STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018276	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARITY CARE VILLA	3017 MANN STREET MARSHFIELD, WI 54449

(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 10/29/2025, Surveyors conducted a complaint (x3) investigation at Clarity Care Villa. Data collection continued through 11/03/2025. Two of 3 complaints were substantiated. Two deficiencies were identified. Census: 8	N 000		
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 Resident 1 received prompt and adequate treatment appropriate to his/her needs. Findings include: Between 07/31/2025 and 09/15/2025, the Department received three complaints alleging concerns with staffing, meals, transportation and resident care pertaining to Resident 1's foot care. The facility is licensed to serve up to 8 residents in the client groups emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, developmentally disabled, traumatic brain injury, physically disabled, and advanced aged.	N 353		

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

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N 353	Continued From page 1 On 10/29/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 04/04/2022 with diagnoses that included Type 2 diabetes (DM 2), dementia, and mild intellectual disabilities. Resident 1 was discharged on 09/26/2025. According to observation notes, dated 03/12/2025, "[Resident 1] said [his/her] toe hurts. [S/He] said [s/he] stubbed it in January and it still hurts. [S/He] said that [s/he] thinks [s/he] broke it as [his/her] toe points upward now." Observation notes, dated 06/15/2025, noted, "Staff changed [Resident 1] foot padding." Observation notes, dated 07/30/2025, noted, "Has open wound on the side of second toe on the right foot. Toe had drainage and smells. First big toe is wrapped. [Resident 1] was sent to ER." Observation notes, dated 08/07/2025, noted, "LATE ENTRY: [Resident 1] was taken into the emergency room yesterday afternoon for [his/her] right foot. They cleaned it with antibaterial [sic] soap/solution air dryed [sic] it and bandaged it. [S/He] was given an antibiotic while there. [His/Her] medication should be delivered from pharmacy on 08/07/2025 [sic] PLEASE MAKE SURE YOU ARE GIVING HIM/HER THIS ANTIBIOTIC. The er [sic] stated to watch for redness going up [his/her] foot [sic] if this happens [s/he] needs to be sent back in because it is a sign of infection. THE [sic] er [sic] also states that if [his/her] foot is hot [sic] [s/he] also needs to go back in." On 10/29/2025 at approximately 11:50 AM, Surveyor interviewed Division Administrator (DA) A about Resident 1's foot care. DA A reported that the provider did not provide wound care and Resident 1 was being seen by [Named Home Health Agency]. Surveyor asked DA A for Resident 1's home health records. DA A indicated that the provider did not maintain home health records at the facility and Surveyor could request	N 353		

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N 353	Continued From page 2 home health records from [Named Home Health Agency]. On 10/29/2025 at 12:44 PM, Surveyor contacted [Named Home Health Agency] and requested records for Resident 1. [Named Home Health Agency] informed Surveyor that home health did not have Resident 1 as a patient. On 10/29/2025, Surveyor reviewed an "Employee Warning Notice," dated 09-02-2025, regarding Former Program Lead (FPL) D. The Employee Warning Notice, read in part, "An investigation was launched on 08/20/25 due to reported concerns of possible misconduct. Multiple witnesses had reported observing [FPL D] raising [his/her] voice and using profanity in the group home. [FPL D] denied this but could not explain why multiple reports were made citing [s/he] had. Two additional members reported they were asking to seek care for medical conditions. One Member [sic] requested to have [his/her] toes looked at stating they hurt, [FPL D] refused to take [him/her] in citing lack of staff or knowledge of where to take the member. [FPL D] did confirm [s/he] was provided a clinic to take the Member [sic] but still did not make any further arrangements. A second Member [sic] requested to have [his/her] eyes checked(,) in which [FPL D] told [him/her][s/he] couldn't take [him/her] either also citing lack of staff. Per contract, [Provider] must ensure member's health is properly monitored and care is given upon request and/or need. Not completing these tasks is also a violation of our health monitoring policy. Due to complaints received being in violation of expected conduct for a caregiver and member of management(,) it has been determined that [FPL D's] employment is terminated effective immediately." Per the Employee Warning Notice,	N 353		

