STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 09/06/2024, with information gathered through 09/16/2024, Surveyor conducted a standard licensure survey and 2 complaint investigations at The Hearthside. Twenty-three deficiencies were identified. Two of 23 deficiencies were repeat violations (see Statement of Deficiency (SOD) SNYI11). Two of 2 Complaints were substantiated. Census: 8	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure the provider complied with all laws governing the CBRF (community-based residential facility). Findings include: The provider received a regular license on 11/10/2021, as a class CNA (nonambulatory) CBRF able to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, with information gathered through 09/16/2024, Surveyor conducted a standard licensure survey and a complaint investigation.	N 196		

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
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N 196	Continued From page 1 As a result of the survey, twenty-five deficiencies were identified: N0196 DHS 83.14(2)(a) Licensee Ensures Facility Complies With Laws N0219 DHS 83.17(1) Licensee Conduct Caregiver Background Check N0277 DHS 83.25 Continuing Education N0328 DHS 83.31(4)(c) Involuntary Discharge Notice Requirements N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment N0349 DHS 83.32(3)(e) Rights of Residents: Free From Seclusion N0355 DHS 83.32(3)(k) Rights of Residents: Self-Determination N0385 DHS 83.35(2) Temporary Service Plan N0386 DHS 83.35(3)(a) Comprehensive Individualized Service Plan N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved This is a repeat deficiency. See Statement of Deficiency (SOD) SNYI11, dated 07/25/2022. N0394 DHS 83.35(5)(b) Annual Evaluation of Evacuation Limits N0397 DHS 83.36(1)(b) Qualified Staff in Charge, On Duty and Awake N0406 DHS 83.37(1)(g) Disposition of Medications N0415 DHS 83.37(2)(d) Documentation of Medication Administration N0427 DHS 83.38(1)(c) Leisure Time Activities N0435 DHS 83.38(1)(k) Transportation N0450 DHS 83.41(2)(c) Nutrition: Menus N0480 DHS 83.42(3) Access to Resident Records N0481 DHS 83.43(1) Environment Safe, Clean, And Comfortable N0499 DHS 83.45(3) Toxic Substances This is a repeat deficiency. See Statement of	N 196		

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N 196	Continued From page 2	N 196		

Deficiency (SOD) SNYI11, dated 07/25/2022.
N0525 DHS 83.47(2)(d) Fire Drills
N0539 DHS 83.48(1)(c) Sensitivity Testing Performed
N0637 83.59(1)(g) Proper Exit Locations, Sidewalks, Driveways
N0640 DHS 83.59(2)(b) Solid Core Wood Doors or Equivalent

Review of facility records documented 2 previous survey events identifying noncompliance, as follows:

SOD SNYI12 - dated 02/09/2023
On 02/09/2023, Surveyors conducted a verification visit at Hearthside (The). One deficiency was identified.

N0239 DHS 83.20(2)(a)-(d) Department Approved Training Courses

SOD SNYI11 - dated 07/25/2022
On 07/25/2022, Surveyor conducted a complaint investigation and standard survey at The Hearthside. Seven deficiencies were identified.

N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called
N0239 DHS 83.20(2)(a)-(d) Department Approved Training Courses
N0310 DHS 83.29(2) Admission Agreement Include Services, Charges
N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved
N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medications
N0492 DHS 83.45(1)(a) Exterior Areas
N0499 DHS 83.45(3) Toxic Substances

On 09/16/2024 at 2:00 PM, Surveyor interviewed

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N 196	Continued From page 3 Licensee A. Licensee A stated s/he learned a lot through the survey process and would make the corrective actions to ensure compliance.	N 196		
N 219	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure complete caregiver background checks were conducted every four years for 1 of 3 employees reviewed (Caregiver D) Findings include: The provider received a regular license on 11/10/2021, as a class CNA (nonambulatory) CBRF able to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled.	N 219		

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N 219	Continued From page 4 On 09/06/2024, Surveyor reviewed Caregiver D's employment record. Caregiver D was hired 06/2019. Caregiver D's record did not contain a Background Information Disclosure (BID) form. Caregiver D's Department of Justice (DOJ) report and Caregiver Registry report was dated 06/25/2019. Caregiver D's background check should have been reviewed by 06/2023. On 09/15/2024 at 8:58 AM, Surveyor emailed Licensee A regarding the concern. On 09/15/2024 at 1:22 PM, Licensee A emailed Surveyor and stated Manager B thought s/he had reviewed Caregiver D's background in 2022. As of 09/16/2024 at 2:00 PM, Surveyor did not receive any additional documentation.	N 219		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid.	N 277		

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N 277	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 staff (Manager B, Caregiver C, and Caregiver D) records reviewed received all required continuing education in 2023. Findings include: On 09/06/2024, Surveyor reviewed Manager B's, Caregiver D's, and Caregiver C's training records. Manager B was hired 02/01/2022. Manager B's record did not contain any continuing education for 2023. Caregiver C was hired in 01/2020. Caregiver C's record did not contain any continuing education for 2023. Caregiver D was hired 06/2019. Caregiver D's record did not contain any continuing education for 2023. On 09/08/2024, Licensee A and Manager B forwarded Surveyor evidence of continuing education in 2023 for Manager B, Caregiver C, and Caregiver D. The documentation was dated 09/08/2024.	N 277		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or	N 328		

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N 328	Continued From page 6 resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an involuntary discharge notice provided to 1 of 1 resident's (Resident 3) MCO (managed care organization) Care Manager (CM) included a statement that the resident may ask the Department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the Department's regional office with a copy to the CBRF (community based residential facility). The notice did not state that the request must provide an explanation why the discharge should not take place. The notice did not include the name, address, and telephone number of the Department's regional office director.	N 328		

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N 328	Continued From page 7 Findings include: On 09/06/2024, Surveyor reviewed Resident 3's record. Resident 3 moved into the facility on 06/16/2024. Resident 3's 30-day discharge documented: "07/01/2024 - Dear [Resident 3] team. We no longer feel that [Resident 3] is a good fit at [Provider] due to smoking in [his/her] room at least 4 times and including cannabis. FYI for 3rd party questions or to have them review this case please contact within 10 days of receipt of this document: The Long Term Care Ombudsman Program [address and phone number]." The notice did not include a statement that the resident may ask the Department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the Department's regional office with a copy to the CBRF. The notice did not state that the request must provide an explanation why the discharge should not take place. The notice did not include the name, address, and telephone number of the Department's regional office director. On 09/14/2024 at 3:33 PM, Surveyor emailed Licensee A stating that Resident 3's 30-day notice did not follow Chapter 83 regulations. On 09/14/2024 at 4:17 PM, Licensee A emailed Surveyor and stated s/he did not realize Resident 3 needed a formal 30-day notice since s/he had not lived in the facility for 30 days.	N 328		

