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 10/16/2023

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 10/09/2023, with information gathered through 10/16/2023, Surveyors investigated 2 complaints at Clarity Care Bernard on Hoffman. Two of 2 complaints were substantiated and 12 new deficiencies were identified. One out of 12 deficiencies is a repeat violation. See statement of deficiency (SOD) 8Q4L11 dated 10/18/2022. Census 5	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure they reported police contact to the department within 3 working days. Findings Include: On 08/17/2023, the department received a complaint that alleged there was police contact at the residence. On 10/09/2023 at 8:23AM, Surveyor interviewed	N 164		

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

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 10/16/2023

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 164	Continued From page 1 Care Management Director B (CMD-B) regarding any police contact at the residence. CMD-B confirmed the police were called this summer. CMD-B specified the police were called due to a disagreement between the caregiver and Resident 1's family member. CMD-B confirmed this was not reported to the department. On 10/09/2023 at approximately 2:50PM, Surveyor reviewed email correspondence dated 06/20/2023 at 9:45PM, provided by Division Administrator A (DA-A). The email confirmed police responded to the residence on 06/20/2023 due to an escalated disagreement between Caregiver G and Resident 1's family member.	N 164		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident's legal representative was immediately notified of an incident or injury for Resident 1. Findings Include: On 08/17/2023, the department received a	N 169		

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 10/16/2023

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 169	Continued From page 2	N 169		

complaint that alleged a resident's legal guardian was not notified of an incident that required evaluation by urgent care.

On 10/09/2023, at approximately 1:45PM, Surveyor reviewed an incident report that was created on 09/26/2023 at 7:02AM for Resident 1. The incident report noted at 5:30AM, the caregiver checked on Resident 1 and found him/her on the floor. The incident report documented Resident 1's knees were skinned.

On 10/09/2023 at 3:45PM, Surveyor reviewed the Bellin Health Urgent Care Discharge Summary dated 09/27/2023. The discharge noted the following:

"[Caregiver F] was not the caretaker that was on last night, [s/he] just received report that patient had fallen out of bed this morning and it was recommended [s/he] be evaluated in urgent care. When we spoke with [Guardian E], patient's [family member] [s/he] was not notified of injuries and was unaware that anything happened this morning. [Caregiver F] reports there is swelling to the right index finger, pain when the left wrist is touched, and there is bruising to the bilateral knees ..."

On 10/11/2023 at 11:10AM, Surveyor interviewed Guardian E. Guardian E informed surveyor the provider never notified him/her Resident 1 fell and was seen in urgent care for injuries. Guardian E reported s/he found out when the physician at urgent care called him/her for consent to treat.

On 10/09/2023 at approximately 8:50AM, Division Administrator A confirmed s/he did not notify Guardian E of the incident.

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 10/16/2023

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 346	Continued From page 3	N 346		
N 346	83.32(3)(b) Rights of Residents: Confidentiality In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Confidentiality. Confidentiality of health and personal information and records, and the right to approve or refuse release of that information to any individual outside the CBRF, except when the resident is transferred to another facility or as required by law or third-party payment contracts and except as provided in s.146.82(2) and (3), Stats. The CBRF shall make the record available to the resident or the resident ' s legal representative for review. Copies of the record shall be made available within 30 days, if requested in writing, at a cost no greater than the cost of reproduction. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that 2 out of 4 residents health and personal information were kept secured and confidential for Resident 2 and Resident 3. Findings include: On 10/09/2023, from approximately 7:35AM until 8:30AM, Surveyors observed the following signs containing confidential information posted in a common area: -Sign on kitchen cupboard indicated specifics about Resident 2 and Resident 3's cares. The sign stated, "Get [Resident 2] and [Resident 3] dressed for the day (must have on 2 briefs and ...) Change Resident 2 and Resident 3 every two	N 346		

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 10/16/2023

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 346	Continued From page 4 hours ...." -Sign posted on Resident 1's door, visible from hallway, documented Resident 1's shower days. On 10/09/2023 at approximately 9:30AM, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding the signs containing confidential information. DA-A and CMD-A acknowledged the findings and stated they would ensure the signs were removed.	N 346		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure prompt and adequate treatment appropriate to the resident's needs was obtained for Resident 1. Findings Include: On 10/10/2023 at 1:30PM, Surveyor reviewed Resident 1's individual service plan (ISP) updated on 08/24/2023. The ISP specified the following: Vocation: Resident 1 attends the CP Center from 12:30PM to 3:00PM Monday-Friday Mobility and Transferring: Resident 1 requires staff assistance with hoyer for transfers. Uses a power wheelchair.	N 353		

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 10/16/2023

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 353	Continued From page 5	N 353		

Communication: Resident 1 is non-verbal but utilizes key phrases located on his/her tray or the alphabet to spell out words.

