STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 01/30/2025, Surveyor conducted 4 complaint investigations, 1 self- report investigation, and a standard survey at Clarity Care Manette. Additional information was collected through 02/18/2025. Two of four complaints were substantiated. Three deficient practices were identified; 2 resulted from the substantiated complaints and 1 from the standard survey. Census: 5	N 000		
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 record review and interview, the provider did not ensure 5 of 5 residents' private health information remained secured against unauthorized access. Additionally, Resident 3 was made aware of Resident 2's medical appointments without	N 346		

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
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 1 Resident 2's permission. Findings include: On 01/30/2025 at 9:50 AM, Surveyor interviewed Caregiver B in the West kitchen/ dining area of the facility which contained the caregivers' desk, computer, and file cabinets. Resident 3 was sitting alongside of the desk directly in front of Caregiver B. Caregiver B stated there were currently 5 residents that resided at the facility (Residents 1, 2, 3, 4, and 5) and typically it would be staffed with 1 caregiver. Caregiver B stated 2 of 5 residents were at a day program while Residents 1, 2 and 3 were at home. Caregiver B stated s/he would call his/her supervisor (Regional Director A) to come in for the survey as s/he had to take all the residents to Resident 2's medical appointment at approximately 10:15 AM. Caregiver B stated Residents 1 and 3 required supervision and therefore they had to come with to Resident 2's appointment as there were not enough staff available to remain at the facility with the residents if they did not want to come with. Resident 3 then stated, "Oh yeah [Resident 2] has a doctor's appointment today, we have to go to that." Caregiver B stated in front of Resident 3 that Resident 2's appointment was for a neurological medication review. Resident 3 commented if Regional Director A was going to come in it was then his/her preference to stay at home. At approximately 10:15, Surveyor interviewed Resident 2. Resident 2 expressed that s/he did not get along with Resident 3. Resident 2 stated sometimes it was OK if other residents came along for trips and appointments but then stated his/her medical appointments were supposed to be "private." Resident 2 stated s/he had not	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 2 informed the staff that it was OK to share his/her private medical information with Resident 3 or given permission for other residents to be aware of the medical appointments and accompany him/her to the appointments. At approximately 10:00 AM, Caregiver B left the West kitchen/ office area to attend to resident needs for greater than 5 minutes. Surveyor observed the room contained resident health information that was not secured against unauthorized access. Surveyor observed an open file cabinet with resident medical paperwork, a closet with no door that contained Manila files with the residents' physician orders, an unsecured file cabinet containing Resident 1's hydrocortisone cream with the prescription information attached, and a large calendar placed on the desk space that included identifying resident information along with upcoming medical appointments. Surveyor observed Resident 3 entered and exited the West kitchen/ office room multiple times during the survey while being on a personal phone engaged in a conversation with 1 and at times more than 1 persons via speakerphone and live video camera feed. At approximately 10:30 AM, Surveyor was touring the house, including conducting observations of the medication closet, when Resident 3 entered the room with his/her phone on while in the midst of a conversation that had video feed. Surveyor observed the phone was intermittently positioned towards Surveyor, the open medication cabinet, the desk containing open private health information, and other residents. The recipients on the other end of the phone could see and hear into the facility including other residents and their private information.	N 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 At approximately 11:00 AM, Surveyor interviewed Regional Director A. Regional Director A acknowledged the areas within the room where medical records and private health information was not being kept secured when not within caregivers visual control. Regional Director A commented that s/he was aware Resident 2 and Resident 3 did not get along and that Resident 3 should not have knowledge of Resident 2's private health information, including medical appointments. Regional Director A stated the provider usually tries to ensure that medical appointments are kept private but at times other residents have had to accompany to appointments when there were not enough staff available to stay at the home to supervise the other residents. Regional Director A stated s/he was aware Resident 3's phone created a condition of risk and breach in confidentiality and privacy. Regional Director A stated the provider has had to have discussions with Resident 3 about keeping phone conversations private, including not allowing the recipient of the calls to hear other residents conversations via speakerphone and see other residents and the home via live video feed. Regional Director A stated s/he was aware of the risk this posed and that s/he would immediately address the issue again.	N 346		
N 431	83.38(1)(g) Health monitoring. 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	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 431	Continued From page 4 the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Resident 1 received health monitoring to meet his/her needs. Resident 1 had a physician ordered medical test that required the staff to submit a biological sample within a time frame prior to a subsequent medical appointment. The provider did not meet the initial set time frame with a viable sample, or the rescheduled time frame causing the medical appointment to be rescheduled twice which	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 431	Continued From page 5	N 431		

caused an approximate 2 month delay in the resident's health monitoring and treatment.

Findings include:

On 06/12/2024, the Department received a complaint alleging the provider did not submit a lab sample after 2 deadlines which caused a resident to miss 2 physician appointments.

On 01/30/2025, Surveyor reviewed Resident 1's record and noted Resident 1 was admitted to the facility on 06/17/2022 with diagnosis including Down Syndrome, anxiety disorder, irritable bowel syndrome, inflammation of the small intestine, abdominal pain, and behavioral changes.