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N 348	Continued From page 8	N 348		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure 8 of 8 residents were free from physical and mental abuse. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 08/13/2024 and 08/20/2024, the Department received concerns alleging residents were not treated with respect. On 09/06/2024, at approximately 10:30 AM, Surveyor interviewed Resident 1. Resident 1 stated Manager B is always yelling, often in anger. Resident 1 explained, "[Resident 6] has Huntington's and eats a specialized diet. [S/he] is not allowed to eat with the other residents. We could all hear [Manager B] yelling at [Resident 6] while [s/he] was assisting [him/her] with eating. 'If you choke, I can't save you because you are a	N 348		

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N 348	Continued From page 9	N 348		

DNR (do not resuscitate).' [Manager B] is always yelling at [Resident 6]."

On 09/06/2024, at approximately 11:50 AM, Surveyor interviewed Resident 2. Resident 2 stated, "[Manager B] is always yelling at the residents. [S/he] has anger issues." Resident 2 explained, "When [Resident 6] is getting yelled at it makes me very angry, but I can't do anything. I don't want to get into trouble."

On 09/06/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3. Resident 3 stated Manager B treats the residents poorly. Resident 3 stated, "[S/he] is being nice today because you are here. [S/he] is always mad. Nobody here wants to talk because they are afraid of retaliation." Resident 3 explained, "[Resident 6] seems to always being yelled at by [Manager B], [s/he] can't do anything right."

On 09/06/2024, at approximately 3:05 PM, Surveyor interviewed Resident 6. Resident 6 stated, "I want to live somewhere else! [Manager B] is different."

On 09/06/2024, Surveyor requested the 2023 and 2024 resident satisfaction surveys from Manager B.

On 09/10/2024, Surveyor reviewed the resident satisfaction surveys which documented:
"I am treated respectfully at all times - NO."
"I feel that my rights are being protected - Somewhat."
"I feel safe and comfortable here - Somewhat."
"The rules here are enforced with an iron fist. There are no gentle reminders. If you break a rule it is shouted out to everyone - you don't make a private mistake."

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N 348	Continued From page 10 "Workers are very argumentative." On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he had discussed tone of voice with Manager B and would need to address the concern again. Licensee A stated s/he would consult with the Ombudsman about resident rights training. Cross Reference: N0355 83.32(3)(k) Rights of Residents: Self-Determination Cross Reference: N0356 83.32(3)(l) Rights of Residents: Least Restrictive Environment Cross Reference: N0358 83.32(3)(n) Rights of Residents: Safe Environment	N 348		
N 349	83.32(3)(e) Rights of Residents: Freedom from seclusion In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Be free from seclusion. This Rule is not met as evidenced by: Based on observation and interview, 1 of 1 resident (Resident 2) was secluded from the other residents during meals. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, at approximately 12:05 PM, Surveyor observed the noon meal being served to the residents. Surveyor observed Resident 2	N 349		

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N 349	Continued From page 11	N 349		

sitting in a room off the dining area, sitting at a table that appeared to be too small for him/her. The room appeared to be utilized as office space as there was a large desk and chair where staff had a computer. There were shelving units in the room. Staff and residents could access the garage door, which was directly behind Resident 2's chair. Surveyor noted there had been 4 residents sitting at the dining table and a resident sitting at the kitchen island, directly behind a resident sitting at the dining table.

On 09/06/2024, at approximately 12:55 PM, Surveyor interviewed Resident 2. Resident 2 stated, "[Manager B] and I didn't get along at first and now I just want to try and make [him/her] not be mad at me."

On 09/15/2024 at 8:58 AM, Surveyor emailed Licensee A requesting clarification as to why Resident 2 was secluded from the other residents during meals.

On 09/15/2024 at 1:22 PM, Licensee A emailed Surveyor and stated, "[Resident 2] had a behavior of passing gas and laughing about it at the dinner table and other residents complained and didn't want to eat with [him/her] so due to that and social distancing rules we moved them to the sunroom and haven't heard any complaints. We can ask [him/her] about it and see if [s/he] wants to eat at the table again with other residents and agree to respect their wishes for decorum."

On 09/15/2024, Surveyor reviewed Resident 2's individual service plan, dated 03/10/2024, did not document any guidelines/concerns regarding Resident 2's restrictions due to his/her behaviors.

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N 349	Continued From page 12 On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he understood that the set-up could be viewed as a resident rights violation.	N 349		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 8 of 8 resident's right to make decisions related to daily routines and other aspects of life which enhance the resident's self-reliance and support the resident's autonomy and decision making. Resident 3 was not allowed to watch television during NOC hours in his/her bedroom. Resident 5 was not allowed to smoke cigarettes when s/he wanted to. Residents were not allowed to watch television in the main living room unless they had permission by staff. Residents have to purchase their own snack options and are only allowed to eat them when staff grant permission. Residents have curfews as to when they have to retreat to their rooms for the evening. Findings include:	N 355		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 13 On 08/13/2024 and 08/20/2024, the Department received concerns alleging residents were not treated with respect. The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. Example 1: Resident 3 On 09/06/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3. Resident 3 stated that s/he spends most of his/her time in his/her room. Resident 3 explained, "I cannot always sleep, so I watch tv. Then the staff will come in and turn the tv off and take away my remote control. If the tv is too loud, all they have to do is say turn it down, nope, they just tell you what to do. We are treated so poorly here." Resident 3 stated, "Basically don't watch tv or do anything that they might be able to hear after 9:00 pm or you will be in trouble. I am moving tomorrow, thank god." On 09/06/2024, at approximately 3:00 PM, Surveyor reviewed Resident 3's observation notes which documented: "07/06/2024: Came up at 10:52 PM as I could hear [Resident 3's] tv thru the monitor. ... Went to [his/her] room and told [him/her] I needed [his/her] remote. [S/he] said 'Can you hear it downstairs.' Told [him/her] 'yes' ... I put the remote on the desk and went downstairs ..." On 09/15/2024 at 9:58 AM, Surveyor emailed Licensee A asking for clarification as to when residents were to retire to their room for the	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 14	N 355		

evening.