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N 353	Continued From page 3 FPL D was terminated. On 10/29/2025 at approximately 3:49 PM, Surveyor interviewed Caregiver C. Surveyor asked Caregiver C about Resident 1's cares and transportation. Caregiver C reported, "When [FPL D] was here, the residents were not getting to appointments. Caregiver C stated that Resident 1 had a sore (wound) on his/her right toe and the facility called 911 on 07/30/2025 for Resident 1's toe. Caregiver C reported that the paramedics did not take Resident 1 to the emergency room on 07/30/2025, but suggested that Resident 1 be seen by his/her provider. Caregiver C commented that Resident 1 had a follow up appointment, but "[FPL D] canceled it." Caregiver C verified that Resident 1 was sent to the emergency room on 08/06/2025 for the wound on his/her right foot. On 10/30/2025 at approximately 09:50 AM, Surveyor interviewed Resident 1's Guardian (Guardian E) via telephone. Surveyor asked Guardian E about Resident 1's cares and transportation. Guardian E reported that Guardian E had concerns about Resident 1's right foot since January 2025. Guardian E reported that Resident 1 had a sore on his/her right foot and was supposed to be seen by a podiatrist to have his her/her toenails clipped. Guardian E reported that s/he had concerns that the provider was not ensuring care for Resident 1's right foot. Guardian E stated that Resident 1 did not always get to his/her medical appointments (podiatry, GI) because the provider canceled his/her appointments. Guardian E informed Surveyor that when Guardian E would inquire about the missed appointments, the provider would state, "We did not know about the appointment (or) We did not have the staff to take [him/her]." Guardian E stated, "There were a lot of staff changes and	N 353		

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N 353	Continued From page 4 [Resident 1] was not getting what [s/he] was supposed to be getting; They dropped the ball on [Resident 1]." Guardian E indicated that Resident 1 was moved out of the facility on 09/26/2025. On 10/30/2025 at approximately, 10:30 AM, Surveyor interviewed Division Administrator (DA) A via telephone. Surveyor asked DA A about Resident 1's medical appointments and missed appointments. DA A stated that Resident 1 missed appointments at times "due to not having staff in the building." DA A reported that FPL D set up appointments and canceled appointments. DA A verified that FPL D was terminated on 09/07/2025 due to unprofessional conduct and for not ensuring resident care. On 10/30/2025 at approximately, 10:45 AM, Surveyor interviewed Caregiver F via telephone. Surveyor asked Caregiver F about Resident 1's cares and transportation. Caregiver F stated that Caregiver F "helped fill in" at the facility. Caregiver F reported that there had been staffing concerns and medical appointments were canceled "due to lack of staff." Caregiver F commented that the canceling of medical appointments had been going on for a long time - "Going on since [FPL D] worked and prior." Caregiver F stated that Resident 1 had a wound on his/her right toe. Caregiver F reported that Caregiver F "found the wound" on 07/30/2025. Caregiver F stated that staff called the EMTs on 07/30/2025 due to Resident 1's right toe wound. According to Caregiver F, the EMTs responded to the facility on 07/30/2025 and did not transport Resident 1 to the emergency room, but instructed staff to have Resident 1 be seen by his medical provider as soon as possible. Caregiver F was not aware of any medical follow up for Resident 1 after 07/30/2025. Caregiver F verified that	N 353		

