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 _____	R-C 02/05/2026

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 02/02/2026, with information gathered through 02/05/2026, Surveyors conducted a complaint investigation and verification visit at Clarity Care Manette. The complaint was substantiated. As a result of the survey, two (2) deficiencies were identified. Two (2) of 4 previous deficiencies were corrected. Two (2) deficiencies were repeat deficiencies. See Statement of Deficiency 69T612, dated 07/16/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{N 000}		
{N 161}	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate an injury of unknown source for Resident 1. On 09/21/2025, provider staff documented Resident 1 had blood on his/her finger. When asked, Resident 1 reported another resident had pushed him/her to the floor. No additional documentation, follow-up, or investigation was completed.	{N 161}		

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

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{N 161}	Continued From page 1	{N 161}		

This is a repeat violation. See Statement of Deficiency (SOD) 69T612, dated 07/16/2025.

Findings include:

On 02/02/2026, Surveyors conducted a verification visit.
Surveyor reviewed Resident 1's record and noted s/he moved to the facility on 06/17/2022, with diagnoses of down syndrome, behavioral dyscontrol, and anxiety disorder. Resident 1 had a legal guardian.

Surveyor reviewed Resident 1's provider observation notes and on 09/21/2025, Direct Support Professional (DSP) C wrotex, "When staff was getting [Resident 1] ready to put on [his/her] clothes, staff noticed blood on [his/her] finger and asked what happened. [Resident 1] said that a resident had pushed [him/her] to the floor yesterday. When staff asked [Resident 1] did you tell anyone, [Resident 1] said No!"
Surveyor reviewed Resident 1's other observation notes and incident reports and did not find evidence in Resident 1's record to identify the source of the blood/injury on Resident 1's finger and any additional information regarding Resident 1 alleging s/he was pushed to the floor on 09/20/2025.

On 02/02/2026 at 12:45 PM, Surveyors interviewed Division Administrator (DA) A who reported s/he was not aware of an injury, an observation note about an injury or Resident 1's report of being pushed down. DA-A said DSPs should be reporting all incidents and injuries to Program Leads, and Program Leads report them to management. DA-A said Program Leads were also to review observation notes, follow up and

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{N 161}	Continued From page 2 report any notes of concern to management. S/he said there was an "Investigation Team" who would then investigate any allegations or injuries of unknown source. Surveyor inquired whether blood on Resident 1's finger or the allegation of him/her being pushed down by another resident was reported and investigated. DA-A reviewed his/her personal correspondence and documentation regarding Resident 1 and was unable to locate any evidence of an investigation. S/he said, "I don't see anything for 09/21[/2025]." On 02/03/2026 at 12:00 PM, Surveyors interviewed DA-A and Director of Residential Services (DRS) B who verified an investigation was not completed for Resident 1 having blood on his/her finger and him/her reporting s/he was pushed down by another resident.	{N 161}		
{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 record review and interview, the provider did not ensure 1 of 2 (Resident 1) residents reviewed received all prescribed medications in the dosage and at intervals prescribed by a practitioner. Resident 1 had an order for Fluocinolone Oil 0.01% (percent) Ear Drops to place 4 drops to	{N 352}		

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{N 352}	Continued From page 3	{N 352}		

each ear Monday and Thursday at night before bedtime for chronic external ear eczema. Resident 1 did not receive the medication on 10/09/2025 and 10/13/2025. Resident 1 had an order for Acetaminophen ER (Extended Release) 650mg (milligrams) tablet to take one tablet by mouth 2 times a day for pain. Resident 1 did not receive the medication on 11/10/2025.

Additionally, Resident 1 had an order for Ensure High Protein drink dated 10/08/2024. Resident 1 did not receive the drink from 10/08/2024 through 10/21/2025.

Findings Include:

On 07/28/2025, the Department received a complaint regarding resident medications.

On 02/02/2026, Surveyor conducted an onsite visit to the facility. A sample of residents was selected, including the resident record of Resident 1.

Resident 1 admitted to the facility on 06/17/2022 with diagnoses to include impaired thyroid function, behavioral dyscontrol, abdominal pain, primary osteoarthritis of both knees, anxiety disorder and down syndrome.