On 09/15/2024 at 1:32 PM, Licensee A emailed Surveyor and stated, "Perhaps there is a misunderstanding. We have no rules about being in rooms at 9 or any other time. At 10pm when awake staff leave, they transfer a motion monitor to the on-call staff who are allowed to sleep. If a resident uses their call light or comes out of their room the on-call staff will be alerted to come check on them."

Surveyor noted the incident documented on 07/06/2024 stated staff heard Resident 3's tv on the monitor, not that resident's were complaining that the tv was too loud.

On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he would review the policies and processes with staff and residents as this could be viewed as a resident rights violation.

Example 2: Resident 5

On 09/06/2024, while Surveyor was touring the facility between 10:15 AM and 3:15 PM, s/he observed a posting that outlined a smoking schedule. Surveyor asked Manager B who required a smoking schedule. Manager B stated there were currently 3 residents who smoked and followed the smoking schedule.

On 09/06/2024, at approximately 1:50 PM, Surveyor interviewed Resident 5 while s/he was outside smoking. Resident 5 stated s/he had to follow the smoke schedule. Resident 5 did not believe s/he should have to follow a schedule.

On 09/09/2024, Surveyor reviewed Resident 5's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 15	N 355		

"Individual Service Plan," dated 07/07/2023 and 07/2024, documented:
"Capacity for self direction: Needs assistance, Makes needs known."
"Supervision: Needs some supervision - Reminder and cueing."
"Capacity for self care: Independent."
"Orientation: Needs continue reminder on when to do smoke breaks."

On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated there was a posted smoke schedule. Licensee A confirmed that the 3 residents that smoked did not need to be supervised during smoke breaks. Licensee A could not provide a response as to why a smoke schedule had to be followed.

Example 3: Television

On 09/06/2024, at approximately 10:30 AM, Surveyor interviewed Resident 1. Resident 1 stated staff controlled the remote to the television set and if they did not want the television on, it would not be turned on. Resident 1 stated, "We have to ask when we can use the television, asking like a little kid. We have to listen to [Caregiver D's] religious podcasts, because that is what [s/he] wants to hear when [s/he] is working. I don't want to hear it! I have watched [Resident 6] get agitated when [s/he] is not allowed to watch a tv show in the living room."

On 09/06/2024, at approximately 11:20 AM, Surveyor interviewed Resident 7. Resident 7 stated, "When the tv is on, it is usually a show that [Resident 2] wants to watch, because [s/he] doesn't have a tv of [his/her] own."

On 09/06/2024, at approximately 11:50 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 16	N 355		

Surveyor interviewed Resident 2. Resident 2 stated s/he did not have a personal television and rarely watched television in the living room as staff determine when the television could be turned on.

On 09/06/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3. Resident 3 stated staff want residents to stay in their room, so s/he did not utilize the community television set.

On 09/06/2024, at approximately 1:50 PM, Surveyor interviewed Resident 5. Resident 5 stated activities were not scheduled in the community area, so s/he did not utilize the community television set.

On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated some residents work on crafts in the living room and do not want the television on; this could upset other residents. Licensee A stated s/he would review the concern as it could be viewed as a resident rights violation.

Example 4: Snacks

On 09/06/2024, at approximately 10:15 AM, Surveyor arrived at the facility and observed the following sign on the front door:
"09/11/2023 - Attention - If you are bringing in food for the residents, please stop to give to staff so they can put their names on it and put up for them. NO food is allowed in resident's rooms."

On 09/06/2024, at approximately 10:30 AM, Surveyor interviewed Resident 1. Resident 1 stated, "We are not allowed any food in our room, snacks are locked in a closet. Staff will give you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 17	N 355		

one snack, even though you bought them, they will hand you one snack at 8:00 PM. That is the only time you will receive a snack." Resident 1 showed Surveyor a copy of the house rules Resident 1 had been provided upon admittance which documented, "Snacks should be stored in designated cabinets and pantries to avoid pests in resident rooms. These are available at meals and snack times."

On 09/06/2024, at approximately 11:20 AM, Surveyor interviewed Resident 7. Resident 7 stated, "We are not allowed any food in our rooms. I am allowed 2 soda cans to be placed in the refrigerator. I can have my soda with a meal or at 8:00 PM, during snack time, no other time. We really aren't allowed in the kitchen."

On 09/06/2024, at approximately 11:50 AM, Surveyor interviewed Resident 2. Resident 2 stated, "I can't have a soda in my room, we are always in our room, and this is my home, but I try not to say anything because I just want [Manager B] to like me." Resident 2 stated, "Snack time is at 8:00 PM. You provide the snacks and staff lock them up and you only get them at 8:00 PM."

On 09/06/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3. Resident 3 stated, "We can have our personally bought snacks once a day, 8:00 PM. The only snacks available is what we buy ourselves."

On 09/06/2024, at approximately 1:50 PM, Surveyor interviewed Resident 5. Resident 5 stated, "There are no snacks. I used to have Reese's cups. I don't even know where they are."

On 09/06/2024, at approximately 2:30 PM, Surveyor asked Manager B to show Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 18	N 355		

where the resident's snacks are stored. Manager B went to a closet in the hallway, that was locked with a pad lock. Manager B unlocked the closet and Surveyor observed all the resident snacks. Manager B stated when residents purchase snacks, they are stored in the closet as food is not allowed in resident rooms.

Surveyor noted there was a sign on the closet door that stated, "09/21/2022 - Please let staff know if you need towels or washcloths. They will get for you. Or sheets/pillowcases. Or if you need to put clean towels in closet. (Due to cross contamination)." Surveyor observed linens stored with the snacks.

On 09/10/2024, Surveyor reviewed the program statement that the provider had on file with the Department, which documented:
"Meals: ... Snacks will be served at least twice a day."

On 09/14/2024 at 3:33 PM, Surveyor emailed Licensee A requesting guidance regarding resident's purchasing the available snacks and only being allowed to have them at designated times.

