in danger. Do NOT Call for: Wanting to talk or feeling bored. Asking for the time, TV, or snacks. Minor discomforts that can wait for staff in the morning. Anything that's not an emergency or life threatening ..." On 11/03/2025 at 11:30 AM, Surveyor interviewed Team Lead EE. Team Lead EE stated Resident 3 would frequently call the house phone to get a hold of caregivers at night when s/he needed assistance. Team Lead EE stated Resident 3 would "constantly" be calling and the phone was so loud that the other residents were regularly	N 356		

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N 356	Continued From page 19	N 356		

woken up. Team Lead EE stated this was particularly difficult at night when there was only 1 caregiver present as the only caregiver would then have to tend to all the other resident's needs while Resident 3 had to wait until the caregiver could get to him/her and during that time Resident 3 would keep calling the house phone. Team Lead EE stated due to Resident 3 frequently calling for caregiver assistance at night and waking up other residents, s/he reached out to the Managed Care Organization and they assisted him/her to develop the sign in Resident 3's room.

On 11/03/3035 at 9:45 AM, Surveyor interviewed Caregiver FF. Caregiver FF stated s/he worked both day and overnight shifts and stated s/he told Resident 3 that s/he could call anytime at night when s/he was working. Caregiver FF stated other staff prefer Resident 3 not call because the ringing may wake up other residents or Resident 3 would call only to have staff put a streaming TV service code in a device. Caregiver FF stated only 1 staff worked the overnight shift and that 2 other Residents stayed up until 3:00 or 4:00 AM frequently.

On 11/03/2025 at 1:00 PM, Surveyor interviewed DA Q and Team Lead EE. DA Q confirmed s/he was aware Resident 3 frequently called overnight and that it caused a strain on the 1 caregiver present to meet all the resident needs timely as other resident were frequently awake as well. Team Lead EE and DA Q confirmed sleep staff were not allowed. Team Lead EE showed Surveyor the house phone which was a portable phone and, upon Surveyor observation request, Team Lead EE was able to demonstrate the volume of the portable phone could be turned down to a level that the caregiver could hear but

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	0017539	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

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N 356	Continued From page 20 would not wake other residents. Neither DA Q or Team Lead EE offered an explanation for why the phone's volume would needed to be turned up to the level that would wake other residents. On 11/04/2025 at 1:00 PM, Surveyor conducted an exit interview with Administrator A. While describing reasons s/he believed the current staffing pattern was sufficient, Administrator A referenced Resident 3 not needing assistance at night because Resident 3 did not ask to get up during the overnight shifts. Administrator A acknowledged the Resident's right to be up at anytime and acknowledged the sign in Resident 3's room that was used to discourage the Resident from seeking staff assistance overnight that resulted in Resident 3 believing s/he was not allowed to ask to get up during the overnight shift. Administrator A acknowledged residents had the right to call for assistance at anytime, for whatever they deemed necessary, including asking for a snack, activity, social interaction, to get up from bed, and all needs or wants that were non-emergent. Administrator A acknowledged the sign was not congruent with resident rights under Chapter 83 codes and that the sign placed a rule/ expectation on the resident to not exercise his/her rights. Administrator A acknowledged SOD X67Q12 findings and that the sign was a continuation of restricting Resident 3's rights, which could reasonably cause Resident 3's continued emotional and mental duress. Cross Reference: N0158 DHS 83.12.(2)(a) Caregiver: Investigating Abuse & Neglect N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0396 DHS 83.36(1)(a) Adequate Staff To Meet Resident Needs	N 356		

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N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure adequate staff were present to meet 2 out of 5 residents' needs at all times. Resident 3 and Resident 5 were assessed to require the assistance of 2 staff for transferring while the provider had 1-2 staff working during the day and PM shifts and only 1 staff working overnight. The provider is licensed to serve up to 5 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, developmentally disabled, emotionally disturbed/ mental illness and/ or traumatic brain injury. Findings include: On 11/03/2025, Surveyor reviewed Resident 3 and Resident 5's records: Resident 3's record noted s/he was admitted to the facility on 03/05/2025 with diagnoses including major depressive disorder, anxiety disorder, insomnia, spastic diplegic cerebral palsy, hallucinations, and suicidal ideations. Resident had an Activated Power of Attorney for Health Care (POA) X and his/her Individual Service Plan (ISP) (undated, unsigned, last dated entry 03/10/2025) indicated s/he required full assistance with eating, was a choking risk, needed full assistance with mobility, was a fall	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017539	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE CARDINAL	1410 CARDINAL LANE GREEN BAY, WI 54313

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N 396	Continued From page 22	N 396		

risk, needed assistance with positioning, needed full assist with toileting, and transferred with a full body lift with 2 staff assisting. Surveyor noted Resident 3's ISP contained a discrepancy under "Transferring Mechanical Lift (ADLs Mobility Transferring.)" The "Directions" noted, "[Resident 3] requires a mechanical lift/ Hoyer for all transfers. Hoyer 1 staff assist [Resident 3] is only to be transferred via Hoyer," whereas "Resident's Needs" noted, "[Resident 3] requires a mechanical lift/ Hoyer for all transfers. Hoyer, 2 staff assist."