On 1/30/2025 at approximately 12:00 PM, Surveyor interviewed Administrator A. Administrator A stated s/he recalled Resident 1's first stool sample (May 2024) was contaminated and that the staff had to collect a 2nd stool sample (June 2024,) but did not recall the circumstances in detail. Administrator A stated the second canceled appointment (06/20/2024) may have been due to the stool sample not being submitted timely by the provider but could not give further details.

On 06/12/2024, the Department received a timeline of events that was reviewed by Surveyor on 01/30/2025. During the interview on 01/30/2025, Surveyor reviewed the submitted circumstances and timeline with Administrator A:

Resident 1's physicians orders included a stool sample be obtained by the facility and submitted for testing prior to a scheduled appointment with Resident 1's gastroenterologist in May of 2024. The initial stool sample had been collected but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 431	Continued From page 6	N 431		

was found to be contaminated. The appointment had to be canceled. An order was placed for a new sample (ordered on 05/06/24) for collection prior to 06/11/2024 to have the test completed for an appointment with the ordering physician on 06/20/2024. A meeting was held on 05/23/2024 with Resident 1's POA (POA D,) Lakeland, and the provider. During the meeting POA D was assured the sample would be collected in time for the next appointment. On 06/11/2024 the sample had not been collected by the provider and the 06/20/2024 physician appointment was canceled. The appointment was rescheduled for 07/23/2024.

After review of the provided timeline and information, Administrator A confirmed the events and stated to his/her recollection the timeline and events reviewed were correct. Administrator A could not offer any further detail as to why the 2nd stool sample collection had not occurred except for noting that there had been change in management at the time the stool sample was due for collection and speculating that there may have been a breakdown in communication.

Surveyor reviewed Resident 1's observation notes and noted an appointment for a capsule endoscopy was rescheduled for 7/23/2024. Surveyor noted there was no documentation communicating the order to collect a stool sample between 05/06/2024 (when the 2nd stool sample was ordered) through 06/11/2024 (when the sample was due) in the observation notes or Resident 1's Task Administration Record (TAR.)

On 02/05/2025 at 11:41 AM, Surveyor interviewed Caregiver B. Caregiver B recalled the first stool sample from May 2024 had been contaminated. Caregiver B stated s/he could not recall the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 431	Continued From page 7 reason, but confirmed the 2nd medical appointment (06/20/2024) had been canceled. Caregiver B stated s/he had collected and submitted the sample that was needed for the appointment on 07/23/2024 Caregiver B stated s/he would look back through records to recall the circumstances and timeline of events and would call with his/her findings and/or send Surveyor any relevant documentation. As of 02/28/2025 no additional information was received.	N 431		
N 454	83.42(1) Resident record maintained. The CBRF shall maintain a record for each resident at the CBRF. Each record shall include all of the following: (a) Resident ' s full name, sex, date of birth, admission date and last known address; (b) Name, address and telephone number of designated contact person, and legal representative, if any; (c) Medical, social, and, if any, psychiatric history; (d) Current personal physician, if any; (e) Results of the initial health screening under s. DHS 83.28(4) and subsequent health examinations under s. DHS 83.38(1)(g); (f)Admission agreement; (g) Documentation of significant incidents and illnesses, including the dates, times and circumstances; (h) Assessments completed as required under s. DHS 83.35(1); (i) Individual service plan and resident satisfaction evaluation; (j) Documentation to accurately describe the resident's condition, significant changes in condition, changes in treatment and response to treatment; (k) Results of the annual resident evacuation evaluation; (l) Documentation of sensory impairment of the resident as required under s. DHS 83.48(7)(b); (m) Summary of discharge information as required under s.DHS	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 454	Continued From page 8 83.31(7); (n) Any department-approved resident-specific waiver, variance or approval; (o) Physician ' s orders or other authorized practitioner ' s written orders for nursing care, medications, rehabilitation services and therapeutic diets; (p) Current list of the type and dosage of medications or supplements; (q) Results of the quarterly psychotropic medication assessments as required in s. DHS 83.37(1)(h)1; (r) Documentation of administration of all medications, supplements, the person administering the medications or supplements, any side effects observed by the employee or symptoms reported by the resident, the need for PRN medications and the resident ' s response, refusal to take medication, omissions of medications, errors in the administration of medications and drug reactions; (s) Photocopy of any court order or other document authorizing another person to speak or act on behalf of the resident, or other legal documents as required which affect the care and treatment of a resident; (t) Documentation of all other services including rehabilitation services, treatments and therapeutic diets; (u) Completed notice of pre-admission assessment requirement under s. DHS 83.30; (v) Nursing care procedures and the amount of time spent each week by a registered nurse or licensed practical nurse in performing the nursing care procedures. Only time actually spent by the nurse with the resident may be included in the calculation of nursing care time; (w) Plans of care for terminally ill residents; (x) Date, time and circumstances of the resident's death, including the name of the person to whom the body is released. This Rule is not met as evidenced by: Based on record review and interview, the	N 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 454	Continued From page 9	N 454		

provider did not ensure Resident 1's record documented when PRN pain and anxiety medications were offered and refused. The provider documented symptoms of anxiety and pain in the Observation Notes (OBS) while not documenting if prescribed as needed (PRN) medication was offered.