On 09/14/2024 at 4:17 PM, Licensee A emailed Surveyor and stated, "We respect resident rights to their own food and accommodate they're choices for snacks. The snacks are available at all times upon request and house snacks are provided as well if they are interested. We keep them locked and monitored due to a guardian's request that we divvy out a certain number of cokes per days so we don't run out. We also have a scheduled snack time at 8 where we remind residents about their snacks, so they don't forget."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 19 On 09/16/2024, Surveyor reviewed the program statement that the provider had filed with the Department upon licensure, dated 04/06/2021, which documented: "Meals: Snacks will be served at least twice a day." The program statement was amended prior to licensure that did not include guidelines for meals. On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated snacks are listed on the menus. If residents did not want that snack, then they could utilize their personal snacks. Licensee A stated, "I could remind resident's that there are other snacks available." Licensee A confirmed that residents were not to have food in their bedrooms and there was a scheduled snack time. Licensee A stated s/he would discuss the concern with residents and staff as this could be viewed as a resident rights violation. Surveyor had requested the menu's when onsite 09/06/2024 but was informed by Manager B they were not available at that time. Surveyor had observed a menu whiteboard that documented: Snack (It was left blank). Example 5: Bedroom Hours On 09/06/2024, at approximately 10:30 AM, Surveyor interviewed Resident 1. Resident 1 stated that Manager B would be working all shifts until Monday. Resident 1 stated Manager B sleeps on the couch. Resident 1 stated, "When [Caregiver D] works, s/he lives downstairs, so [s/he] uses a monitor to track us. We have to be in our room by 9:00 PM." Resident 1 stated that	N 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 20	N 355		

staff will not allow resident's to get any anything out of the kitchen. Resident 1 stated, "That is there space and we are not to be in there."

On 09/06/2024, at approximately 11:20 AM, Surveyor interviewed Resident 7. Resident 7 stated, "We are not allowed any food in our rooms. I am allowed 2 soda cans to be placed in the refrigerator. We really aren't allowed in the kitchen so I have to wait for staff to get my soda for me." Resident 7 explained, "We have to be in our room by 9:00 PM, it used to be 10:00 PM. They used to keep the lights on in the house, now the lights are off by 8:00 PM."

On 09/06/2024, at approximately 11:50 AM, Surveyor interviewed Resident 2. Resident 2 explained, "We are not to even lie down during the day, staff will wake you up. The house is locked up at 10:00 PM."

On 09/06/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3. Resident 3 stated, "We are to be in our rooms by 9:00 PM and then staff control what you are allowed to do in your room at that time. Basically a "lights out" mentality."

On 09/15/2024 at 9:28 AM, Surveyor emailed Licensee A and requested clarification on the resident's curfew for the evening.

On 09/15/2024 at 1:32 PM, Licensee A emailed Surveyor and stated, "Perhaps there is a misunderstanding. We have no rules about being in rooms at 9 or any other time. At 10pm when awake staff leave they transfer a motion monitor to the on-call staff who are allowed to sleep. If a resident uses their call light or comes out of their room the on-call staff will be alerted to come

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 355	Continued From page 21 check on them." On 09/16/204 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he had been out to speak with the residents that day and would be addressing their concerns with staff.	N 355		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not prepare and implement a temporary service plan for 1 of 1 resident (Resident 3) upon admittance. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, Surveyor reviewed Resident 3's record. Resident 3 moved into the facility on 06/16/2024. Resident 3's record did not contain a temporary service plan. On 09/06/2024, at approximately 10:45 AM, Surveyor requested Resident 3's record from	N 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 385	Continued From page 22 Manager B. Manager B stated s/he would need to forward that documentation to Surveyor as it was not in the facility. On 09/08/2024 at 6:10 PM, Licensee A emailed Surveyor and stated Resident 3's temporary service plan was not available as s/he had moved out of the facility on 09/07/2024 and his/her documentation was sent to the new facility. On 09/14/2024 at 3:28 PM, Surveyor emailed Licensee A and stated s/he was responsible for maintaining resident documentation for 7 years. On 09/15/2024 at 8:36 AM, Licensee A emailed Surveyor and confirmed that if the documentation was available, it should have been provided to Surveyor when s/he returned to the facility on 09/07/2024, prior to Resident 3 moving out.	N 385		
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.	N 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 386	Continued From page 23	N 386		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 1 and Resident 3) had a comprehensive individual service plan (ISP) within 30 days after admission.

Findings include:

On 09/06/2024, Surveyor requested Resident 1's and Resident 3's record from Manager B. Manager B stated s/he would need to forward that documentation to Surveyor as it was not in the facility.

On 09/08/2024, Surveyor reviewed Resident 1's and Resident 3's record.

Example 1: Resident 1

Resident 1 was admitted on 04/24/2024. Resident 1's available ISP was dated 06/22/2024.

On 09/15/2024 at 8:36 AM, Licensee A emailed Surveyor and stated Resident 1 had requested several revisions so there was a delay in his/her comprehensive ISP.

Surveyor noted all resident ISPs reviewed during the survey process contained all revisions on the same form, with new dates added. Resident 1's ISP did not contain any documented revisions.

Example 2: Resident 3

On 09/06/2024, at approximately 12:10 PM, Surveyor toured the facility and noted a urine like scent emanated from Resident 3's room. Surveyor interviewed Resident 3 who stated s/he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 386	Continued From page 24 had moved into the facility in June. Surveyor requested Resident 3's record from Manager B. Manager B stated s/he would need to forward Resident 3's ISP to Surveyor as it was not in the facility. On 09/08/2024 at 6:10 PM, Licensee A emailed Surveyor and stated Resident 3's ISP was not available as s/he had moved out of the facility on 09/07/2024 and his/her documentation was sent to the new facility. Licensee A forwarded Resident 3 his/her pre-admission assessment. On 09/09/2024, Surveyor requested Resident 3's managed care organization (MCO) documentation from the organization which documented that Resident 3 had moved into the facility on 06/16/2024. On 09/14/2024 at 3:28 PM, Surveyor emailed Licensee A and stated s/he was responsible for maintaining resident documentation for 7 years. On 09/15/2024 at 8:36 AM, Licensee A emailed Surveyor and confirmed that if the documentation was available, it should have been provided to Surveyor when s/he returned to the facility on 09/07/2024, prior to Resident 3 moving out. Licensee A also stated Resident 1 had requested several revisions.	N 386		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 387	Continued From page 25	N 387		

acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure the resident's Individual Service Plan (ISP) was signed by the resident or resident's legal representative and/or placing agency acknowledging their involvement in, understanding of, and in agreement with the plan for 4 of 4 resident records (Resident 1, Resident 2, Resident 5, and Resident 6) reviewed.

