| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 110458 | A. BUILDING: _____ B. WING _____ | R 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REM JONATHON | 223/225 JONATHON DR JANESVILLE, WI 53548 |

| (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<br><br>On 01/15/2026, Surveyor conducted a verification visit at REM Jonathon, a CBRF in Janesville.<br><br>One deficiency was identified. This is a repeat deficiency. See statement of deficiency (SOD) #OO8S11, dated 06/25/2021, SOD # OO8S12, dated 09/29/2021, and SOD # ZNNV11, dated 09/30/2025. Four of the 5 deficiencies from SOD ZNNV11, dated 09/30/2025, were substantially corrected.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 6 | {N 000} | | |
| {N 403} | 83.37(1)(d) Documentation.<br><br>Documentation. As required in s. DHS 83.42 (1) (m), when a resident is taking prescription or over-the-counter medications or dietary supplements, the resident ' s record shall include a current list of the type and dosage of medications or supplements, directions for use, and any change in the resident ' s condition.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the provider did not ensure that documentation was completed in the Medication Administration Record (MAR) for 2 of 2 residents. Residents 1 and Resident 2 had missing documentation for August 2025 and September 2025. | {N 403} | | |

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 |
|---|---|---|---|
| | 110458 | A. BUILDING: _____ B. WING _____ | R 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REM JONATHON | 223/225 JONATHON DR JANESVILLE, WI 53548 |

| (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 403} | Continued From page 1<br>This is a repeat violation from Statement of Deficiency (SOD) #OO8S11, dated 06/25/2021, SOD # OO8S12, dated 09/29/2021 and SOD ZNNV11, dated 09/30/2025.<br><br>Findings include:<br><br>Example 1 - Resident 1<br><br>Surveyor reviewed Resident 1's MAR for December 2025 and January 2026.<br><br>Gabapentin 250 mg give 3 times daily<br><br>There was no documentation in Resident 1's MAR the following dates:<br><br>01/01/2026<br><br>Lamotrigine 200 mg give 1 time daily<br><br>There was no documentation in Resident 1's MAR for the following dates:<br><br>01/01/2026<br><br>Levetiracetam 100 mg give 2 times daily<br><br>There was no documentation in Resident 1's MAR for the following dates:<br><br>01/01/2026<br><br>Example 2 - Resident 2<br><br>Surveyor reviewed Resident 2's MAR for December 2025 and January 2026. | {N 403} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 110458 | A. BUILDING: _____ B. WING _____ | R 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REM JONATHON | 223/225 JONATHON DR JANESVILLE, WI 53548 |

| (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 403} | Continued From page 2<br><br>Benzatropine<br><br>There was no documentation in Resident 2's MAR for the following dates:<br><br>12/02/2025<br>12/22/2025<br>12/23/2025<br>12/24/2025<br>12/25/2025<br>12/26/2025<br>01/07/2026<br>01/08/2026<br>01/11/2026<br>01/12/2026<br><br>Clonazepam<br><br>There was no documentation in Resident 2's MAR for the following dates:<br><br>12/02/2025<br>12/22/2025<br>12/23/2025<br>12/24/2025<br>12/25/2025<br>12/26/2025<br>01/07/2026<br>01/08/2026<br>01/11/2026<br>01/12/2026<br><br>There was no documentation in Resident 2's MAR for the following dates: | {N 403} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 110458 | A. BUILDING: _____ B. WING _____ | R 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| REM JONATHON | 223/225 JONATHON DR JANESVILLE, WI 53548 |

| (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 403} | Continued From page 3<br><br>Escitalopram<br>12/02/2025<br>12/22/2025<br>12/23/2025<br>12/24/2025<br>12/25/2025<br>12/26/2025<br>01/07/2026<br>01/08/2026<br>01/11/2026<br>01/12/2026<br><br>On 01/15/2026 at 11:30 a.m., Surveyor discussed the above concerns with Program Director G. Program Director A acknowledged the missing documentation in the MAR. Program Director G stated that Resident 2 goes home with family and staff did not fill in the MAR. Program Director G did state that staff were trained to pass medications. | {N 403} | | |