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 _____	R-C 05/22/2025

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 05/20/2025, with information gathered through 05/22/2025, Surveyor conducted a verification visit at Hearthside (The). Three deficiencies were identified. One of 3 deficiencies were repeat violations (see Statement of Deficiency (SOD) YFMI11). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 8	{N 000}		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure 1 of 1 resident's Individual Service Plans (ISPs) was updated when there was a change of condition in the resident's needs, abilities, or physical or mental condition.	N 389		

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
	0018574	A. BUILDING: _____ B. WING _____	R-C 05/22/2025

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 389	Continued From page 1 Resident 9's ISP was not updated when s/he was placed on a smoking schedule. Findings include: On 05/20/2025, at approximately 1:50 PM, Surveyor interviewed Resident 9 in his/her room. Resident 9 stated s/he had to follow the smoke schedule. Resident 9 did not believe s/he should have to follow a schedule as s/he was independent with his/her ability to smoke. Resident 9 stated, "All I am asking for is two additional smoke breaks, I like to smoke when I wake up and I like to smoke after I eat. When I am at work, I have a different smoke schedule and the days that I do not work, there is no flexibility as to when a person can have a smoke break." Resident 9 stated, "If you press the issue then you are told 'I am not playing around.'" Resident 9 stated, "You just stay in your room, it is depressing. [Manager B] tells me to get into your room, always told to go to your room." As Surveyor was exiting Resident 9's room, s/he observed a sign on the door that stated, "Smoke Breaks - 9:15 AM, 11:15 AM, 1:45 PM, 5:45 PM, 7:45 PM." On 05/20/2025, Surveyor reviewed Resident 9's "Individual Service Plan," dated 04/01/2025, which documented: "Orientation and Memory: Oriented to Person, Oriented to Place, Oriented to Time or Date" "Communication: Able to make needs known" "Transfer: Independent" "Ambulation/Mobility: Independent" "Behavior: No Concerns - sensitive to approach for cueing" "Socialization/Activities: List of Interests - Smoking ..."	N 389		

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 _____	R-C 05/22/2025

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 389	Continued From page 2 "Drug/Alcohol History: Requires 1:1 when OOF (out of facility)" "Smoking Risk: Demonstrates safe use of cigarettes and no indication of burns on skin, clothing, etc. - Supervision outside not necessarily r/t (related to) smoking." "Fall Risk - No Concerns" On 05/20/2025, at approximately 2:30 PM, Surveyor interviewed Licensee A. Surveyor asked for clarification regarding Resident 9's smoking schedule. Licensee A stated Resident 9 was to be supervised during smoke breaks, so a schedule was set up that worked with the staff schedule. Surveyor stated that the restrictive measure was not identified in Resident 9's ISP. Licensee A stated s/he would update his/her ISP accordingly.	N 389		
N 408	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the	N 408		

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 _____	R-C 05/22/2025

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 408	Continued From page 3	N 408		

medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure that 3 of 3 residents prescribed PRN (as needed) psychotropic medication was documented on the Individualized Service Plan (ISP). The ISP did not include a rationale for use, nor a detailed description of the behaviors which indicate the need for administration of the PRN psychotropic.

Resident 6's and Resident 7's prescribed Hydroxyzine was not listed on his/her ISP.
Resident 9's prescribed PRN Quetiapine was not listed on his/her ISP.

Findings include:

Example 1: Resident 6

On 05/20/2025, at approximately 11:10 AM, Surveyor observed Resident 6's blister card of Hydroxyzine in the med cart. The blister card documented, "Take 0.5 (one-half) table to 1 (one) tablet by mouth once daily as needed at approximately 3-4 PM for agitation. Start Date: 02/28/2025."

On 05/20/2025, Surveyor reviewed Resident 6's record.

Resident 6's ISP, dated 03/27/2025, documented:
"Mood - Angry or Agitation. Staff to redirect and deescalate."
"Behavior - Verbal aggression/threats, Physical aggression self/others. Staff to redirect when

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 _____	R-C 05/22/2025

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 408	Continued From page 4	N 408		

aggressive."
"Medications - Staff assist. Document meds given and PRN effectiveness."

The ISP did not identify that Resident 6 was on PRN Hydroxyzine or include a rationale for use nor a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication.

Example 2: Resident 7

On 05/20/2025, Surveyor reviewed Resident 7's record.

Resident 7's May 2025 Medication Administration Record (MAR), dated 05/01/2025 to 05/20/2025, documented:
"Hydroxyzine HCL (hydrochloride) 50 MG (milligram) tab (tablet) - Take 1 tablet by mouth daily at bedtime as needed for anxiety."

Resident 7's ISP, dated 04/01/2025, documented:
"Mood - Depression/Withdrawn. Staff to document mood changes."
"Behavior - No concerns. Staff to document incidents or ineffective de-escalation."
"Medications - Staff assist. Document meds given and PRN effectiveness."

The ISP did not identify that Resident 7 was on PRN Hydroxyzine or include a rationale for use nor a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication.

Example 3: Resident 9

On 05/20/2025, at approximately 11:10 AM, Surveyor observed Resident 9's blister card of

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 _____	R-C 05/22/2025

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 408	Continued From page 5	N 408		

Quetiapine in the med cart where 29 of 30 tablets remained. The blister card documented, "Take 1 tablet by mouth at bedtime as needed for agitation. Start Date: 11/05/2024.

On 05/20/2025, Surveyor reviewed Resident 9's record.

Resident 9's ISP, dated 04/01/2025, documented: "Mood - Appropriate. Mild depression. Mild Anxiety. Staff to document mood changes." "Behavior - Sensitive to approach for cueing." "Medications - Staff assist. Document meds given and PRN effectiveness."

The ISP did not identify that Resident 9 was on PRN Quetiapine or include a rationale for use nor a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication.

On 08/24/2021 at 9:30 AM, Surveyor interviewed Director-B. Surveyor stated that Resident 1's ISP should include the type of PRN psychotropic medication a resident is on, along with the rationale for use. Director-B stated the MAR stated the Lorazepam was prescribed for anxiety. Surveyor asked how staff would know when Resident 1 was not within in his/her baseline since the MAR appears to be documenting insomnia as a use for the Lorazepam. Director-B stated s/he understood concern and would be updating the ISP and working with staff. Surveyor asked if Director-B had any additional documentation regarding the monthly review of the Lorazepam. Director-B stated s/he did not.

On 05/20/2025, at approximately 2:30 PM, Surveyor interviewed Licensee A. Surveyor discussed the requirement for the rationale for

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 _____	R-C 05/22/2025

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 408	Continued From page 6 PRN psychotropics to be identified in the ISP, along with the psychotropic medication. Licensee A stated s/he would review the resident ISPs and update accordingly.	N 408		
{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. This is a repeat deficiency. See Statement of Deficiency (SOD) YFMI11, dated 09/16/2024. Findings include: On 05/20/2025, at approximately 12:30 PM, Surveyor requested the facility life safety code documentation from Licensee A. Licensee A went through his/her records and found an invoice stating that the smoke detectors had been inspected in 09/2024. Surveyor asked if s/he had documentation showing that an acceptable sensitivity test of the smoke detectors had been completed in the last five years. Licensee A stated s/he would contact the vendor. On 05/20/2025 at 5:24 PM, Licensee A emailed Surveyor and stated that the vendor would schedule a time to complete the required sensitivity test.	{N 539}		