STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525390	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Haven	3400 N Cty Trk Hwy F Janesville, WI 53547

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to follow professional standards for 1 of 3 residents (R8) reviewed for Power of Attorney (POA) status out of a total sample of 15. Findings include: Review of R8's undated Face Sheet, located under the Face Sheet tab in the electronic medical record (EMR), indicated R8 was admitted to the facility on [DATE] with diagnoses that included fracture of the left pubis, cancer, and Alzheimer's disease. Review of R8's admission Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of [DATE], indicated R8 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated R8 was moderately cognitively impaired. Review of R8's Advance Directive including Power of Attorney for Health Care, which was provided by the facility and signed by R8 on [DATE], revealed R8's spouse had been selected as the resident's health care agent. The form recorded, . If the health care agent is unable or unwilling to make choices for me, then my next choice for a health care agent is . and Daughter1 was named. The form continued to record, . If the alternate health care agent is unable or unwilling to make these choices for me, then my next choice for a health care agent is . and Daughter2 was named. This was presented to the facility at the time of admission. Review of R8's Social Service Progress Note, provided by the facility and dated [DATE] at 3:33 PM, revealed, . Family came in today to inform resident her husband passed away last evening. Review of R8's EMR revealed a second Power of Attorney for Health Care, which was provided by the facility and signed by R8 on [DATE]. In this POA document, under the section of Designation of Health Care Agent the form recorded, If I am no longer able to make health care decision for myself, due to my incapacity, I hereby designate . and [Daughter 1's Name] was named. The form continued to record, . If he or she is ever unable or unwilling to do so, I hereby designate . and [Daughter 2's Name] was named. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R8's Social Service Progress Note, provided by the facility and dated [DATE] at 4:59 PM, revealed, This writer heard from [R8's] daughter [name of Daughter1]. She [Daughter1] stated she doesn't know what to do because she relinquished as POA some months back because she had a health concern and wasn't able to make the trip each week. She [Daughter1] had been driving 300 miles about every week and a half to take her father to doctor's appointments and care for her mother [R8]. One day after she [R8] was admitted here the family came in to let her know her husband died. At this time [sic] she [R8] still thinks she is going home to him, In the meantime, [Daughter2] the other daughter went to the bank had everything transferred so she [Daughter2] could be POA over finances and went to an attorney to get the health POA changed so she [Daughter2] is in control. This writer had [R8] sign a new POA for health on 04.10.2025 since [R8's] husband passed away. [R8] said it was fine once this writer told her nothing would change. This writer kept it the same way, [Daughter1] was first, then [Daughter2] . During an interview on [DATE] at 1:16 PM, the Social Worker (SW) stated, The day she [R8] was admitted her whole family was here with her to tell her that her husband had passed away the night before. The family was attentive and did what they could. Her husband had passed away and he was her original POA along with the two daughters as alternates. Wherever I have worked before and while I have been here, I have just drawn up a new one [POA] if this happened. I didn't see anything wrong with doing it that way. Everything stayed exactly the same except the husband was removed. The SW was asked when she had conversations with R8 and/or R8's daughters regarding preparing a new POA document. The SW replied, I talked to her [name of Daughter1] a lot. The SW was asked if she had documentation of these conversations with R8 and/or R8's daughters and the SW stated, Let me go and I will bring it back to you. The SW returned with a copy of the progress notes dated from [DATE] through [DATE]. The SW confirmed she documented the progress notes. Review of the progress notes presented reflected only one conversation, dated [DATE] at 4:59 PM. The SW was asked if she had any further documentation to reflect conversations with R8 and/or R8's daughters prior to the new POA document being prepared and signed by R8 on [DATE] and the SW replied, No, I guess I didn't document the ones that I had. The SW was asked if there should have been documentation to reflect R8's wishes to form a new POA document prior to R8 signing this document and she stated, I guess there should have been. During an