On 10/10/2023, at approximately 2:00PM, Surveyor reviewed Lakeland Care, Incorporated Case Management Notes.
07/24/2023: Contact received from Service Coordinator C (SC-C).
Note: SC-C works at the CP Center where Resident 1 attends Monday-Friday.
"Bump and bruising noted to [Resident 1's] left ankle. Follow up with [Division Administrator D] of Bernard Home ..."
07/31/2023: "Report received from Clarity Care staff indicating that [Resident 1] was complaining of pain to [his/her] left ankle on 7/30/2023."

On 10/09/2023, at approximately 1:40PM, Surveyor reviewed an incident report that was created on 07/30/2023 at 9:30AM for Resident 1. The incident report noted the following:

" ...[Resident 1] was in the living room facing the TV finishing up [his/her] breakfast. [Resident 1] yelled from the living room while staff was in the office reading over ECP tasks and updates. Staff approached and [Resident 1] asked to call [his/her] [family member], while [Resident 1] was spelling out [family member's name], staff noticed that [his/her] left foot was discolored and very swollen compared to the other. Staff got a closer look and asked [Resident 1] if [his/her] foot hurts currently, [Resident 1] nodded yes. Staff asked [Resident 1] to wait while staff grabbed the phone and gloves. When returning staff called [Resident 1's family member] as requested while inspecting [his/her] foot. [Resident 1's] foot appears to have deep bruising apparent by the red/purple discoloration. [Resident 1's] foot is noticeably

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 10/16/2023

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 353	Continued From page 6	N 353		

larger compared to [his/her] other foot and is very sore to the touch as [Resident 1] jumped when staff lightly touched the top. There also appears to be a large blister on the top part of [his/her] foot, yellow in color."

On 10/09/2023 at 1:12PM, Surveyor interviewed SC-C regarding the injury to Resident 1's ankle/foot. SC-C reported on 07/24/2023, Resident 1 was screaming and making vocalizations. SC-C explained Resident 1 is non-verbal, but is a "good speller," and uses a letter board to communicate. SC-C asked Resident 1 what was wrong, and Resident 1 spelled out, "Feet Hurt." Resident 1 indicated it was the left foot. SC-C asked Resident 1 if s/he could remove Resident 1's socks and shoes to observe. Resident 1 agreed. SC-C reported s/he observed the foot area was swollen and there was a golf ball size bruise on the front of the ankle area. The bruise was yellow and blue in color. SC-C stated s/he emailed the care team, guardian, and provider.

On 10/09/2023 at 8:23AM, Surveyor interviewed provider staff, Care Management Director B (CMD-B). CMB-D regarding Resident 1's injured left ankle/foot. CMD-B confirmed they were notified by the CP Center on Monday, 07/24/2023 by email. The information was sent to provider staff, Division Administrator D (DA-D). DA-D stated they would look into it, but CMD-D was never provided any follow up information. The following Friday, 07/28/2023, CMB-B stated DA-D asked CMD-B if s/he saw Resident 1's foot and showed CMD-B a picture. After viewing the picture, CMD-B advised Resident 1 needed to be sent to the emergency room immediately for evaluation. DA-D stated, "ok," then left. CMD-B reported on Sunday, 07/30/2023, Guardian E

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 10/16/2023

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 353	Continued From page 7	N 353		

called and reported Resident 1 had not been taken to the emergency room. CMD-B reported DA-D was terminated at that time. Resident 1 was finally seen at the ER on 07/30/2023 and was diagnosed with a fractured left foot and infection.