This is a repeat deficiency. See Statement of Deficiency (SOD) SNYI11, dated 07/25/2022.

Findings include:

On 09/09/2024, Surveyor reviewed Resident 1's, Resident 2's, Resident 5's, and Resident 6's record.

Resident 1 was admitted on 04/24/2024.
Resident 1 was represented by Power of Attorney (POA) E and managed care organization (MCO) Care Manager (CM) G.
Resident 1's available ISP, dated 06/22/2024, did not contain POA E's or CM G's signature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 387	Continued From page 26 Resident 2 was admitted on 03/10/2023 and was his/her own person and was represented by a MCO CM. Resident 2's available ISP, dated 03/10/2023 and 03/10/2024, did not contain the MCO CM's signature. Resident 5 was admitted on 02/04/2022 and was represented by a guardian and an MCO CM. Resident 5's ISP had a review date of 07/07/2023 which did not contain the MCO CM's signature. Resident 5's ISP had a review date of 07/2024 which did not contain the guardian's or the MCO CM's signature. Resident 6 was admitted in 04/2022 and is represented by Guardian H and MCO CM I. Resident 6's available ISP, dated 03/10/2024, did not contain Guardian H's or MCO CM I's signature. On 09/15/2024 at 8:23 AM, Surveyor emailed Licensee A and stated that resident ISPs were not signed by the resident or their representative, along with the placing agency. On 09/15/2024 at 8:56 AM, Licensee A emailed Surveyor and stated, "The MCOs have their version of ISPs as well which are in addition to our version. Come to think of it I think we only sent you our in house version." On 09/15/2024 at 9:26 AM, Surveyor emailed Licensee A stating they could email me the MCO ISPs. As of 09/16/2024 at 2:00 PM, Surveyor did not receive any additional documentation.	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 394	Continued From page 27	N 394		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 resident records reviewed (Resident 8) were evaluated annually to determine their mental or physical capability to respond to a fire alarm. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/14/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the facility in 06/2023. Resident 8's evacuation assessment was dated 06/30/2023. On 09/15/2024 at 8:58 AM, Surveyor emailed Licensee A about the concern. On 09/15/2024 at 1:22 PM, Licensee A emailed Surveyor and stated the evacuation assessment had been sent by mistake because the Surveyor did not request it.	N 394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 406	Continued From page 28	N 406		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure outdated medications were separated from other medications in current use in the facility and disposed of. Resident 4's outdated prescribed Carbamide Peroxide (ear drops), Polyethylene Glycol (eye drops) and Cetirizine (allergy medication) were stored with his/her current prescribed medications.	N 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

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N 406	Continued From page 29	N 406		

Resident 7's outdated prescribed Melatonin (medication for sleep assistance) was stored with his/her current prescribed medications.

Findings include:

Example 1: Resident 4

On 09/06/2024, at approximately 2:40 PM, Surveyor observed the medications stored in the med cart. Surveyor observed Resident 4's opened bottle of Carbamide Peroxide, with a fill date of 01/30/2023; an opened bottle of Polyethylene Glycol with a fill date of 02/01/2023; and a blister card of Cetirizine, with a fill date of 05/05/2023 and an expiration date handwritten in of 05/31/2024.

On 09/06/2024, Surveyor requested Resident 4's record.

On 09/10/2024, Surveyor reviewed Resident 4's record.

Resident 4's September 2024 Medication Administration Record (MAR) documented:
"Carbamide Peroxide - Instill 5 - 10 drops into both ears 2 times daily as needed. Start Date: 06/01/2019."
"Cetirizine - Take 1 tablet by mouth daily as needed for allergies. Start Date: 10/31/2014."
The MAR did not document a prescription for Polyethylene Glycol eye drops.

Example 2: Resident 7

On 09/06/2024, at approximately 2:40 PM, Surveyor observed the medications stored in the med cart. Surveyor observed Resident 7's blister

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 406	Continued From page 30 card of Melatonin with a fill date of 08/31/2023 and an expiration date handwritten in of 08/31/2024. On 09/06/2024, Surveyor requested Resident 7's record. On 09/10/2024, Surveyor reviewed Resident 7's record. Resident 7's September 2024 MAR documented: "Melatonin - Take 1 to 2 tablets by mouth at bedtime as needed. Start Date: 11/11/2021." On 09/15/2024 at 8:58 AM, Surveyor emailed Licensee A and stated there were expired medications in the med cart. On 09/15/2024 at 1:22 PM, Licensee A emailed Surveyor and stated, "I was recently made aware of a recently expired ear drop that expired since our last cart audit." Licensee A was not aware of any other expired medications.	N 406		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented.	N 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 415	Continued From page 31	N 415		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure proper documentation of the Medication Administration Record (MAR) for 2 of 4 residents.

Resident 1's blood pressure (BP) levels were not documented to ensure proper medication administration of Midodrine (medication to treat orthostatic hypotension).
Resident 4's blood sugar levels, pulse, and BP levels were not documented as scheduled.

Findings include:

On 09/06/2024, Surveyor reviewed Resident 1's and Resident 4's record.

Example 1: Resident 1

Resident 1 was admitted to the facility, 04/24/2024, with diagnoses including diabetes and essential hypertension (high blood pressure).

Resident 1's September 2024 MAR, dated 09/01/2024 to 09/06/2024, documented:
"Blood Pressure Check before administering Midodrine. Scheduled at 8:00 AM, 12:00 PM, 5:00 PM. If the SBP (systolic blood pressure - highest pressure in your arteries when your heart beats) reading is below 110, administer the Midodrine."
09/03 12:00 PM - BP numbers written in and then scratched out
09/05 12:00 PM - no BP numbers written in
09/06 12:00 PM - BP numbers written in are not readable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 415	Continued From page 32 Example 2: Resident 4 Resident 4 was admitted to the facility, 2002, with diagnosis including diabetes. Resident 4's September 2024 MAR, dated 09/01/2024 to 09/06/2024, documented: "Blood Pressure Daily" - Not documented on 09/04/2024 "Pulse Daily" - Not documented on 09/04/2024 "Blood Sugar Readings - Scheduled at 8:00 AM, 12:00 PM, 5:00 PM, 7:30 PM" - Not documented 09/05/2024 at 12:00 PM On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he would re-educate staff on the importance of medication administration documentation.	N 415		
N 427	83.38(1)(c) Leisure time activities. 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 residents in all of the following areas: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents.	N 427		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 427	Continued From page 33	N 427		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not provide or arrange services adequate to meet the needs of 8 residents and provide a daily activity program to meet the interests and capabilities of the residents.