interview on [DATE] at 4:00 PM, the Administrator stated, Once I learned of this incident occurring, I went and emailed our legal department to get guidance on what our practice should be in this situation. It was my understanding that the POA document did not need to be redone in this instance. Since the husband had passed away, the next in line that was listed as the alternate health care agent would been her daughter that was listed, then if that daughter was unwilling or was unable then it went to the next daughter listed on the document. Review of the email between the legal department of the facility and the Administrator, provided by the facility and dated [DATE] at 9:35 AM, revealed, . Staff should never be assisting with the creation of a new POA if the original POA has been activated . Most POA forms designate a POA to act in case the first person can't/won't act. In a situation where the first person designated passes away or declines to act, the alternate person would then be the POA. There is no need to create a new document foin order for this to take effect . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Position Description for the Classification Title of Position for Master Social Worker revealed, The incumbent of this position works with the interdisciplinary team and administration of [name of facility] to promote and protect residents' rights and the psychosocial well being [sic] of each resident. By coordinating medically related social services at [name of facility], the incumbent assists each resident to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being . Review of the Authorized Social Worker Practice, published under s.35.93, Wis. Stats., by the Legislative Reference Bureau, Chapter 6, Page 827, [DATE], revealed, . A certified social worker may evaluate and assess difficulties in psychosocial functioning, develop a plan to alleviate those difficulties, and either carry out the plan or refer clients to other qualified resources for assistance. Intervention plans may include counseling of individuals, families, and groups; advocacy; referral to community resources; and facilitation of organizational change to meet social needs based on psychosocial evaluation .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to prevent significant medication errors for 2 out of 7 residents (R1 and R4) reviewed for medication administration out of a total sample of 15 residents. R1 was administered medications prescribed for R2 on 04/16/25. This medication error caused R1 to be transferred to the hospital due to an accidental medication overdose. The facility's failure to prevent significant medication errors, continually assess the resident after the medication error, and immediately notify the physician of the medication errors created a finding of immediate jeopardy that began on 4/16/25. Surveyor notified the Administrator and Assistant Director of Nursing (ADON) of the immediate jeopardy on 6/5/25 at 10:20 AM. The immediate jeopardy was removed on 6/4/25, however, the deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as evidenced by the following example. R4 was administered R3's nebulizer medication. Findings include: Review of the facility's policy titled, Medication Administration revised 4/21/25, indicated, . The person who prepares the dose for administration is the person who administers the dose . Review of the facility's policy titled, Medication Error, revised 04/21/25 indicated, . In addition, the facility will follow the procedure listed below: Contact Poison Control if applicable. Contact PCP for notification. Contact POA if applicable. A Medication Error Report Form will be initiated (see attached form) A Post Medication Error monitoring flow sheet or monitoring via [by] EHR [electronic health record] Nurses' To Do List will be initiated and will continue for a full 3-day [sic] post error unless continued monitoring is directed by the MD [Medical Doctor] (see attached form) Education will be provided to staff on an as needed basis to prevent future errors Medication errors will be reviewed by the ID [Interdisciplinary] team and brought to Quality Assurance no less than quarterly . 1. Review of R1's Face Sheet, located under the Face Sheet tab in the electronic medical record (EMR), indicated R1 was admitted to the facility on [DATE] with diagnoses that included stroke, diabetes mellitus, bipolar disorder, hypertensive chronic kidney disease, and seizures. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's quarterly Minimum Data Set (MDS), located under the MDS tab in the EMR and with an Assessment Reference Date (ARD) of 1/21/25, indicated R1 had short- and long-term memory loss with modified independence in making daily decisions. Review of R1's Medication Administration Record (MAR), provided by the facility and dated 4/2025, indicated that on 4/16/25 at 7:00 AM, R1 had been administered amlodipine 10 mg (milligrams) (a blood pressure medication), lamotrigine 225 mg (a bipolar medication), Keppra 500 mg (a seizure medication), metoprolol 25 mg (a blood pressure medication), and losartan 50 mg (a blood pressure medication) while in the dining room. Review of R2's Face Sheet, located under the Face Sheet tab in the EMR, indicated R2 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, hypertension, anemia, atrial fibrillation, and depression. Review of R2's annual MDS, located under the MDS tab in the EMR and with an ARD of 4/5/25, indicated R2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R2's MAR, provided by the facility and dated 4/2025 indicated that on 4/16/25, R2 had been administered Lasix 20 mg (a fluid pill), amlodipine 10 mg, carvedilol 12.5 mg (a blood pressure and heart failure medication), venlafaxine 150 mg (a depression medication), magnesium 500 mg (a supplement), and iron (a medication to treat anemia) while in the dining room for breakfast. Review of the Executive Summary, provided by the facility, indicated on 4/16/25 at 8:44 AM, Certified Nursing Assistant 1 (CNA) observed several pills mixed in with R1's food in the divided plate that belonged to R1. CNA1 notified Unit Manager 1 (UM) of this finding. UM1 came to the unit, took the plate, and separated the pills out of the food and then administered these medications to R1. UM1 then walked through the dining room and noted two pills lying on the floor where R1 sits at the dining room table. UM1 took these two medications to the medication cart and reviewed R1's medication profile in the computer. UM1 noted that these medications were not R1's. UM1 then looked in the computer at R2's medication profile, knowing that R2 sat beside R1 at the dining table, and compared these medications when UM1 noted the two medications that were found on the floor belonged to R2. As UM1 continued to review the medication profile of R2, she noted the medications that she had administered to R1 were actually R2's medications. UM1 recognized she had made a medication error. Continued review of the Executive Summary revealed, . -At 8:55 AM, UM1 went to the morning IDT [Interdisciplinary Team] meeting and told [name of the ADON] that [UM1] need to talk to her after the meeting. Throughout the meeting [UM1] told [ADON] that she needed to talk to [ADON] about a med [medication] error that she had made. -9:15 AM, [UM1] sent a text message to the . nurses' cell requesting [LPN1] to please assess [R1] vitals [vital signs] immediately. -9:17 AM, [UM1] sent a text message to . nurses' cell requesting [LPN1] call the PCP (Primary Care Provider) to notify [sic]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-9:34 AM, [UM1] stepped out of the morning meeting and [UM1] called [LPN1] who was the nurse . and working with R1. [UM1] explained what had happened and requested she assess [R1's] vitals immediately and then also assess her [R1's] vitals at 1130 [sic]. [UM1] then came back into the room and spoke with [DON], [ADON], and . Supervisor about the med error [sic]. [LPN1] stated she immediately assessed vitals after getting off the phone with [UM1] which were: T [temperature] 98.2, P [pulse] 72, BP [blood pressure] 122/76, O2 [oxygen saturation] 100% RA [room air]. -10:30 AM, Vitals assessed: T 97.4, P 76, BP 122/74, O2 100% RA. -10:43 AM, . [LPN1] stated that she had watched the resident [R2] put the meds in her mouth and take a drink of her water. [LPN1] had thought that the resident [R2] had swallowed her pills. -10:45 AM, [DON] and [UM1] attempted to call [name of medical doctor] to notify him of the med error, he did not answer. A message was sent asking him to call back to discuss a med error. -12:00 PM, [LPN1] states she returned from her lunch to find [R1] with her arms hooked over the arms of the wheelchair, slid down out of the wheelchair in the dining room. [LPN1] states that [R1's] eyes were rolling back and [R1] was yelling 'help me I am dying.' [LPN1] immediately came over and called for help . were able to unhook [R1's] arms and lower her to the floor. [LPN1] ran to get assistance . The resident's [R1] BP was 92/50 HR [heart rate] 58. -12:03 PM, A code blue [sic] called, resident [R1] was reporting dizziness and was disoriented. [UM1] heard the code blue called and ran onto the unit from the main building. -12:05 PM, BP was 100/65, HR 58, R [respirations] 20, 97% [oxygen saturation] RA. -12:06 PM, Call placed to [name of MD] again, code blue called on resident [R1], we had attempted to call earlier and sent a text message to update him [MD] at 10:45a [sic] . on the med error made earlier this morning. Resident [R1] received another residents [sic] [R2] AM [morning] medications by mistake . [UM1] reported to [MD] that [R1's] BP was 92/60 and that the resident [R1] was disoriented and had been lowered to the floor . [MD] instructed for us to send [R1] to the ER via 911. Informed [MD] that [UM1] had instructed the nurse [LPN1] on the unit to monitor BPs once at 9:35 and again at 11:30 [sic]. -12:08 PM, 911 was called, information given to them on the resident [R1] receiving the wrong medications this morning . resident's [R1] BP of 92/60, resident disoriented [sic]. -12:15 PM, EMS [Emergency Medical Services] arrived, transfer packet including a list of resident's medications that were administered and the incorrect medications that were administered. 