On 10/09/2023 at 3:45PM, Surveyor reviewed the Bellin Health Emergency Department After Visit Summary, dated 07/30/2023. The summary documented Resident 1 was treated for a closed fracture of the left foot and cellulitis of the left foot. Resident 1 was prescribed doxycycline hyclate (antibiotic) for the cellulitis and hydrocodone-acetaminophen for pain.

According to the Centers of Disease Control and Prevention (CDC), Cellulitis is a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin. If untreated, it can spread and cause serious health problems. Information was retrieved on 10/09/2023 at 2:53PM at https://www.cdc.gov/groupastrep/diseases-/public/Cellulitis.html#cellitis-causes.

Beginning on 07/24/2023, the CP Center noted Resident 1 was yelling out in pain. SC-C notified the provider by email regarding bruising and swelling to Resident 1's left foot. DA-D was tasked with following up on the concern. By 07/28/2023, no medical interventions were provided, and CMB-B advised DA-D to take Resident 1 to the emergency room for evaluation. According to the incident report dated 07/30/2023, Resident 1 was still complaining of pain to the left ankle/foot. Resident 1's guardian advised Resident 1 still had no medical intervention, which was six days after the initial discovery of the injury. Resident 1 was finally

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 10/16/2023

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 353	Continued From page 8 evaluated by Bellin Emergency Department on 07/30/2023. Resident 1's left foot was fractured and developed cellulitis. Resident 1 experienced pain from the injury from 07/24/2023 until finally receiving medical intervention on 07/30/2023.	N 353		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation and interview the provider did not safeguard residents from environmental hazards to which it is likely the residents will be exposed, as evidenced by the presence of a mold like substance observed behind the kitchen sink along the caulking. Findings include: The provider is licensed as a class CNA (nonambulatory) to provide care for the following resident types: traumatic brain injury, irreversible dementia/Alzheimer's, public funding, developmentally disabled, emotionally disturbed/mental illness, advanced age and physically disabled. This requirement is being cited for a second time. See Statements of Deficiency (SOD) 8Q4L11	N 358		

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 10/16/2023

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 358	Continued From page 9 dated 10/18/2022. On 10/09/2023, from approximately 8:00am, Surveyors observed a mold like substance behind the kitchen sink along the caulking where the counter meets the wall. The mold like substance was black and reddish brown in color and noticeable from a distance. According to the Centers of Disease Control and Prevention (CDC), "Mold can cause many health effects. For some people, mold can cause a stuffy nose, sore throat, coughing or wheezing, burning eyes, or skin rash. People with asthma or who are allergic to mold may have severe reactions. Immune-compromised people and people with chronic lung disease may get infections in their lungs from mold ...Mold will grow where there is moisture, such as around leaks in roofs, windows, or pipes..." Information retrieved on 10/09/2023 at 1:09PM from: https://www.cdc.gov/mold/default.htm. On 10/09/2023 at approximately 9:30AM, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding the mold like substance. DA-A and CMD-A acknowledged the findings and stated they would ensure it was cleaned up.	N 358		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review, interview and	N 388		

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 10/16/2023

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 388	Continued From page 10	N 388		

observation, the provider did not ensure individual service plans (ISP) were implemented and followed as written for Resident 1 and Resident 2.

Findings Include:

On 08/03/2023 and 08/17/2023, the department received complaints related to falls and not ensuring weights were taken.

RESIDENT 1:

On 10/10/2023 at 1:30PM, Surveyor reviewed Resident 1's ISP updated on 08/24/2023. The ISP specified the following:
Diagnosis: Cerebral Palsy Not Otherwise Specified and moderate intellectual disabilities.
Mobility and Transferring - Resident 1 requires assistance with positioning. Resident 1 experienced a fall on 07/31/2023. Resident 1's bed should be lowered, and a mat placed next to it.

On 10/10/2023, at approximately 2:00PM, Surveyor reviewed Lakeland Care, Incorporated Case Management Notes.
07/31/2023: Contact from Clarity Care - "Additional follow up: request made for floor matt/cushion for next to bed."