Findings include:

The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled.

On 09/06/2024, from approximately 10:15 AM to 3:15 PM, Surveyor did not observe an activity calendar while onsite at the facility.

On 09/06/204, at approximately 10:30 AM, Surveyor interviewed Resident 1. Resident 1 stated, "If we are lucky, we will get one Bingo game per week. Since you are here today, we will probably get a game today."

On 09/06/2024, at approximately 11:20 AM, Surveyor interviewed Resident 7. Resident 7 stated, "We are short on staff, that can affect if we can play Bingo or not. We can take a taxi to the senior center."

On 09/06/2024, at approximately 11:50 AM, Surveyor interviewed Resident 2. Resident 2 stated, "They try to do a game of Bingo once a week."

On 09/06/2024, at approximately 12:10 PM, Surveyor interviewed Resident 3. Resident 3 stated, "There are no activities. [Manager B] is promising to play Bingo today, but that is because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 427	Continued From page 34 you are here." On 09/06/2024, at approximately 1:30 PM, Surveyor interviewed Resident 4. Resident 4 stated, "We can go to activities in the community, but the taxi service gets to be expensive." On 09/06/2024, at approximately 1:50 PM, Surveyor interviewed Resident 5. Resident 5 stated, "There are no activities. I work on my puzzles in my room." On 09/06/2024, at approximately 2:40 PM, Manager B played Bingo with Resident 2, Resident 4, and Resident 7 until 3:00 PM. On 09/06/2024, Surveyor requested the 2023 and 2024 resident satisfaction surveys from Manager B. On 09/10/2024, Surveyor reviewed the resident satisfaction surveys which documented: "I miss Bingo." "More help is needed not enough staff." "Activities you would like to have but are not available - Bingo." "There are no activities here. I don't play cards or Bingo so a lot of options would not interest me." "The facility offers a variety of activities for me to choose from - NO." On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated there had been a shortage of staff and based on the concerns, activities are being neglected. Licensee A stated s/he would discuss the concern with current staff.	N 427		
N 435	83.38(1)(k) Transportation.	N 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 435	Continued From page 35 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 residents in all of the following areas: Transportation. The CBRF shall provide or arrange for transportation when needed for medical appointments, work, educational or training programs, religious services and for a reasonable number of community activities of interest. CBRFs that transport residents shall develop and implement written policies addressing the safe and secure transportation of residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure transportation was provided or arranged for when needed for medical appointments or for a reasonable number of community activities of interest. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, at approximately 11:20 AM, Surveyor interviewed Resident 7. Resident 7 stated s/he liked to visit the local senior center and s/he paid the local transportation cab service to transport her/him to and from.	N 435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 435	Continued From page 36	N 435		

On 09/06/2024, at approximately 1:30 PM, Surveyor interviewed Resident 4. Resident 4 stated s/he utilized the local transportation cab service and s/he had experienced late pick ups times, arriving late to appointments, and the service is expensive.

On 09/10/2024, Surveyor reviewed Resident 1's admission agreement, dated 06/29/2024, which documented:
"Activity Program: Opportunities for leisure, entertainment and socialization are provided and are organized to meet the needs of the residents of [license company]. The resident is encouraged to participate in community events. [License company] provides a daily schedule of activities that encourages participation to maximize independence and maintain interests. The programs are both flexible and structured to meet group and individual needs."
"Excluded Services: The following are the financial responsibility of the Resident: All transportation, including emergency transportation, provided, however, that if the Resident is unable to secure transportation for medical appointments within the City of Madison, [License Company] will provide transportation services."
Surveyor noted the home being surveyed was in Janesville.

On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he had met with Resident 4 earlier in the day and s/he had informed him/her of his/her concerns about transportation. Licensee A stated, "I honestly do not know who is paying for his/her medical transportation and I do not know what is considered a reasonable number of community activities." Licensee A stated s/he would review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 435	Continued From page 37 his/her contract with the residents managed care organizations (MCOs) and determine a policy regarding transportation to community events. Cross Reference: N0427 DHS 83.38(1)(c) Leisure Time Activities	N 435		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not make weekly menus available to residents and deviations from the planned menu were not documented on the menu. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 08/13/2024, the Department received a complaint alleging menus were not conducive to resident dietary needs. On 09/06/2024, at approximately 10:15 AM,	N 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 450	Continued From page 38	N 450		

Surveyor arrived at the facility and observed a menu whiteboard that documented:
Breakfast - Cereal, Toast, Yogurt, Fruit
Lunch - BBQ Wing, Pasta, Corn on the Cob, Cake
Supper - Deli Sandwich, Chips, Cookies

On 09/06/2024, at approximately 10:30 AM, Surveyor interviewed Resident 1. Resident 1 explained that s/he was diabetic and required dialysis treatments and s/he did not feel the menu that was provided was conducive to his/her diagnosis. Resident 1 stated, "I supplement the menu with my personally purchased food items, so I can increase my protein intake. Then I have to hope there is room in the refrigerator for it to be stored, because that can be an issue."

On 09/06/2024, at approximately 11:20 AM, Surveyor interviewed Resident 7. Resident 7 stated, "The food is pretty good, but it is limited. We used to get 3 pieces of bacon or sausage, now we maybe get one piece. If we are offered muffins, they are the mini muffin size, not even a full-sized muffin."

On 09/06/2024, at approximately 11:50 AM, Surveyor interviewed Resident 2. Resident 2 stated s/he had ordered her/himself a pizza as s/he did not care for the food that was being served.

On 09/06/2024, at approximately 12:05 PM, Surveyor observed residents receive the noon meal which consisted of barbecue chicken wings, mini corn on the cob, and a pasta salad.