12:25 PM, Resident [R1] exited the building with EMS . Review of R1's Nursing Progress Notes, provided by the facility and dated 4/16/25 at 1:59 PM, revealed, . family/guardian [name], POA (Power of Attorney) updated that there was a medication error, explained the situation, Resident became symptomatic around noon, was sent to ED [emergency department] [sic] . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/2/25 at 1:25 PM, LPN1 stated she had given R1's medications around 7:00 AM while R1 and R2 were eating at the dining room table together on 4/16/25. LPN1 stated R2 was given her medications and drank a full glass of water, so she assumed that R2 had swallowed her medications. LPN1 stated that R2 will sometimes refuse to take her medications but to the best of her knowledge, R2 did not have any behaviors in pocketing her medications in her cheek or spitting out her medications. LPN1 stated she then went on her morning break, and when she returned to the unit, she was informed that [UM1] had been given R1's divided plate, and it had her pills in the food. LPN1 stated she and UM1 had figured out together that R1 had received R2's medications in error, and UM1 stated she was going to her office to make some phone calls which included the doctor. LPN1 was asked if Poison Control was called and notified of the medication error to seek advice from them. LPN1 stated, I am not sure, but the DON said it was done in the ED. LPN1 continued to state, Her [R1's] vital signs were checked at 9:20 and again at 10:30, then I didn't take them at 11:30 because I went to lunch. She [R1] was drinking lots of fluids, going to the bathroom, and told me she felt fine. LPN1 stated, When I came back from lunch, I saw her [R1] slumped over in her chair, took her vital signs, and called for help. She wasn't responding to us but when we laid her down and put her legs up, she started to respond to us better. We called 911 and the ambulance came and transferred the resident to the hospital. During an interview on 6/3/25 at 8:45 AM, CNA1 stated, I was cleaning up after breakfast and saw [R1's] divided plate had pills in the food that was left on the plate. I knew [LPN1] was on break, so I called [UM1] and told her of what I had found. [R1] and [R2] always sit beside each other in the dining room for their meals and [R1] is the only resident at that table that has a divided plate. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/2/25 at 2:08 PM, UM1 stated, [CNA1] called me and told me that they had found pills in [R1's] food that was left in her divided plate. I do not know for sure it was [R1's] food or not or if it was a plate that [R1] was eating out of. I went onto the unit and [CNA1] verified that this was [R1's] divided plate that she was eating out of. I then for some reason separated the meds [medications] from the food and [CNA2] went into [R1's] room, and I administered those pills to [R1]. I came back through the dining room and saw two more pills on the floor under the table, and the CNAs confirmed that [R1] was sitting there in that place. I went to the medication cart and reviewed [R1's] medication profile that has the picture of the medications and did not see the two pills that I found under the table on her profile. I know who was sitting beside [R1] at the table, so I looked at [R2's] medication profile. That was when I discovered that the medications that I had administered to [R1] belonged to [R2]. I went to our meeting at that time, and I was sitting next to [ADON] and told her I needed to talk to her about a medication error. I told her as the meeting went on that I accidentally gave the wrong meds to the wrong resident. I sent a text message to the medication nurse [LPN1] and told her to get her [R1's] vital signs now and check them again at 11:30. She [LPN1] did check it [vital signs] more frequently than that. But as far as I know, [R1] had received everything [medications] that she was supposed to receive that morning. UM1 was asked if she should administer medications to a resident that she did not prepare and UM1 stated, No you shouldn't give them [medications] to residents especially if you are not the nurse preparing the medications. I should have locked the medications up until the nurse that prepared the medications originally could have looked at them to see if they had belonged to [R1] or