On 10/09/2023 at 3:45PM, Surveyor reviewed the Bellin Health Urgent Care Discharge Summary dated 09/27/2023. The summary documented the following:
" [Resident 1] presents to urgent care today for evaluation of injuries, specifically bilateral knees, right index finger, left wrist ...Patient ls non-verbal and wheelchair bound due to spastic quadriplegic disorder secondary to Cerebral Palsy. [Caregiver F] reports that today patient was found on the

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 10/16/2023

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 388	Continued From page 11 floor and had fallen out of bed. Bed estimated to be about 12 inches off the floor ... [Caregiver F] reports there is swelling to the right index finger, pain when the left wrist is touched, and there ls bruising to the bilateral knees. The fall this morning was not witnessed. Fall from bed has happened previously. PCP note from 08/07/2023 was reviewed. Patient was seen in follow-up by primary care on this day due to 2 ER visits, 1 being 7/30/2023 for a left foot injury and the second being 07/31/2023 after [s/he] reportedly fell out of bed ...." On 10/09/2023 at 9:01AM, Surveyor interviewed Caregiver F. Caregiver F explained when in bed, Resident 1 should be placed as far away from the bed as possible to prevent him/her from rolling out. Caregiver F reported there was a previous fall that occurred on 07/31/2023. At that time, Division Administrator D advised to lower the bed. Surveyor inquired if there was a mat available to place next to the bed. Caregiver F confirmed there was not a mat and stated, "There was talk about a mat, but it went to the wayside." Resident 1 had a fall on 07/31/2023. The ISP was updated on 08/24/2023 and included there should be a mat beside the bed. The interview with Caregiver F confirmed the provider did not ensure a mat was secured or placed next to the bed to prevent further injuries from subsequent falls. On 10/10/2023 at 1:30PM, Surveyor reviewed Resident 1's ISP updated on 08/24/2023. The ISP specified the following:" [Resident 1] weight should be taken weekly. [His/her] wheelchair weighs 82.21lbs [pounds]. [S/he] has a target weight between 81lbs - 92lbs. [Resident 1's] weight should not fall below 87lbs ..."	N 388		

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 10/16/2023

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 388	Continued From page 12 On 10/11/2023 at 11:10AM, Surveyor interviewed Guardian K. Guardian K expressed concerns about Resident 1's weight. Guardian E reported Resident 1 requires a pureed diet and is non-ambulatory. Guardian E expressed concern the provider was not feeding Resident 1 correctly as s/he lost 10 pounds since being admitted in May 2023. On 10/09/2023 at 3:45PM, Surveyor reviewed the Bellin Health Urgent Care Discharge Summary dated 09/27/2023. The discharge noted the following: "Wt [weight] Readings from Last 3 encounters: 07/31/2023 92lb ... 05/02/2023 89lb ... 01/10/2023 88lb ..." On 10/12/2023 at 8:03PM, Care Management Director B (CMD-B) sent email correspondence to Surveyor that stated, "There are no weights entered into ECP for [Resident 1] as we do not have a wheelchair scale." On 10/12/2023 at 9:12AM, Surveyor received email correspondences from Provider Quality Manager H, the managed care organization, Lakeland Care Inc. The email stated, "Per [sic] the RN [registered nurse] Care Manager, the member weighed 88 pounds prior to moving to Clarity Care-Bernard which, according to a dietician, was a good weight for [him/her]. RN reported when weighed at [New Provider], [s/he] weighed 78 pounds." Weight was obtained after admission to the skilled nursing facility between 09/27/2023 and 09/28/2023. Note: Adult Protective Services assisted	N 388		

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 10/16/2023

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 388	Continued From page 13	N 388		

Resident 1 with finding placement at a skilled nursing facility on 09/26/2023.

Resident 1's ISP stated s/he should be weighed weekly. Resident 1's weight should not fall under 87lbs. documentation provided by Lakeland Care Inc. noted at the time of Resident 1's admission to the skilled nursing facility, his/her weight was 78lbs. The provider did not monitor Resident 1's weight due to not having a wheelchair scale; therefore, were unable to know when s/he was under the documented desired weight.

RESIDENT 2:

On 10/09/2023 at 1:28PM, Surveyor reviewed Resident 2's updated ISP dated 09/06/2023. The ISP specified the following:

Grooming: Resident 2 needs assistance with all grooming needs. Staff should pull Resident 2's hair up every morning so it is out of his/her face. Staff will shave Resident 1's face daily and s/he has an electric shaver.