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N 353	Continued From page 5 Resident 1 was sent to the emergency room on 08/06/2025 for his/her right toe wound. On 10/30/2025 at approximately 10:58 AM, DA A noted via email, "I have attached the notes for [Resident 1]. I have also looked at all the status logs and appointments that I had in my calendar with them being completed or missed. I am not sure if [s/he] had more appointments or not that I have missed, these are just the ones that were sent to me and on my calendar." DA A noted the following "Completed/Missed' appointments for Resident 1: - Annual appointment- 12/17/24 COMPLETED - Podiatry- 4/1/25 RESCHEDULED - Dental- 4/8/25 COMPLETED - GI Appointment- 4/10/25 MISSED - Podiatry- 4/15/25 COMPLETED - Wood County Human Services- 5/22/25 COMPLETED - Ear Cleaning- 5/27/25 MISSED - Podiatry- 6/13/25 COMPLETED - Audiologist- 6/23/25 COMPLETED - Audiologist- 7/25/25 COMPLETED - GI- 8/18/25 MISSED - Audiology- 9/1/25 MISSED On 10/30/2025 at approximately 12:09 PM, Surveyor interviewed Emergency Medical Technician (EMT) G via telephone. EMT G verified that EMTs responded to the facility on 07/30/2025 to see Resident 1. EMT G stated, "We highly recommended to staff that [Resident 1] be seen by a wound care doctor." EMT G commented that EMTs did not take Resident 1 to the emergency room on 07/30/2025 because Resident 1's toe wound was not an "emergency situation, but due to a lack of care."	N 353		

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N 353	Continued From page 6 On 10/30/2025 at approximately 2:16 PM, Surveyor interviewed DA A via telephone. DA A verified that EMTs saw Resident 1 at the facility on 07/30/2025 for a toe wound. After 07/30/2025, DA A verified that Resident 1 was not seen by a medical provider until Resident 1 was sent to the emergency room on 08/06/2025 for his/her right toe wound. On 10/30/2025 at approximately 4:20 PM, Surveyor interviewed Resident 1's Case Worker (CW H) via telephone. Surveyor asked CW H about Resident 1's cares and transportation. CW H reported that Resident 1's Guardian (Guardian E) wanted Resident 1 moved because Resident 1 missed several appointments while at the facility and Resident 1 had an ongoing sore on his/her right foot. CW H informed Surveyor that the provider would give the following excuses for missed appointments: "We did not have staff to take [him/her]; We did not know [s/he] had an appointment." CW H commented that the provider did not schedule follow up appointments as needed. CW H reported that CW H would ask staff if Resident 1's right foot was healing and staff would say, "yes, but staff could not explain what the wound looked like." CW H reported that Resident 1 was moved out of the facility on 09/26/2025. The provider did not ensure prompt and adequate treatment appropriate to Resident 1's needs.	N 353		
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	N 431		

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N 431	Continued From page 7 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 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 interview and record review, the provider did not arrange services adequate to meet the needs of Resident 1 in the following area: Health Monitoring. Resident 1 did not receive as needed medication, blood sugars were not rechecked, and provider was not notified of blood sugars below 70, per physician orders. Findings include: According to the American Diabetes Association	N 431		

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N 431	Continued From page 8 (ADA), low blood sugar (hypoglycemia) is categorized into three levels based on glucose levels and symptom severity. -Level 1, blood sugar (or blood glucose) is less than 70 mg/dL -Level 2, blood sugar less than 54 mg/dL. -Level 3, altered mental and/or physical status, regardless of blood sugar level. [https://diabetes.org/sites/default/files/2025-04/Severe-Hypoglycemia-Patient-2025-4-22-25.pdf, 10/30/2025]. On 10/29/2025 at 12:30 PM, Surveyors reviewed Resident 1's record. Resident 1 was admitted on 04/04/2022 with diagnoses including Type 2 diabetes (DM 2), dementia, and mild intellectual disabilities. Resident 1's physician orders included the following: -01/24/2024, Glucose tablet, take four tablets by mouth, once daily, as needed, for low blood sugar. Med Pass Notes: Give if blood sugar is below 70, give PRN (as needed), and recheck blood sugar in 15 minutes. Contact provider if remains under 70. -10/17/2024, Autoshield Pen, four times per day, for DM 2. -05/28/2025, Januvia (oral diabetic medication), 25 mg daily for DM 2. -06/11/2025, Semglee (long-acting insulin), 12 units at bedtime for DM 2. -06/12/2025, Novolog (rapid acting insulin), 4 units at breakfast, 5 units at lunch, 6 units at dinner for DM 2. -06/12/2025, Test strips, use to test blood sugars four times per day for DM 2. -06/16/2025, Metformin ER (oral diabetic medication), 500 mg twice daily for DM 2.	N 431		