to [R2]. Then the medications should have been destroyed, and the PCP would have been notified of [R2] spitting out her medications and not have taken them. UM1 stated R1 was found slumped over in her wheelchair and then LPN1 called out for help to assist with R1. UM1 stated a Code Blue was called to get extra people on hand on the unit, then the doctor was notified, and 911 was called. UM1 stated R1 was transferred out to the ED. UM1 was asked if Poison Control was called while R1 was in the facility, and UM1 replied, No, they were not called. UM1 was asked why the physician was not notified earlier than he was when the medication error was discovered. UM1 stated, I had texted [LPN1] asking that she notify the doctor about the error, but we didn't find out until after this incident that the nurses' cell phone that they have does not accept text messaging. Then when he [doctor] was called and texted after that, we did not call any further because [R1] was doing ok and we just waited until he would call us back. UM1 was asked when the family/guardian was notified. She stated, I believe it was after the resident went to the ED. During an interview on 6/2/25 at 2:43 PM, CNA2 stated, [UM1] came up to me and asked if I would go with her to [R1's] room while she gave [R1] her medications. So that is what I did. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/3/25 at 11:14 AM, the PCP for R1 stated, A lot of the time the staff will text me and I will call them right back but on this incident, I do not know why the text did not come through. I have worked with the DON to tell staff if they cannot get me on the phone and I do not answer a text message, then they are to call the 24-7 answering service at the hospital, and the on-call doctor could have been notified and probably have the resident sent to the ER. I would have expected to have been notified as soon as this error was discovered. That way we could have worked as a team and collaborate for what needed to be done for [R1]. For example, I could have given orders to administer IV [intravenous] fluids and to monitor her vital signs more frequently than once an hour and asked for updates in her condition to be called after the fluids started. Then maybe we wouldn't have had the issues of [R1's] blood pressure going low. Then if the fluids didn't help her blood pressure, then I would have decided to have the resident go to the ER. Since this incident, the DON and I have started planning on myself or a resident doctor to have staff education on what to do in certain instances such as changes in condition or falls to help prevent this from happening and give the staff more insight on what to assess and when. During an interview on 6/5/25 at 5:54 PM, the Administrator stated, I expect the RNs [Registered Nurses] to perform assessments when they see the resident has a change in condition for whatever reason and notify the physician immediately of these changes. If the physician does not respond or cannot be reached, the staff will send the residents out to the ER in good faith that they are doing the right thing for the residents at that time. That they [staff] don't leave the residents alone during these changes in condition assessments. We need to make sure we are practicing safely and if there is harm to a resident, then we will report that to the state agency. Education will begin immediately for all licensed personnel to ensure this does not happen again to any other residents. During an interview on 6/2/25 at 2:55 PM, the Director of Nursing (DON) stated, There were several things that we have learned from this medication error. One is that the doctor should have been called immediately after we discovered the medications error. Then we should have called Poison Control to seek their advice on what to do. The family should have been notified earlier than they were and of what the plans were for [R1] at that time. We started the education for the nurses on 4/16/25 of the five rights of medication administration, and that a medication error was a change in condition, and the physician was to be notified of this immediately. I called the physician for [R1] which is also the Medical Director and asked what to do if we were unable to get him on the phone and he said to call the answering service at the hospital, so we educated the nurses on this. Both nurses involved were put on leave, then when they returned to work, both nurses had to take a medication test and have the education of the five rights of medication administration. [LPN1] was observed by the nurses and the pharmacy consultant for medication administration and with those there had not been any identified concerns with those observations. The failure to prevent significant medication errors, continually assess a resident after discovery of a medication error, and immediately notify the physician of a medication