On 10/09/2023 at approximately 7:45AM, Surveyors observed Resident 2 sitting at the dining room table eating cereal. Resident 2's hair was hanging down covering his/her entire face. Resident 2 looked up, and Surveyors observed Resident 2's chin was noticeably full of hair. The growth was beyond stubble and appeared soft in texture.

On 10/09/2023 at approximately 9:30AM, Surveyors interviewed Caregiver F. Caregiver F identified s/he was a team lead for the residence. Surveyors identified Resident 2's chin appeared to not be shaved for many days as it was grown beyond stubble. Caregiver F stated s/he would

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 10/16/2023

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 388	Continued From page 14 have a talk with the caregivers and ensure Resident 2's chin is shaved daily. On 10/11/2023, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding the concern, and they acknowledged the findings.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the individual service plan (ISP) was updated annually or upon change for Resident 1. Findings Include: On 08/03/2023 and 08/17/2023, the department received complaints that alleged poor care of the residents.	N 389		

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 10/16/2023

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 389	Continued From page 15 On 10/10/2023 at 1:30PM, Surveyor reviewed Resident 1's ISP updated on 08/24/2023. The ISP specified the following: Mobility and Transferring: Resident 1 requires assistance with positioning. The ISP identified Resident 1 only likes to be positioned in one certain way. The ISP further specified positioning should ensure comfort and prevent pressure ulcers. Note: There was no specific information on how Resident 1 should be positioned while in bed. On 10/09/2023 at 9:01AM, Surveyor interviewed Caregiver F. Caregiver F identified s/he is the team lead for the residence. Caregiver F explained how Resident 1 was to be positioned while in bed. Caregiver F stated Resident 1 liked to lie on his/her right side, but also liked to lean a bit forward, so that s/he was on the right but also on his/her stomach. Due to this position, Resident 1 was able to rub his/her knees back and forth on the sheets. Caregiver F reported it could be a possible cause for the abrasions to the knees. On 10/09/2023 at 3:45PM, Surveyor reviewed the Bellin Health Urgent Care Discharge Summary dated 09/27/2023. The summary noted Resident 1 was seen due to falling out of the bed and sustaining injury including, "swelling to the right index finger, pain when the left wrist is touched, and there is bruising to the bilateral knees." The summary further stated, " "The facility manager reports that patient prefers to sleep 'face down" in bed and will 'kick [his/her] legs' which ls [sic] why there are abrasions on [his/her] knees. Also, patient will 'kick [his/her] legs in [his/her] sleep' and 'roll [his/herself] out of the bed" and this is how the bruising on the knees have occurred ...[Resident 1] became quite	N 389		

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 10/16/2023

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 389	Continued From page 16 agitated here in urgent care due to the length of time in the department and even with [his/her] level of agitation there was NO movement of [his/her] legs or even thrashing of [his/her arms]. [S/he] should not be placed in a supine position for sleeping given risk of suffocation and his/her] quadriplegic state ..." On 10/11/2023 at 10:00AM, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding items that were not updated in Resident 1's ISP to provide intervention for injury. The provider acknowledged the findings. Review of the ISP documented Resident 1 requires assistance to be positioned; however, it did not identify anything specific as to how Resident 1 should be safely positioned. During the interview with Caregiver F, it was determined that Resident 1 preferred to sleep on the right side but leaned over towards his/her stomach. This allowed for Resident 1's legs to have direct contact with the bed more of a supine position. Caregiver F identified could be a possible cause for injuries found on the knees. Additionally, the physician from Bellin noted Resident 1 should never be in a supine position due to the risk of suffocation.	N 389		
N 426	83.38(1)(b) Supervision. 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	N 426		

