STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011573	A. BUILDING: _____ B. WING _____	C 08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTSONG ASSISTED LIVING	**415 EAST AVENUE BELLEVILLE, WI 53508**

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N 000	Initial Comments On 08/19/2025, the bureau of assisted living southern regional office conducted a complaint investigation at Heartsong Assisted Living a CBRF located in Belleville, WI. As a result of this survey, 1 violation of DHS Chapter 83 was identified. The complaint was substantiated. Census: 14	N 000		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a comprehensive individualized service plan (ISP) was developed for each resident; and the ISP included all of the following: identification of the resident ' s needs and desired outcomes, program services,	N 386		

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

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frequency and approaches under s. HFS 83.38(1) the CBRF will provide, established measurable goals with specific time limits for attainment and specified methods for delivering needed care and who is responsible for delivering the care.

On 08/19/2025, Surveyor reviewed Resident 1 and Resident 2's records. Resident 1's record documented a single paged temporary ISP. The temporary ISP did not list Resident 1's medical or psychiatric diagnoses. Resident 2's ISP did not document his/her history of over-dose and preference to not have administered his/her as needed (PRN) muscle relaxer, pain reliever and anti-anxiety medication simultaneously.

FINDINGS INCLUDE:

On 08/19/2025, Surveyor arrived at facility for a complaint investigation.

EXAMPLE 1: Resident 1

On 08/19/2025. Surveyor reviewed facility self-reports involving Resident 1:

1.) On 07/11/2025, Administrator A sent a self-report to the department for police presence at the facility. Administrator A documented Resident 1 had accused another resident of exposing himself/herself and then threatening Resident 1.

2.) On 07/31/2025, Administrator A sent a self-report to the department for police presence. Administrator A documented Resident 1 told a clinical staff that Manager B didn't like him/her, and that clinical staff had called the police.

On 08/19/2025 at 9:30 AM, Surveyor discussed

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N 386	Continued From page 2 the self-reports involving Resident 1 with Administrator A, Manager B and Manager C. Manager B explained the 07/11/2025 self-report occurred when Resident 1 accused Resident 3 of exposing his/her genitals to him/her in the dining area and raising his/her cane in the threatening manner. Manager B explained facility completed an investigation and the local police were called. The police nor facility- uncovered substantial evidence to support Resident 1's allegations. Manager B stated Resident 1 and Resident 3 have not had any hostile interactions since that incident. Manager B stated to maintain a therapeutic environment for both Resident 1 and Resident 3 the staff have created 2 separate smoking areas outside of the house so Resident 1 and Resident 3 do not interact with each other. Manager B explained the 07/31/2025 self-report happened because Resident 1 was upset Manager B didn't make conversation with him/her in the van while on their way to Resident 1's medical appointment. Resident 1 reported to the clinical staff that Manager B was mad at him/her and not treating them fairly. Manager B stated the clinical staff called the police to the facility. When the police arrived Resident 1 denied reporting anything to the clinical staff and refused to even talk to the police. Manager B stated the police investigation did not substantiated mistreatment. Manager B reported Resident 1 had been admitted from a local inpatient psychiatric facility and was diagnosed with Schizophrenia with bipolar disorder. Manager B reported Resident 1 suffered from mood swings which made behavior support/management difficult. Administrator A stated Resident 1 was currently in contact precautions for an RSV infection, and Resident 1 had been treated for the infection in the local emergency room (ER).	N 386		

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N 386	Continued From page 3 On 08/19/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/05/2025. Resident 1 was his/her own person. Resident 1 was diagnosed but not limited to generalize anxiety disorder, memory impairment, major depressive disorder, schizoaffective disorder (bipolar type), brachial neuropathic pain, hypertension and chronic obstructive pulmonary disease. On 08/19/2024, Surveyor reviewed discharge paperwork dated 05/02/2025. The discharge paperwork was from [Name of Inpatient Psychiatric Facility]. On 08/19/2025, Surveyor reviewed Resident 1's clinical after visit summary dated 08/04/2025. Resident 1 was treated for an upper respiratory infection and returned to the facility. On 08/19/2025, Surveyor reviewed Resident 1' s July 2025 medication administration record (MAR). Resident 1 was prescribed the PRN psychotropic medication Lorazepam 0.5 mg tablet prescribed up to 3 times daily for anxiety. Resident 1 was documented as taking the psychotropic PRN on a near daily basis. On 08/19/2025, Surveyor reviewed Resident 1's ISP. The ISP was not dated or signed by Resident 1. The ISP was a single page. The ISP didn't list Resident 1's medical or psychiatric diagnoses. The ISP didn't document Resident 1's psychotropic PRN lorazepam, nor his/her mental health symptoms with interventions tied into measurable goals. EXAMPLE 2: Resident 2 08/19/2025 at 10:30 AM, Surveyor interviewed	N 386		