On 09/06/2024, at approximately 1:30 PM, Surveyor interviewed Resident 4. Resident 4 stated, "We had chicken wings for lunch, there is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 450	Continued From page 39	N 450		

no meat on chicken wings. I can't eat the corn, because I have Crohn's disease (a chronic inflammatory bowel disease (IBD) that can affect any part of the digestive tract, from the mouth to the anus), so I ate the pasta. We don't really get decent helpings of protein."

On 09/06/2024, at approximately 3:00 PM, Surveyor asked Manager B for the provider's menus. Manager B stated they were not available, as Caregiver D had taken them to go grocery shopping.

On 09/06/2024, at approximately 3:15 PM, Surveyor requested the 2023 and 2024 resident satisfaction surveys from Manager B.

On 09/10/2024, Surveyor reviewed a menu that Manager B had forwarded to him/her. The menu did not document what days it was for and was a one-week menu.

On 09/10/2024, Surveyor reviewed the program statement that the provider had on file with the Department, which documented:
"Meals: Will have a variety of nutritional home cooked meals three times a day. We will assess likes, dislikes, allergies, and special diets and plan accordingly. There will always be an alternative meal for a resident who does not like the meal being served. Snacks will be served at least twice a day."

On 09/10/2024, Surveyor reviewed the resident satisfaction surveys which documented:
"We have the same meals over and over again."
"The food served is of a wide variety: NO."
"The food served is always enough: Some meals are small."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSIDE (THE)	2203 HANCOCK LANE JANESVILLE, WI 53545

(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 450	Continued From page 40 On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he would review the menu to determine the variety of food and if the menu was conducive to resident diets and requests.	N 450		
N 480	83.42(3) Access to resident records. The employee in charge on each work shift shall have a means to access resident records. This Rule is not met as evidenced by: Based on observation and interview, the provider did not allow the employee in charge on each work shift to have means to access 8 out of 8 resident records. Findings include: On 09/06/2024, at approximately 10:15 AM, Surveyor arrived at facility and requested a resident roster and staff listing from Manager B, who was the only staff member in the home. Manager B stated s/he had the resident binders at his/her home, as s/he had been updating them. Surveyor asked Manager B if another individual could assist the Surveyor with the survey process, so s/he could go to his/her home and bring the binders to the facility for review. Manager B stated s/he lived an hour away and Licensee A was unavailable. On 09/06/2024 at 1:14 PM, Surveyor emailed Licensee A stating that s/he did not have access to the resident records. On 09/06/2024 at 1:51 PM, Licensee A emailed Surveyor and stated, "Sorry, I guess our manager	N 480		

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	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

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N 480	Continued From page 41 was working from home. Please let me know what documents you need, and I will be happy to help. On 09/06/2024 at 2:13 PM, Surveyor emailed Licensee A and stated s/he was compiling a list and asked if Manager B would be retrieving them from his/her home. On 09/06/2024 at 2:17 PM, Licensee A emailed Surveyor and stated, "What would you prefer? I could come down and relieve [him/her] so [s/he] could go to [city] and get them. Or [s/he] could email scans of them after [s/he] gets home after [his/her] shift. I'm in [city] so it would take some time to get there." Surveyor determined it would be a minimum of a 3-hour wait time for Licensee A to arrive and then for Manager B to drive to his/her home, retrieve the documents, and return to the facility. Surveyor received the documentation on 09/07/2024 and 09/08/2024.	N 480		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that is safe,	N 481		

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N 481	Continued From page 42 clean, comfortable, and homelike. Findings include: On 09/06/2024, from approximately 10:15 AM to 3:15 PM, Surveyor toured the facility and observed the following: Community Area -The bathroom wallpaper border was not adhered to the wall and cobwebs were hanging from it. -The ceiling fan had what appeared to be dust build up on the blades. -Fire sprinklers had what appeared to be cobwebs hanging from them. -Wall vents had what appeared to be cobwebs/dirt buildup hanging on them. Basement Door -Cobwebs were hanging from the interior door frame. Freezer -The ice build up was encompassing the food that was in the freezer creating a higher probability of freezer burn. Resident 2's Bathroom -Toilet paper rod was missing -Toilet bowl had a yellow/brown appearance, due to what appeared to be an irregular cleaning routine. Resident 3's Bathroom -Cobwebs hanging off of ceiling vent/fan. Resident 4's Bathroom -Layer of what appeared to be dust build up on the toilet paper holder. -Layer of what appeared to be dust hanging from	N 481		

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N 481	Continued From page 43	N 481		

the ceiling vent/fan.
-Bathroom vanity had what appeared to be powder spilled around the sink.
-Wood soap dish was covered in a layer of what appeared to be dust buildup.
-Linoleum around the toilet had a dark gold buildup around the toilet base.

Resident 4's bedroom contained a patio door that could not be easily opened more than 12 inches.

Resident 5's Bathroom
-Bathtub appeared to have soap scum build up and a layer of dirt and hair.
-Bathtub/shower tile grout appeared to have a buildup of a black substance.
-Sink appeared to have soap scum build up and a layer of dirt and hair.

Resident 6's Bedroom and Bathroom
-Bathroom vanity appeared to have soap and dirt buildup on the cabinetry
-Shower basin had what appeared to be dirt and hair buildup.
-Layer of what appeared to be dust hanging from the ceiling vent/fan.
-Electric furnace panels had what appeared to be a buildup of dirt.
-The walls contained a brown colored smear above the electric furnace panels

Resident 7's Bedroom
-Dresser had what appeared to be dust buildup along the base.

On 09/06/2024, Surveyor requested the 2023 and 2024 resident satisfaction surveys from Manager B.