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 10/16/2023

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 426	Continued From page 17 residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review, interview and observation, the provider did not ensure supervision was provided to meet the needs of the residents for Resident 2, Resident 3 and Resident 4. Findings Include: On 08/03/2023 and 08/17/2023, the department received complaints that alleged concerns with quality and consistency of care of all residents. On 10/09/2023 at 7:35AM, Surveyors arrived and were greeted at the door by the overnight caregiver. After entry into the residence, the caregiver left the common area to tend to other residents. Surveyors observed Resident 2, Resident 3 and Resident 4 eating breakfast in the dining room. The observation continued until approximately 8:30AM when Caregiver F arrived. The caregiver on duty was not present for the entirety of the observation. RESIDENT 2: On 10/09/2023 at 1:28PM, Surveyor reviewed Resident 2's ISP updated 09/06/2023. The ISP specified the following: Wandering Risk: "[Resident 2] will wonder off or go out open doors." Chronic Illness: " ...[Resident 2] has seizure s and also has a low thyroid ...."	N 426		

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 10/16/2023

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 426	Continued From page 18	N 426		

Maturation: "It is believed that [Resident 2] functions as a 6 month old 1 ½ year old ..."
Eating: " ..."[S/he] does throw [his/her] food onto the table. However, [s/he] will pick it up with [his/her] hands and eat it ..."

During the observation on 10/09/2023 from 7:35AM until 8:30AM, Surveyor observed Resident 2 to throw his/her breakfast bowl off the table and begin eating bits of cereal off the clothing protector.

RESIDENT 3:

On 10/09/2023 at 1:40PM, Surveyor reviewed Resident 3's ISP updated ISP on 10/09/2023. The ISP specified the following:
Diagnosis Included: Self-Injury, Diabetes and Seizures.
Eating: " ...Maintain a diabetic diet according to doctors [sic] recommendations or orders ...Resident has been identified as a choking risk. Desired Outcomes Noted: "To maintain adequate food/nutrition intake" and "To be free of choking episodes."
Mobility and Transferring: [Resident 3] requires staff monitoring and/or reminders and cues when ambulating ...[Resident 3's] walking can make [him/her] a risk fall [sic]. [S/he] [sic] legs want to give in on [him/her] when [s/he] is walking a lot ...." Desired Outcomes: "To be free of falls."

During the observation on 10/09/2023 from 7:35AM until 8:30AM, Surveyor observed Resident 3 eating Cap'n Crunch Berries. Resident 3 was observed to get up from the table. S/he turned the kitchen faucet to "hot" and proceeded to drink several cups of water. Resident 3 was observed walking around the kitchen.

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 10/16/2023

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 426	Continued From page 19 According to information found at Nutritionvalue.org, "Cereal (Quaker Cap'n Crunch's Crunchberries) contains 139 calories per 35 g serving. This serving contains 1.7 g of fat, 1.6 g of protein and 30 g of carbohydrate. The latter is 15 g sugar and 0.9 g of dietary fiber, the rest is complex carbohydrate ..." Information retrieved on 10/12/2023 at 1:04PM from: https://www.nutritionvalue.org/Cereal_%28Quaker_Cap%27n_Crunch%27s_Crunchberries%29_57119000_nutritional_value.html. RESIDENT 4: On 10/09/2023 at 1:52PM, Surveyor reviewed Resident 4's updated ISP 10/09/2023. The ISP specified the following: Diagnosis: Unspecified Intellectual Disability, anxiety and Cerebral Palsy. Eating: "..requires staff to monitor food consumption ...[Resident 4] has no physician prescribed specialized diet at this time Team members do encourage healthy options as [Resident 4] has a very sweet tooth." Desired Outcome: "To consume adequate proper/nutrition." Mobility and Transferring: Identified as a fall risk - "[Resident 4 is fully ambulatory ...[Resident 4 may need verbal cues to slow down while [s/he] is walking, and may reach out to hold Team Member ...." Desired Outcome: "For [Resident 4] to remain free of further falls." Meal Preparation: "[Clarity Care Team Members will prepare all of [Resident 4's] food. Food needs to be cut into bite size pieces ..." During the observation on 10/09/2023 from 7:35AM until 8:30AM, Surveyor observed	N 426		

