STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Knoll Health Care	N7135 Rocky Knoll Parkway Plymouth, WI 53073

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not ensure an allegation of sexual abuse was reported to the State Agency (SA) for 2 residents (R) (R2 and R5) of 3 sampled residents. On 4/21/24, R5 approached R2 in the lobby. R5 kissed R2 on the mouth and R2 touched R5's breast. The allegation of sexual abuse was not reported to the SA. Findings include: The facility's Freedom From Abuse, Neglect, and Exploitation policy, with a review date of 10/23, indicates: The facility will provide a safe resident environment and protect residents from abuse .Sexual abuse includes, but is not limited to: Unwanted intimate touching of any kind especially of breasts or perineal area. Generally, sexual contact is non-consensual if the resident either: Appears to want the contact to occur, but lacks the cognitive ability to consent; or does not want the contact to occur. Capacity means a resident has the ability to understand potential consequences and choose a course of action for a given situation. A resident's apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent .Initial Report: For alleged violations .that do not result in serious bodily injury, the facility will report the allegation no later than 24 hours .7. If an incident potentially meets the federal definition, it is not necessary to review the state definitions. 8. Federal definitions do not specify that the alleged incident has to involve a caregiver, so mistreatment by anyone, including resident-to-resident incidents, if appropriate, must be submitted to the Division of Quality Assurance (DQA) immediately. On 7/3/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including vascular dementia with moderate behavioral disturbance, major depressive disorder, and anxiety disorder. R2's Minimum Data Set (MDS) assessment, dated 3/1/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated Power of Attorney for Healthcare (POAHC) and passed away at the facility on 6/25/24. On 7/3/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with late onset, dementia in other diseases with mood disturbance, generalized anxiety disorder, and major depressive disorder. R5's MDS assessment, dated 4/24/24, had a BIMS score of 4 out of 15 which indicated R5 had severely impaired cognition. R5 had an activated POAHC. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE N7135 Rocky Knoll Parkway Plymouth, WI 53073	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's medical record contained an incident note, dated 4/21/24 at 1:05 PM, that indicated: R2 was wheeling R2's self back from the dining room when R5 sought out R2, pulled back R2's wheelchair, and kissed R2 on the mouth. R2 responded by caressing R5's right breast. R5 removed R2's hand from R5's breast and stated, No, no. We can't do that. R2 and R5 were separated and supervised when R2 and R5 were out of their rooms. Administrative staff and R2 and R5's POAHC were updated. All were in agreement with the separation/supervision plan. R5's medical record contained an incident note, dated 4/21/24 at 11:16 AM, that indicated: Late Entry: R5 sought out R2 who was using the railing for assistance to wheel R2's self out of the dining room. R5 pulled R2 around in R2's wheelchair and kissed R2 on the mouth. R2 responded by caressing R5's breast. R5 removed R2's hand from R5's breast and stated, No, no. We can't do that. Staff assessed R5's right breast and noted no injury, bruising or pain. R5 and R2 were separated and supervised when R5 and R2 were out of their rooms. Administrative staff and R5 and R2's POAHC were updated. All were in agreement with the separation/supervision plan. On 7/3/24, the facility provided a risk management incident report which included the Wisconsin Department of Health Services (DHS) form P-00361, dated 6/2018, and titled Resident to Resident Interaction Decision Tree. Highlighted on the decision tree was the following: Did the Resident Act Willfully? The facility answered Yes. The decision tree then led to the question: Did the other resident suffer pain, physical injury, psychological or emotional harm as a result of the altercation? If the victim cannot give a response, consider whether a reasonable person would have experienced psychological distress. The facility highlighted No which led to the decision to not report the incident to the SA. The facility also provided DHS form P-00976 Misconduct Definitions, dated 11/2017, that contains 2 columns. The first column lists the Code of Federal Regulations CFR 483.5. On the form, sexual abuse is defined as nonconsensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault. The form states: Note that the federal definition of abuse indicates that the act needs to be willful and that it needs to have resulted in physical or psychosocial harm to the resident or, if the resident cannot provide a response, would be