STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525337	A. Building B. Wing	07/11/2025

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. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure an allegation of abuse was reported timely to the State Agency (SA) for 1 resident (R) (R1) of 4 sampled residents. This had the potential to affect resident safety in the facility.R2 hit R1 in the dining room on 5/30/25. The allegation of abuse was not reported to the SA in a timely manner.Findings include:Review of the facility's Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property policy, revised 03/25, indicates: Initial Report, a. For alleged violations of abuse or if there is resulting serious bodily injury, the facility will report the allegation immediately, but no later than 2 hours after the allegation is made .Review of the admission Record found under the Profile tab in the electronic medical record (EMR) revealed R2 was admitted on [DATE] with diagnoses of neurocognitive disorder with Lewy bodies, dementia without behavior disturbance, psychotic disturbance, mood and anxiety disturbance, and anxiety disorder. Review of the Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/13/25, indicated R2 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R2 had moderately impaired cognition.Review of the admission Record found under the Profile tab of the EMR revealed R1 was admitted on [DATE] with diagnoses of Alzheimer's late onset, dementia without behavior disturbance, psychotic disturbance, mood and anxiety disturbance, and hearing loss.Review of the Quarterly MDS assessment, with an ARD of 5/29/25, indicated R1 had a BIMS score of 00 out of 15 which indicated R1 had severely impaired cognition.Review of the facility's report to the SA indicated on 6/1/25, a Registered Nurse (RN) read an email that was sent on 5/30/25 from an agency Licensed Practical Nurse (LPN) that indicated R2 became agitated during dining and grabbed R1. There was no injury noted and behavior charting was started for R2.A progress note for R2 indicated R2 became agitated in the dining room and began hitting and kicking at staff when staff tried to assist R2 back to R2's table to finish eating. R2 stood from the chair and grabbed onto R1's right arm. Staff assisted R2 back to the chair. R2 was finished eating and staff brought R2 to R2's room for night cares. R1 and R2 were separated and assessed for pain and injury at the time of the incident. None were noted. R2 was placed on 1:1 supervision. Dining room seating was reorganized to separate R1 and R2 and keep other residents out of R2's reach. The police were notified. During an interview on 7/11/25 at 11:48 AM, Certified Nursing Assistant (CNA)3 revealed that R2 became agitated in the dining room on 5/30/25 at approximately 5:45 PM. R2 was yelling and stood up from the table and grabbed R1's arm. CNA3 indicated someone ran to get a nurse. R1 and R2 were separated and LPN1 took R2 out of the dining room. CNA3 indicated there was a lot going on that evening and it was chaos. During an interview on 7/11/25 at 11:59 AM, CNA4 revealed that R2 became upset in the dining room on 5/30/25 at approximately 5:45 PM and stood up from the table yelling. R1 told R2 to shut the hell up. R2 then grabbed R1's arm and hit R1. CNA4 indicated CNA3 ran to get a nurse and R1 and R2 were separated. CNA4 stated LPN1 entered the dining room and tried to calm R2 down. LPN1 was at eye level with R2 in R2's wheelchair when R2 kicked LPN1 in the chest. LPN1 then took R2 out of the dining room. CNA4 stated R1 was assessed, had no injuries, and didn't say anything. CNA4 stated they were all shocked because R1 never says anything.During an interview on 7/11/25 at 12:36 PM, LPN1 revealed LPN1 heard LPN1's name called and went to the dining room. LPN1 tried to calm R2 and was at eye level with R2 in R2's wheelchair when R2 kicked LPN1 in the chest. LPN1 took R2 to the nurses' station and continued to try to calm R2 down. When that didn't work, LPN1 pushed R2 around the building. After R2 calmed down, LPN1 took R2 back to the dining room to eat dessert. LPN1 informed LPN2 (R2's primary nurse) the next time LPN1 saw LPN2 which was between 6:45 PM and 7:00 PM.During an interview on 7/11/25 at 2:12 PM, CNA5 revealed R2 was yelling and R1 told R2 to shut the hell up on 5/30/25 at approximately 5:45 PM. R2 then grabbed R1's arm and hit R1. CNA5 indicated someone ran to get a nurse and R1 and R2 were separated. R2 was taken out of the dining room by LPN1. CNA5 stated there was a lot going on that evening. CNA5 revealed that LPN1 was told what happened.LPN2 was unavailable for interview.According to the facility's investigation, LPN2 overheard two CNAs discussing the event in the dining room on 5/30/25 at 9:00 PM. LPN2 asked the CNAs to write statements and notified the charge Registered Nurse (RN), who was not available for interview after three attempted calls. LPN2 also sent an email to the Director of Nursing (DON) which was read on 6/1/25. The incident was then reported to the SA.During an interview on 7/11/25 at 4:45 PM, Surveyor and the Nursing Home Administrator (NHA) discussed the facility's Abuse policy which