EAR DROPS
Surveyor reviewed Resident 1's October 2025 MAR (Medication Administration Record). Surveyor noted Resident 1 had an order for Fluocinolone Oil 0.01% (percent) Ear Drops to place 4 drops to each ear Monday and Thursday at night before bedtime for chronic external ear eczema. On 10/09/2025, the MAR indicated "REF" with a note on the back of the MAR stating, "Refused by Resident" and "[S/he] do[sic] not

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{N 352}	Continued From page 4 have it." On 10/13/2025, the MAR indicated "OTH" with a note on the back of the MAR stating, "Other (provide reason in notes)" and "[S/he] do[sic] not have it." On 02/03/2026, Surveyor reviewed a facility "Incident Report" dated 10/09/2025. The report stated, "[Resident 1] did not receive [his/her] Flucinolone ear oil on 10/09/2025. Staff states it was not in the home. Medication was in fact in the home." The report stated the medication error was found during a medication audit. The Surveyor reviewed another facility "Incident Report" dated 10/13/2025. The report stated, "[Resident 1] did not receive [his/her] Flucinolone ear oil on 10/13/2025. Staff states it was not in the home. Medication was in fact in the home." The report stated the medication error was found during a weekly medication audit. Resident 1 did not receive the medication on 10/09/2025 and 10/13/2025. PAIN MEDICATION Surveyor reviewed Resident 1's November 2025 MAR. Surveyor noted Resident 1 had an order for Acetaminophen ER 650mg tablet to take one tablet by mouth 2 times a day for pain. On 11/10/2025 at 8 PM, the MAR indicated "OTH" with no note on the back of the MAR indicating the reason. However, on 11/11/2025, the back of the MAR states Acetaminophen ER was not passed with a reason of "Other" and "staff did not administer." On 02/03/2026, Surveyor reviewed a facility "Incident Report" dated 11/10/2025. The report stated, "On 11/11/2025 at 8pm, management was notified that [Resident 1's] 8p acetaminophen was not administered."	{N 352}		

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{N 352}	Continued From page 5 Resident 1 did not receive the medication on 11/10/2025. On 02/03/2026 at approximately 10:00 AM, Surveyor received an email from Division Administrator A. Division Administrator A sent the incident reports regarding the medication errors and stated, "The staff that had the medication error did redo our medication administration class, we then had a staff meeting regarding the placement of all medications and who to contact if they could not be found." ENSURE Surveyor reviewed Resident 1's record and noted an "After Visit Summary" dated 10/08/2024 from Resident 1's Gastroenterology physician. The summary stated Resident 1 was to start taking Ensure High Protein drink once daily by mouth. Surveyor reviewed Resident 1's September, October and November 2025 MAR. Surveyor noted Resident 1 did not receive the drink until 10/22/2025. On 02/02/2026 at approximately 10:00 AM, Surveyor interviewed Division Administrator A regarding the Ensure. Division Administrator A stated that around 09/24/2025 Resident 1's guardian requested Resident 1 receive Ensure. Division Administrator A stated they did not have an order for the Ensure so needed to contact the physician for the order. The order was received on 10/07/2025. Division Administrator A stated the facility ordered the Ensure immediately, however, it was not the high protein nor the flavor that was requested, so the facility needed to place another order. Division Administrator A stated s/he placed the new order from their supplier and Resident 1 started receiving the Ensure on 10/22/2025.	{N 352}		

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{N 352}	Continued From page 6 On 02/03/2026, at approximately 9:30 AM, Surveyor sent an email to Division Administrator A indicating there was an order for Ensure High Protein dated 10/08/2024. Surveyor requested a copy of the order from 10/08/2024 and to explain why the order wasn't on Resident 1's MAR until October 2025. Division Administrator A replied that s/he checked their electronic records and the ensure was not an order prior to 10/2025 and that the pharmacy does place the initial link for all orders on the electronic MAR and Division Administrator A didn't see it on Resident 1's discontinued medications either. On 02/03/2026 at approximately 10:20 AM, Surveyor interviewed Triage Technician D. Triage Technician D verified s/he works for the pharmacy that is contracted with the facility to provide medications. Triage Technician D stated the pharmacy did receive an order on 10/08/2024 for the Ensure High Protein. Triage Technician D stated there was a high copay so the pharmacy called Resident 1's legal decision maker and the legal decision maker requested to not fill that for Resident 1. Triage Technician D stated there is a note that stated the legal decision maker didn't want it filled and that they would work with the facility to get the order filled. On 02/03/2026 at approximately 11:30 AM, Surveyor interviewed Division Administrator A and Director of Residential Services B regarding the Ensure. Division Administrator A and Director of Residential Services B were both unaware of any previous order for the Ensure prior to October 2025. Director of Residential Services B stated they would review Resident 1's record to look for any documentation indicating Resident 1 received the Ensure in 2024 and 2025.	{N 352}		

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{N 352}	Continued From page 7 On 02/03/2026 at approximately 1:20 PM, Surveyor received an email with the monthly order forms indicating the facility ordered the Ensure High Protein, however the monthly order form is not specific to Resident 1 and there is no documentation that Resident 1 received the Ensure High Protein. Surveyor replied to email requesting documentation of Resident 1 receiving the protein drink from 10/08/2024 through 10/21/2025. At the time of writing, Surveyor did not receive any further documentation from the provider.	{N 352}		