expected to have caused harm to a reasonable person. The form also states: For a definition of willful refer to the interpretive guidance at F689 where, under resident-to-resident altercations it notes: A resident-to-resident altercation should be reviewed as a potential situation of abuse which should be investigated under the guidance of 42 CFR 483.12. Willful means the individual intended the action itself, regardless of whether or not the individual intended to inflict injury or harm. Even though a resident may have cognitive impairment, he/she can still commit a willful act. The 2nd column on the form lists Wisconsin Administrative Code Chapter DHS 13 Caregiver Misconduct Definitions. The column provides a definition of abuse as an act or repeated acts by a caregiver or non-client resident. The facility highlighted in the DHS Caregiver Misconduct definitions column the following: Abuse does not include an act or acts of mere .incapacity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE N7135 Rocky Knoll Parkway Plymouth, WI 53073	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 3:57 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Assistant Administrator (AA)-C regarding reporting to the SA. NHA-A and AA-C indicated the facility did not report the allegation of sexual abuse to the SA because they determined the incident was not an abuse situation and no harm occurred as indicated by R5's skin assessment. When Surveyor asked if R2 or R5 suffered emotional or psychological harm in the days following the event, AA-C stated the facility completed a Social Services Assessment for R5 and provided Surveyor with a copy of the assessment. Surveyor noted the assessment was completed on 4/24/24 (which was more than 24 hours after the initial report was due to the SA). In addition, Surveyor requested any assessments related to capacity to consent for R2 and R5. The facility provided a Social Services Assessment, dated 4/24/24 (which was more than 24 hours after the incident occurred), which indicated R5's decision making was severely impaired. The assessment indicated R5 was able to make simple decisions as to whether R5 preferred coffee or milk, but complex medical decisions were made by R5's family. Section 12 of the assessment, titled Intimacy, assessed the following: Are you currently in a relationship? The assessment indicated R5 was not in a current relationship. Do you have any interest in pursuing a relationship while at the facility? The assessment indicated R5 did not have an interest in pursuing a relationship while at the facility. Surveyor noted the check boxes for an intimacy care plan were not checked. AA-C and NHA-A confirmed official capacity to consent assessments were not completed for R2 or R5.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE N7135 Rocky Knoll Parkway Plymouth, WI 53073	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on staff interview and record review, the facility did not thoroughly investigate an allegation of sexual abuse for 2 residents (R2 and R5) of 3 sampled residents. On 4/21/24, R5 approached R2 in the lobby. R5 kissed R2 on the mouth and R2 touched R5's breast. The facility did not thoroughly investigate the allegation of sexual abuse. The facility's investigation did not include interviews with R5 and R2, interviews with other resident interviews, and interviews with staff who were working at the time of the incident. Findings include: The facility's Freedom from Abuse, Neglect, and Exploitation policy, with a revised date of 10/23, indicates: Protection and Investigation: 6. Begin a thorough investigation. 7. Information will be collected that corroborates or disproves the incident and findings documented for each incident. 9. An analysis will be conducted as to why the situation occurred, risk factors that contributed to the abuse, and whether there is a need for systemic action. A thorough investigation may include the following: .3. Interviewing the alleged victim(s) witnesses(es): b. in cases of potential sexual abuse, evaluating and determining if the resident(s) has the capacity to consent and whether the resident actually consented to the sexual activity. Refer to Capacity to Consent policy and procedure. 4. Interviewing accused individuals. 5. Interviewing other residents to determine if they have been abused or mistreated. 6. Interviewing staff who worked the same shift .to determine if they witnessed any mistreatment by the accused; 7. Interviewing staff who worked other shifts to determine if they were aware of an injury or incident. 