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N 386	Continued From page 4 Resident 2. Resident 2 stated earlier that month Caregiver D attempted to poison him/her. Resident 2 stated Caregiver D attempted to administer his/her PRN pain medication, PRN anti-anxiety and PRN muscle relaxer at the same time. Resident 2 stated s/he asked for his/her pain medication and muscle relaxer but not the anti-anxiety pill. Resident 2 stated s/he looked at the pill cup and found the third pill and refused to take any medication prepared by Caregiver D. Resident 2 reported s/he called the police and Manager B. Resident 2 stated Manager B was relieved s/he refused to take the combination of PRN medications because it could have given him/her a "heart attack." Resident 2 denied a physician telling him/her not to take these 3 PRN medications co-currently. On 08/19/2025 at 10:40 AM, Surveyor observed the medication cart with Manager B. Manager B stated Resident 2 had a significant history of drug abuse and over-dose. Manager B stated Resident 2 didn't want to take his/her PRN Oxycodone 5 mg tablet, PRN Methocarbamol 500 mg tablet and PRN Hydroxyzine 25 mg tablet co-currently due to fear of another over-dose. Manager B stated s/he agreed with Resident 2's decision to keep the administration of these PRN medications separated by at least an hour. Manager B stated Resident 2 had discussed this system with staff before the incident with Caregiver D. Manager B acknowledged Resident 2's MAR on the medication did not have any communication to medication passing staff or Resident 2's requested system of PRN administration. On 08/19/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 02/22/2025. Resident 2's ISP documented staff	N 386		

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were to administer his/her medications per the physician's order. Resident 2's ISP did not mention Resident 2's history of recreational drug abuse, over-dose or preferences related to PRN administration.

On 08/19/2025, Surveyor reviewed Resident 2's August 2025 MAR. The following PRN orders were documented:
1.) Hydroxyzine 25 mg tablet - take 1 tablet by mouth (PO) once every 6 hours PRN for anxiety.
2.) Methocarbamol 500 mg tablet - take 1 tablet PO 4 times daily PRN for musculoskeletal pain.
3.) Oxycodone 5 mg tablet - take 1 tablet PO every 6 hours PRN for pain.

INTERVIEW:

On 08/19/2025 at 9:55 AM, Surveyor spoke with Officer E. Officer E reported Resident 1 didn't want to talk to police on 07/31/2025 about allegations of forced labor. Officer E reported Resident 1 seemed more upset the clinical staff had reported his/her conversation to the police. Officer E reported police didn't substantiate any criminal concerns at facility involving Resident 1. Officer E stated Resident 2 had reported Caregiver D had attempted to poison him/her on 08/09/2025. Officer E stated police investigated Resident 2's concerns but didn't find substantial evidence of wrongdoing on Caregiver D's part.

On 08/19/2025 at 12:00 PM, Surveyor discussed the above concerns with Administrator A and Manager B. Administrator A reviewed the electronic health record (EHR) and stated Resident 1 hadn't been provided any assessments in the July 2025 or August 2025. Administrator A and Manager B acknowledged Resident 1 wasn't provided assessments upon

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N 386	Continued From page 6 changes in condition and/or needs. Administrator A acknowledged the only ISP available to facility staff for Resident 1 was the single-paged ISP reviewed by Surveyor. Administrator A acknowledged Resident 1's ISP was not dated or signed, and didn't list his/her medical or psychiatric diagnoses. Administrator A and Manager B acknowledged Resident 1's ISP didn't document a behavior plan related to their mood swings or delusional thought patterns. Administrator A and Manager B acknowledged Resident 2's history of overdose and need to have his/her PRN pain medication, PRN muscle relaxer and PRN anti-anxiety pills administered separately hadn't t been documented in his/her ISP. Administrator A and Manager B acknowledged this resulted in Caregiver D unknowingly administering his/her PRN medications in a manner Resident 2 found to be dangerous.	N 386		