On 09/10/2024, Surveyor reviewed the resident

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	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

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N 481	Continued From page 44 satisfaction surveys which documented: "Needs to be vacuumed and dusted." "More help is needed not enough staff." "My room, as well as the rest of the facility, is kept neat and clean - Somewhat." On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he would discuss the concerns with staff.	N 481		
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 and toxic substances were stored in a secured area. This is a repeat deficiency. See Statement of Deficiency (SOD) SNYI11, dated 07/25/2022. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, from approximately 10:15 AM to 3:15 PM, Surveyor conducted an onsite survey and observed the following: Bathroom off kitchen:	N 499		

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N 499	Continued From page 45 -32 fluid ounce bottle of advanced power clinging gel toilet bowl cleaner -A clear bottle with a clear liquid inside. The bottle was labeled "disinfectant." Stairwell to Basement: A basket was hanging on the wall that contained a 5.5 fluid ounce bottle of laundry stain remover. Kitchen sink cabinet: -32 fluid ounce bottle of glass cleaner Garage: -Shelves full of paint cans, spray cans of paint, tubes of caulk, cleaners with bleach, furniture polish, wood cleaner, weed killer, ant killer, etc. These areas were accessible to all residents. Residents were observed moving freely throughout the facility. On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he would place a locking device on the garage door.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that	N 525		

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N 525	Continued From page 46 simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct quarterly fire drills (including at least one fire evacuation drill simulating the conditions during usual sleeping hours) with both employees and residents in 2022 and 2023. The provider only completed 2 of 4 fire drills in 2022. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, Surveyor requested the 2022 and 2023 fire drills from Manager B. Manager B stated s/he would need to forward the documentation to the Surveyor as the information was not onsite, On 09/09/2024, Surveyor reviewed the 2022 and 2023 fire drills that had been forwarded to Surveyor by Licensee A and Manager B. Fire drills were completed 09/22/2022, 12/13/2022, 03/10/2023, 06/24/2023, 09/14/2023 and 12/17/2023. The drills did not document the time of day the drill was completed.	N 525		

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N 525	Continued From page 47 On 09/14/2024 at 3:21 PM, Surveyor emailed Licensee A regarding the concern. On 09/14/2024 at 4:48 PM, Licensee A stated, "I just reread the code again and it does say to document what time they were conducted so I will amend our form moving forward."	N 525		
N 539	83.48(3)(b) Sensitivity testing performed Sensitivity testing shall be performed at intervals in accordance with NFPA 72. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the smoke and heat detection system had sensitivity testing for each device performed at intervals in accordance with NFPA (National Fire Alarm and Signaling Code) 72 requirements. Findings include: On 09/06/2024, at approximately 10:30 AM, Surveyor requested the facility life safety code documentation from Manager B. Manager B stated s/he would need to review the provider's files to determine if the provider had an acceptable sensitivity testing completed in the last five years. On 09/08/2024 at 6:50 PM, Licensee A emailed Surveyor an invoice, dated 11/30/2023, that stated, "1 inspection - 3 annual maintenance, fire extinguishers." On 09/14/2024 at 3:05 PM, Surveyor responded to Licensee A and stated the documentation	N 539		

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N 539	Continued From page 48 provided did not define if the provider had an acceptable sensitivity testing completed in the last five years. On 09/14/2024 at 4:20 PM, Licensee A emailed Surveyor and stated that was the only documentation s/he had regarding smoke detector testing.	N 539		
N 637	83.59(1)(g) Proper exit locations, sidewalks, driveways. All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exits, sidewalks and driveways used for exiting shall be kept free of ice, snow, and obstructions. For facilities serving only ambulatory residents, the CBRF shall maintain a cleared pathway from all exterior doors to be used in an emergency to a public way or safe distance away from the building. For facilities serving semi-ambulatory and non-ambulatory residents, a CBRF shall maintain a cleared, hard surface, barrier-free walkway to a public way or safe distance away from the building for at least 2 primary exits from the building. All other required exits shall have at least a cleared pathway maintained to a public way or safe distance from the building. An exit door or walkway to a cleared driveway leading away from the CBRF also meets this requirement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not provide an unobstructed entrance/exit for	N 637		

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N 637	Continued From page 49 3 of 3 residents. Resident 1, who utilized a wheelchair, Resident 3, who utilized an electric wheelchair, and Resident 6, who utilized a walker struggled to open the front door to the facility. Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, from approximately 10:15 AM to 3:15 PM, Surveyor observed Resident 3 enter and exit the facility. Surveyor noted that Resident 3 struggled to get the door open, as the door was not equipped with an electric handicap door opener. On 09/06/2024, at approximately 1:50 PM, Surveyor walked outside and noted the front door was heavier than most doors found on a home, and it was a self-closing door. Once outside, when Surveyor attempted to enter the home, s/he struggled at first to open the door, as s/he was not prepared for how heavy the door was going to be. On 09/06/2024, at approximately 2:40 PM, Surveyor observed Resident 6 enter the home. Another individual held the door open for him/her. Surveyor noted that Resident 6 displayed involuntary jerking and fidgeting movements of his/her limbs and body. On 09/06/2024, at approximately 3:00 PM, Surveyor interviewed Resident 3. Resident 3	N 637		

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N 637	Continued From page 50 stated the door is heavy and difficult to maneuver through. Resident 3 stated, "If you look at the door, you will see all the scrapes on it from my wheelchair." On 09/06/2024, at approximately 3:15 PM, Surveyor interviewed Resident 1. Resident 1 stated the door is heavy and difficult to maneuver through. Resident 1 stated, "The goal is to get a staff member to assist you, but they often will tell you you can do it on your own. I feel really bad for [Resident 6] who has Huntington's." On 09/06/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he would look at the door mechanisms and determine if a resolution to the concern could be accomplished.	N 637		
N 640	83.59(2)(b) Solid core wood doors or equivalent A solid core wood door or an equivalent fire resistive door shall be provided at any interior stair between the basement and the first floor. The door shall have a positive latch and an automatic closing device and normally shall be kept closed. Enclosed furnace and laundry areas with self-closing doors in a split level home may substitute for the self-closing door between the first and second levels. Enclosed furnace and laundry areas shall have self-closing solid core wood doors or an equivalent fire resistive door when located on a common level with resident bedrooms. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the door leading to the basement was self-closing, which is located on the same floor as resident bedrooms.	N 640		

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	0018574	A. BUILDING: _____ B. WING _____	C 09/16/2024

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N 640	Continued From page 51 Findings include: The provider is licensed to serve up to 8 residents within the client groups irreversible dementia/Alzheimer's, advanced aged, emotionally disturbed/mental illness, and physically disabled. On 09/06/2024, from approximately 10:15 AM to 3:15 PM, Surveyor conducted an onsite survey and observed the door leading to the basement was self-closing but did not secure upon self-closure. Manager B informed Surveyor that residents do not go downstairs. On 09/16/2024 at 2:00 PM, Surveyor interviewed Licensee A. Licensee A stated s/he was aware of the concern and would be addressing it.	N 640		