9. Involving regulatory authorities who may assist . On 7/3/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including vascular dementia with moderate behavioral disturbance, major depressive disorder, and anxiety disorder. R2's Minimum Data Set (MDS) assessment, dated 3/1/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated Power of Attorney for Healthcare (POAHC) and passed away at the facility on 6/25/24. On 7/3/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with late onset, dementia in other diseases with mood disturbance, generalized anxiety disorder, and major depressive disorder. R5's MDS assessment, dated 4/24/24, had a BIMS score of 4 out of 15 which indicated R5 had severely impaired cognition. R5 had an activated POAHC. R2's medical record contained an incident note, dated 4/21/24 at 1:05 PM, that indicated: R2 was wheeling R2's self back from the dining room when R5 sought out R2, pulled back R2's wheelchair, and kissed R2 on the mouth. R2 responded by caressing R5's right breast. R5 removed R2's hand from R5's breast and stated, No, no. We can't do that. R2 and R5 were separated and supervised when R2 and R5 were out of their rooms. Administrative staff and R2 and R5's POAHC were updated. All were in agreement with the separation/supervision plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER: Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE: N7135 Rocky Knoll Parkway Plymouth, WI 53073	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's medical record contained an incident note, dated 4/21/24 at 11:16 AM, that indicated: Late Entry: R5 sought out R2 who used the railing to assist R2 when wheeling out of the dining room. R5 pulled R2 around in R2's wheelchair and kissed R2 on the mouth. R2 responded by caressing R5's breast. R5 removed R2's hand from R5's breast and stated, No, no. We can't do that. Staff assessed R5's right breast and noted no injury, bruising, or pain. R5 and R2 were separated and supervised when R5 and R2 were out of their rooms. Administrative staff and R5 and R2's POAHC were updated. All were in agreement with the separation/supervision plan. When Surveyor requested to review the facility's investigation, the facility provided a risk management report, dated 4/21/24, that indicated R5 and R2 were immediately separated and supervised. The report also indicated R5 and R2's POAHC were updated and in agreement with the interventions put in place. R2's care plan was updated to include a stop sign banner across R2's door so R5 did not enter R2's room. R5's care plan was updated with the following intervention: (R5) seeks affection from male residents and needs to be kept separate from male residents. Closely monitor (R5) when out of room and redirect (R5) away from male peers when attempting to touch or kiss others. The facility also provided staff education regarding updates to R2 and R5's care plans. On 7/3/24 at 3:57 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Assistant Administrator (AA)-C regarding interviewing other residents as part of the investigation. AA-C stated R2 and R5 were the only 2 residents involved in the situation and AA-C was unsure what other residents should have been interviewed. On 7/8/24 at 2:52 PM, the facility provided Surveyor with staff statements regarding the incident via email. The facility did not provide other resident interviews or assessments. On 7/9/24 at 3:50 PM, NHA-A indicated via email that the facility did not complete other resident interviews because the incident was a witnessed, singular event and abuse was ruled out. NHA-A stated residents on the unit had dementia and memory deficits and many were not interviewable. NHA-A also stated because the facility followed the flow sheet and ruled out abuse, the facility did not feel safety was a concern and indicated there were no other incidents beyond the witnessed incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE N7135 Rocky Knoll Parkway Plymouth, WI 53073	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43361 Based on observation, staff interview, and record review, the facility did not ensure care plan interventions were followed which resulted in a resident-to-resident interaction between 2 residents (R) (R2 and R5) of 11 sampled residents. On 4/21/24, R5 approached R2 and kissed R2 on the mouth. R2 then touched R5's breast. The incident occurred while R2 self-propelled R2's wheelchair back from the dining room. R2's care plan contained an intervention to escort R2 to and from R2's room and keep R2 separate from female residents. The intervention was not consistently followed. Findings include: On 7/3/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including vascular dementia with moderate behavioral disturbance, major depressive disorder, and anxiety disorder. R2's Minimum Data Set (MDS) assessment, dated 3/1/24, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R2 had moderately impaired cognition. R2 had an activated Power of Attorney for Healthcare (POAHC) and passed away at the facility on 6/25/24. R2 had a care plan intervention, initiated on 3/18/24, that indicated: Escort (R2) to/from room. To be direct supervision at all times when out of room. To be seated near an exit and sit with all males when in dining room. To be kept separate from female residents. On 7/3/24, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease with late onset, dementia in other diseases with mood disturbance, generalized anxiety disorder, and major depressive disorder. R5's MDS assessment, dated 4/24/24, had a BIMS score of 4 out of 15 which indicated R5 had severely impaired cognition. R5 had an activated POAHC. R2's medical record contained an incident note, dated 4/21/24 at 1:05 PM, that indicated: R2 was wheeling R2's self back from the dining room when R5 sought out R2, pulled back R2's wheelchair, and kissed R2 on the mouth. R2 responded by caressing R5's right breast. R5 removed R2's hand from R5's breast and stated, No, no. We can't do that. R2 and R5 were separated and supervised when R2 and R5 were out of their rooms. Administrative staff and R2 and R5's POAHC were updated. All were in agreement with the separation/supervision plan. R5's medical record contained an incident note, dated 4/21/24 at 11:16 AM, that indicated: Late Entry: R5 sought out R2 who was using the railing to assist R2 when wheeling out of the dining room. R5 pulled R2 around in R2's wheelchair and kissed R2 on the mouth. R2 responded by caressing R5's breast. R5 removed R2's hand from R5's breast and stated, No, no. We can't do that. Staff assessed R5's right breast and noted no injury, bruising or pain. R5 and R2 were separated and supervised when R5 and R2 were out of their rooms. Administrative staff and R5 and R2's POAHC were updated. All were in agreement with the separation/supervision plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Rocky Knoll Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE N7135 Rocky Knoll Parkway Plymouth, WI 53073	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/24 at 12:52 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-G who stated CNA-G was working when the incident between R2 and R5 occurred but did not witness the incident. CNA-G was aware that R2 should be escorted to and from the dining room and stated R2 was seated at a table with all males near the door. CNA-G saw R2 leave the dining room and stated staff would have been a minute behind R2 because staff intervened quickly. On 7/3/24 at 1:06 PM, Surveyor interviewed CNA-F who was a regular staff on the unit. CNA-F was aware that R2 needed to be escorted to and from R2's room. CNA-F stated staff were busy in the dining room assisting residents with eating during meal time. CNA-F confirmed R2 was seated at an all male table near the exit and stated R2 did not always want to wait for staff to escort R2 back to R2's room. When asked if R2 exited the dining room independently on 4/21/24, CNA-F stated R2 probably did because R2 was often impatient. On 7/3/24 at 2:15 PM, Surveyor interviewed Registered Nurse (RN)-E who was working when the incident occurred and wrote the progress notes in R and R5's medical records. RN-E stated RN-E witnessed part of the incident. RN-E observed R2 pull on the railing and head from the dining room toward R2's room. RN-E was near the med cart and there were staff in the vicinity, but R2 was not being escorted. RN-E stated R2 was quick. RN-E heard commotion, looked up, saw R2 and R5's lips come apart, and saw R2's hand touch R5's breast. RN-E stated R5 stopped R2's hand right away. RN-E stated the interaction was unexpected and R5 approached R2 first. RN-E stated R2's care plan interventions regarding female residents were well known to staff. RN-E stated RN-E would have called the on-call manager but could not recall the name of the manager. RN-E completed a skin assessment of R5 to ensure there was no injury to R5's breast and put interventions in place to ensure R5 and R2's safety. On 7/3/24 at 2:45 PM, Surveyor interviewed CNA-D who was working at the time of the incident and intervened after the incident occurred. CNA-D said R2 was often impatient and staff did not bring R2 to the dining room until R2's meal was ready because R2 would not stay in the dining room. CNA-D stated R2 sat at a table with 2 other male residents on 4/21/24 and CNA-D assisted the other male residents while R2 ate. CNA-D stated R2 ate quickly and wanted to leave the dining room as soon as R2 was finished. CNA-D saw R2 leave the dining room and told R2 that CNA-D would be right there, however, CNA-D continued to assist the other 2 residents and forgot to assist R2 back to R2's room. When CNA-D heard a staff state that R5 was near R2, CNA-D got up right away and saw R5 lean over and kiss R2 and saw R2 touch R5's breast. CNA-D stated R2 stopped touching R5 when R5 pushed R2's hand away and said R2 and R5 couldn't do that. CNA-D intervened and took R2 to R2's room. CNA-D was aware that R2 should have been escorted from the dining room to R2's room and confirmed R2 was not being escorted at the time the incident occurred. On 7/3/24 at 3:57 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Assistant Administrator (AA)-C who stated NHA-A and AA-C expect staff to escort R2 to and from the dining room as indicated in R2's plan of care.