Findings include:

On 06/12/2024, the Department received a complaint alleging residents were not receiving PRN medication to meet their needs.

On 01/30/2025, Surveyor reviewed Resident 1's record and noted Resident 1 was admitted to the facility on 06/17/2022 with diagnosis including Down Syndrome, anxiety disorder, irritable bowel syndrome, inflammation of the small intestine, abdominal pain, and behavioral changes.

Resident 1's physicians orders for PRN medication in the Medication Administration Record (MAR) included:
Acetaminophen 500 mg, take 1-2 tablets by mouth every six hours as needed for pain.
Dicyclomine 20 mg, take 1 tablet by mouth 4 times a day as needed for abdominal pain.
Hydroxyzine hydrochloride 25 mg, take 1 tablet by mouth daily as needed for anxiety/ agitation. Only to be given 2 hours prior to [his/her] scheduled dose or 2 hours after [s/he] received [his/her] scheduled dose.

On 01/30/2025 at approximately 12:00 PM, Surveyor interviewed Administrator A. Administrator A stated s/he was aware there had been concern about Resident 1 not receiving PRN medication when s/he reported corresponding symptoms. Administrator A stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 454	Continued From page 10	N 454		

the PRN medication given was documented in the MAR and notations from the caregivers were documented in the resident's OBS. Administrator A stated there were times when Resident 1 would report symptoms and would refuse the PRN medication when offered by the provider. Administrator A stated s/he was uncertain if every refusal was documented as is required.

Surveyor reviewed the Individual Service Plan (ISP) and OBS in relation to the MAR:

OBS 08/13/2024 8:00 PM, Caregiver C, "[Resident 1] is out of bed, states that [his/her] tummy hurts."
The MAR on 08/13/2024 noted Resident 1 received dicyclomine PRN at 1:00 PM. No other notation was made indicating a PRN medication had been offered after the OBS created at 8:00 PM indicated the resident continued to report pain that evening.

OBS 08/22/2024 3:00 PM, Caregiver C, "[Resident 1] began stating that [s/he's] having a lot of pain as soon as the [family member] left ..."

8:00 PM, Caregiver C," [Resident 1] has been crying of stomach pain since I got here at 2:50 PM and it's currently 8:00 PM ... [Resident 1] was given a PRN ... manager has been notified earlier and now ... [Resident 1] kept asking when is [sic] [s/he] going to go to the hospital. [sic] [Resident 1] kept saying that it has to be now ..."

MAR 8/22/2024 7:33 PM, "Hydroxyzine given for anxiety/ depression and crying with significant relief."
No PRN medication for pain or abdominal discomfort was documented as offered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 454	Continued From page 11	N 454		

The OBS detail on 09/04/2024 and 11/03/2024, Resident 1 reported abdominal pain. The MAR for the corresponding dates had no documentation to indicate a medication was offered or received.

The OBS detail on 08/19/2024, 08/21/2024, 08/27/2024, 08/28/2024, and twice on 09/03/2024, Resident 1 reported body pain. The MAR for the corresponding dates had no documentation to indicate a medication was offered or received.

The OBS detail on 08/23/2024, 09/05/2024, and 1/24/2025, Resident 1 is observed to have signs and symptoms of anxiety (identified in his/her ISP dated 08/16/2024 and Behavioral Plan dated 04/01/2024), including crying. The MAR for the corresponding dates had no documentation to indicate a medication was offered or received.

OBS 8/27/2024 at 4:45 PM, Caregiver C, "[Resident 1] called for staff twice. [Resident 1] had [his/her] hand on [his/her] chest breathing heavily. [Resident 1] said [s/he] can't breathe. two [sic] minutes later [Resident 1] stated that [s/he] needs staff help and [s/he] needed to go to the hospital."
There is no documentation in the MAR indicating a PRN medication was offered or received.

OBS 08/20/2024 at 7:06 PM Caregiver C, "... constant crying because of pain. [Resident 1] points at [his/her] hip saying that [s/he] has been in pain all day" The MAR noted PRN pain medication was given and noted, "Effectiveness of PRN medication: significant relief."
There is no documentation in the MAR indicating a PRN medication was offered or received prior to the 7:06 PM dose, despite the OBS notes indicating the resident reported experiencing pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018275	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE MANETTE	1796 CABINET MAKER COURT GREEN BAY, WI 54303

(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 454	Continued From page 12 all day. The documentation did not provide clear or consistent notations to describe the resident's reported changes in condition and the provider's responses, including when PRN mediation was offered and/or refused by the resident.	N 454		