Resident 5's record noted s/he was admitted on 05/23/2024 with diagnoses including spastic diplegic cerebral palsy. Resident 5 was nonverbal and had an Activated Power of Attorney for Health Care. His/her ISP (undated, unsigned) indicated s/he required total assistance for all activities of daily living, including full body lift transfers with the use of a Hoyer. The ISP noted under "Transferring Mechanical Lift (ADLs' Mobility Transferring.) ... Resident's Needs ...the Hoyer transfers are usually done by one staff ..." indicating the transfers may require more than 1 staff at times. There was no accompanying assessment to determine if a 2nd caregiver was needed at times for Resident 5's safety.

On 11/3/2025 at 9:12 AM, Surveyor interviewed Resident 3 who confirmed s/he required a full body lift with transfers and did not always have 2 staff assist with transferring.

On 11/03/2025 at 9:45 AM, Surveyor interviewed Caregiver FF. Caregiver FF stated Resident 3 required 2 staff to assist with full body lift transfers but stated Resident 3 understood when short staffed only 1 staff assisted with full body lift transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017539	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 396	Continued From page 23 On 11/03/2025 at 11:30 AM Surveyor interviewed Team Lead EE. Team Lead EE stated the facility was usually staffed with 1-2 caregivers from 6:00 AM through 9:00 PM and then with 1 caregiver from 9:00 PM to 6:00 AM. Team Lead EE stated Resident 3 and Resident 5 both had Hoyer lifts that required 1-2 staff assistance for transfers. Team Lead EE stated many of the caregivers transferred the residents using the Hoyer lift by themselves, but that there were some caregivers that required 2 staff members to assist for Resident 3 and Resident 5's safety due to their size and inability to assist with positioning. Team Lead EE stated if there was only 1 caregiver present and they needed assistance for Resident 3 and 5's cares, there was someone on-call that usually could come in. Team Lead EE was unsure about the time it would take for a 2nd caregiver to arrive since the person on call would change. On 11/03/2025 at 11:50 AM, Surveyor interviewed Division Administrator (DA) Q. DA Q confirmed the provider had 1-2 staff present from 6:00 AM-9:00 PM and 1 staff present overnight. DA Q stated many of the caregivers were able to transfer the residents using the Hoyer lifts by themselves and a few required a second person to assist. DA Q stated if there was only 1 staff present who needed assistance and Resident 3 or Resident 5 wanted to transfer, another caregiver could be called in to assist. DA Q could not state how long the resident would have to wait for another caregiver to arrive. Regarding the discrepancy discovered in Resident 3's ISP transferring requirement notations, DA Q stated the "Directions" noting	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017539	A. BUILDING: _____ B. WING _____	R-C 11/17/2025

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CLARITY CARE CARDINAL	1410 CARDINAL LANE GREEN BAY, WI 54313

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N 396	Continued From page 24 Resident 3 required 1 assist for transferring was written upon his/her admission and that since his/her admission the MCO recommended 2 staff assist the resident with transfers for safety. DA Q stated the provider's RN (s/he did not clarify which RN and could not recall when the assessment occurred) reassessed Resident 3 and determined for Resident 3's safety, 2 caregivers were needed to assist the resident with Hoyer transfers and subsequently added the new directive under "Resident's Needs." On 11/06/2025 at 4:30 PM, Surveyor interviewed POA X. POA X stated s/he did not understand why Resident 3 received a 30-day discharge. POA X stated when s/he first received the involuntary discharge notice (dated 08/12/2025) s/he was told by the provider (did not state who) it was because the facility was closing. POA X stated then s/he was told Resident 3 was "too much work" and the provider "did not want to staff 2 people at night." POA X stated Resident 3's needs have not changed since s/he was admitted to the facility 8 months ago on 03/05/2025. The provider was aware Resident 3 was assessed as requiring an assist of 2 for his/her safety during transfers and was aware there were staff who continued to transfer the resident by themselves. The provider was aware 2 out of 5 residents care required 2 staff present for assistance and did not staff to continually meet the resident's needs. Cross Reference: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0356 DHS 83.32(3)(l) Rights Of Residents: Least Restrictive Environment	N 396		