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 10/16/2023

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 426	Continued From page 20 Resident 4 eating Oreo Cookies for breakfast. The cookies were whole and not cut into bite sized pieces. Resident 4 was observed to stand up from the table. Resident 4 was hunched over and used the table to balance him/herself and began to walk with a slightly shuffled gait. Resident 4 was wearing socks with no shoes. As Resident 4 made progress, s/he then held onto countertops and walls to maintain balance. On 10/09/2023 at approximately 9:30AM, Surveyors interviewed Caregiver F. Caregiver F identified s/he is a team lead for the residence. Caregiver F stated s/he would have a talk with the caregiver that was on duty as residents should not have been unsupervised. On 10/09/2023 at approximately 9:45AM, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding the lack of supervision by the caregiver on duty. DA-A and CMD-B acknowledged the information.	N 426		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until	N 452		

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 10/16/2023

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 452	Continued From page 21 serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food requiring refrigeration was covered and stored in a sanitary manner. Findings Include: On 10/09/2023 at approximately 8:00AM, Surveyors observed the refrigerator and noted the following items: -Chicken patties were in a bowl and uncovered. -Yogurt was stored in an uncovered bowl. -A package of hot dog franks was cut open and not sealed. -An uncovered pitcher with dark liquid. Contents were frozen. According to the United States Department of Agriculture (USDA), leftover food in the refrigerator should be covered to ensure bacteria is kept out. "Cover leftovers, wrap them in airtight packaging, or seal them in storage containers. These practices help keep bacteria out, retain moisture, and prevent leftovers from picking up odors from other food in the refrigerator. Immediately refrigerate or freeze the wrapped leftovers for rapid cooling." Information obtained from https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/leftov	N 452		

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 10/16/2023

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 452	Continued From page 22 ers-and-food-safety. On 10/09/2023 at approximately 9:30AM, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding the unsanitary storage of food and drinks in the refrigerator. DA-A and CMD-B acknowledged the findings.	N 452		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that the kitchen floor was clean. Findings include: On 10/09/2023, at approximately 7:35AM, Surveyors observed shredded cheese scattered on the bottom interior shelf of the refrigerator and on the kitchen floor. There was also a thick, yellowish, wet substance next to the cheese. Additionally, the bottom of the stove and the kitchen cabinets between the refrigerator and stove were heavily soiled with wet and dried contents. On 10/09/2023 at approximately 9:30AM, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding the observed findings in the kitchen. DA-A and CMD-B acknowledged the findings and stated they would ensure that this was cleaned up and would review the cleaning schedule with staff.	N 491		

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 10/16/2023

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 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds, polishes, insecticides and toxic substances were stored in a secure area. Findings include: The provider is licensed as a class CNA (nonambulatory) to provide care for the following resident types: traumatic brain injury, irreversible dementia/Alzheimer's, public funding, developmentally disabled, emotionally disturbed/mental illness, advanced age and physically disabled. On 08/03/2023, the department received a complaint that chemicals were not stored in a secured area. On 10/09/2023, from approximately 7:35AM until 8:30AM, Surveyors observed 3 residents eating breakfast in the dining room. The caregiver was not present as they were assisting another resident in a bedroom. Surveyors noted the following toxic substances were not stored in a secure area: -Countertop next to the sink: dishwashing liquid and dishwasher detergent -Unlocked and open supply closet - toilet bowl cleaner, Raid insecticide, 3 large bottles of bleach, mopping solution, and Comet. On 10/09/2023 at approximately 9:30AM,	N 499		

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 10/16/2023

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 499	Continued From page 24 Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding the unsecured toxic substances. DA-A and CMD-B acknowledged the findings and stated they would ensure the substances were secured.	N 499		
N 612	83.55(3) Bath and toilet areas: hand drying. Hand drying. All sink areas shall have dispensers for single use paper towels, cloth towel dispensing units that are enclosed for protection against being soiled or electric hand dryers. This requirement does not apply to sink areas located in toilet rooms accessed directly from a resident bedroom. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the sink area in the bathroom had dispensers for single use paper towels. Findings include: On 10/09/2023, from approximately 7:35AM until 8:30AM, Surveyors observed no paper towel dispenser or paper towels in the sink area of the bathroom which is utilized by residents and staff. On 10/09/2023 at approximately 9:30AM, Surveyors interviewed Division Administrator A (DA-A) and Care Management Director B (CMD-B) regarding no paper towel dispenser or paper towels. DA-A and CMD-B acknowledged the findings. CMD-B stated they ordered a paper towel dispenser and would ensure availability of paper towels.	N 612		