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N 431	Continued From page 9 Resident 1's July 2025 medication administration record (MAR) documented the following blood sugars below 70: -07/03/2025 at 8:00 PM, 59 -07/04/2025 at 8:00 PM, 47 -07/06/2025 at 8:00 PM, no documentation. -07/07/2025 at 8:00 PM, 47 -07/09/2025 at 8:00 PM, no documentation. -07/12/2025, at 8:00 AM, 50 -07/12/2025 at 8:00 PM, 55 -07/19/2025 at 8:00 AM, 59 -07/25/2025 8:00 AM, 60 -07/28/2025 at 8:00 AM, 61 -07/31/2025 at 8:00 AM, 60 Resident 1's August MAR documented the following blood sugars below 70: -08/02/2025 at 8:00 AM, 58 -08/05/2025 at 8:00 AM, 47 -08/07/2025 at 8:00 AM, 69 -08/07/2025 at 8:00 PM, 63 -08/10/2025 at 8:00 AM, 58 -08/10/2025 at 4:00 PM, 69 -08/11/2025 at 8:00 AM, 59 -08/12/2025 at 8:00 AM, 62 -08/15/2025, no documentation. -08/16/2025, no documentation. -08/17/2025, no documentation. -08/21/2025 at 8:00 AM, 54 -08/27/2025 at 8:00 PM, 68 -08/30/2025, no documentation. -08/31/2025, no documentation. Resident 1's September MAR documented the following blood sugars below 70: -09/04/2025 at 8:00 AM, 62 -09/09/2025 at 8:00 AM, 58 -09/09/2025 at 8:00 PM, 61 -09/14/2025 at 8:00 PM, 63 -09/18/2025 at 8:00 AM, 62	N 431		

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N 431	Continued From page 10 On 10/29/2025, Surveyor noted Resident 1's July, August, and September MARs did not indicate Glucagon had been administered on the dates Resident 1's blood sugar was below 70. Surveyor noted Resident 1's progress notes for July, August, and September did not include documentation of Resident 1's low blood sugar, if blood sugar was re-checked after 15 minutes, signs or symptoms of low blood sugar (altered mental or physical status), or updates to Resident 1's provider. On 10/29/2025 at 1:26 PM, Surveyor interviewed Division Administrator A and Program Lead B. Program Lead B reported a low blood sugar would be anything under 60. Division Administrator A stated low blood sugars were normal for Resident 1, and staff would update Resident 1's provider per physician orders. Division Administrator A stated Resident 1 did not have blood sugar parameters, and only to hold insulin if a blood sugar was below 80. Surveyor noted Resident 1 had an order to administer glucagon if a blood sugar was below 70, recheck blood sugar in 15 minutes, and if still below 70 update Resident 1's provider. Division Administrator A indicated staff were trained and delegated to complete diabetes management and insulin administration by the facility's corporate nurse. On 10/29/2025 at 3:50 PM, Surveyor interviewed Caregiver C. Caregiver C reported s/he checked Resident 1's blood sugar and acknowledged Resident 1 had blood sugars below 70. Caregiver C stated when Resident 1's blood sugars were low, s/he would call the Program Lead, who was recently terminated. Caregiver C was instructed by the Program Lead to give Resident 1, "sugary	N 431		

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N 431	Continued From page 11 stuff." On 10/30/2025 at 10:20 AM, Surveyor interviewed Caregiver C. Caregiver C confirmed s/he received training from the facility on diabetes management and insulin administration. Caregiver C stated when s/he called the Program Lead s/he was only instructed to give Resident 1 sugary stuff and was not given direction to recheck Resident 1's blood sugar, document any further findings, or update Resident 1's provider. The provider did not arrange services adequate to meet the needs of Resident 1 in the following area: Health Monitoring.	N 431		