error created a reasonable likelihood for serious harm which led to a finding of immediate jeopardy. The facility removed the immediate jeopardy on 6/4/25 when it had completed the following (the deficient practice continues at a scope/severity level of D (potential for more than minimal harm/isolated) based on example 2): Upon identification of the serious concern on June 4, 2025, the facility took the following (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediate corrective measures to protect all residents involved and those who could potentially suffer serious adverse outcomes: Once the error is identified, determine if the resident received a high-risk medication. In the event of any high-risk medication being given in error, the nurse will follow these steps: An assessment by RN should be completed immediately. Evaluate for harm and provide first aid if indicated. Continue close monitoring until instructed otherwise by PCP. Seek medical advice. Place call out to PCP. If not immediately available, call the pharmacy and ask for a pharmacist. If unable to speak with a physician or pharmacist, send to the ER by calling 911. Document the event, including medication, dose, route, and any other relevant information. Describe the circumstances surrounding the event and all actions taken. Notify POA/family contact. Inform of events and planned interventions. The nursing supervisor or management should be called to the unit and remain on the scene until the resident is transported to the ER or the PCP deems the resident stable. Continue to monitor for 12 hours or another interval specified by PCP/ER MD. LPNI has been observed for 4 shifts 4/12/2025,4/12/2025,4/13/2025,5/11/2025. UM1 was provided with training and passed her competency test. She will be observed by the ADON. On 4/12/2025, PharMerica Consultant observed medication pass with LPN1 with no concerns regarding the medication pass and five rights of medication administration ensuring all residents were administered with the right medication. During the March 2025, QAPI, Medication Errors were a topic of discussion, and the facility will continue to address this concern through this quarter. Review any revised or developed policies and procedures related to the IJ situation. The Assistant Director of Nursing (ADON), updated the Medication Error Policy (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525390	A. Building B. Wing	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Haven	3400 N Cty Trk Hwy F Janesville, WI 53547

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and implemented immediate training on the evening of June 4,2025, for licensed nursing staff. The training updates will continue for the clinical team, and those who are not present will review the training prior to assuming duties on the floor. The measure will be validated with our scheduling officer, ensuring that all nursing personnel on the floor have demonstrated compliance with reading and understanding this medication error policy update. Staff education and/or retraining should include return demonstration, if applicable. All clinical staff will be educated on the revised policies and procedures. Education included medication administration and policies regarding medication errors. This training will be conducted by clinical leadership titled Medication Error Policy, managed by the Director of Nursing or designees. Completion Date: 4 June 2025. A make-up training plan is in place for PRN (as needed), agency, or vacationing staff. Staff will not be scheduled to work until they have completed and documented their education. Ongoing monitoring will be conducted to ensure the effectiveness of corrective actions. Monitoring is conducted by the Unit Manager or designated by the Director of Nursing. Frequency-Daily for 2 weeks then weekly for 4 weeks. Results will be reviewed during monthly QAPI (Quality Assurance Performance Improvement) meetings for a minimum of 3 months. Random medication administration observations will continue all shifts including weekends. The Nursing Home Administrator, Medical Director, and Assistant Director of Nursing conducted an ad hoc meeting regarding the serious concern. The Medical Director will provide oversight to the residency physicians and offer additional training to licensed nursing staff. 2. Review of R3's undated Face Sheet, located under the Face Sheet tab in the EMR, indicated R3 was admitted to the facility on [DATE] with the diagnosis of asthma. Review of R3's significant change MDS, located under the MDS tab in the EMR and with an ARD of 2/6/25, revealed R3 had a BIMS score of 13 out of 15, which indicated R3 was cognitively intact. Review of R3's Physician Orders, dated 2/14/25 and located under the Orders tab in the EMR, revealed an order for Ipratropium-Albuterol 0.5 MG/3ML [milligram per milliliter]-2.5 (3) MG/3ML inhalation as needed for shortness of breath. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R4's undated Face Sheet, located under the Face Sheet tab in the EMR, revealed R4 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease. Review of R4's Physician Orders, dated 5/5/25 and located under the Orders tab in the EMR, revealed an order for Ipratropium-Albuterol 0.5 MG/3ML [milligram per milliliter]-2.5 (3) MG/3ML inhalation four times a day for chronic obstructive pulmonary disease. On 5/6/25 at 2:30 PM, R4 reported to the Unit Manager that he had not received his nebulizer treatments all day. Review of the facility reported incident, which was reported to the state survey agency, revealed it was discovered LPN1 had used R3's nebulizer medication for R4 at 8:00 AM on 5/6/25 and had not given R4's nebulizer medication at 12:00 PM. During an interview on 6/3/25 at 12:51 PM, LPN1 stated, I was told in report that morning [05/06/25] that we did not have any nebulizer medication from the pharmacy, nor did we have any in the contingency box on the unit for [R4]. I knew another resident [R3] had an order for the same medication, so I borrowed one from that resident [R3] to administer to [R4]. LPN1 was asked what she should have done instead of borrowing the medication from another resident. LPN1 stated, I should have checked the contingency box myself and if there really wasn't any to administer, then I should have called the pharmacy and let my supervisor know. LPN1 was asked if she had administered the nebulizer medication to R4 at 8:00 AM. She replied, [R4] was in the bathroom with a CNA. I set it up adding the medication [liquid] to the nebulizer chamber, and he [R4] stated he would do it in a minute. But he [R4] must have forgotten to and when I was questioned about it from [UM1], I realized I didn't go back into his room to make sure he had taken the nebulizer treatment. LPN1 was asked if the nebulizer medication was to be left at the bedside for the resident to take. She stated, No, you are not to leave the medication at the bedside. LPN1 was asked if she gave R4 the 12:00 PM dose of the nebulizer medication. She stated, No, I didn't realize he [R4] had a treatment at noon so when [UM1] was asking me about it, I told her [UM1] that I haven't given it, but I could if she wanted me too. [UM1] told me not to give it now because it was 2:30 PM. During an interview on 6/3/25 at 2:00 PM, UM1 stated, I believe that either he [R4] or his family notified me of [R4] not getting his nebulizer treatments at all on 5/6/25. I went to investigate this and interviewed the nurse [LPN1] that was assigned to him that day. When interviewing [LPN1], I asked if she had given him his nebulizer treatments today and [LPN1] stated she had given it to him at 8:00 AM but she did not know that he [R4] was ordered to have any more treatments on her shift. I told her that he was to have one at 12:00 PM. She stated to me that she had not given it to him, but she could go in and give it to him [R4] now if she needed to. It was already 2:30 PM so I told her that we would have the evening shift nurse do a respiratory assessment and give the 4:00 PM dose, and I called the PCP to notify of the missed doses and the monitoring. She [LPN1] also stated to me that because we had not received the DuoNeb [nebulizer medication] solution from pharmacy that she had used another resident's [R3] medication. It was shift change and the evening nurse went with me into [R4's] room to look for the nebulizer equipment and there was a large amount of solution in the nebulizer was 3 ml [milliliters], the dose of the DuoNeb is 3 ml. I took a syringe in the room with me when we went and was able to draw up 3 mls. (milliliters) of a solution. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/3/25 at 3:30 PM, DON stated, The nurse is not to leave medication at the bedside for the resident to self-administer unless they have orders to perform this themselves. I expect the nurses to stay with the resident while the resident is receiving a nebulizer treatment to make sure the resident is administered the whole dose of medication the physician had ordered. DON was asked if R4 had been assessed and if the physician had ordered for R4 to self-administer the nebulizer medication, and the DON stated, No, he had not. Review of the facility's education to the licensed nurses, provided by the facility revealed, . Medication administration is an important part of delivering healthcare. It refers to the process of giving or receiving a medication . A simple checklist covering the basics - referred to as the '5 Rights' - is a standard for safe medication administration [sic]/ These rights include: 1. The right patient, 2. The right drug, 3. The right time, 4. The right dose, 5. The right route . Medications CANNOT [sic] be prepared and left . with the resident to take later. Resident must be watched .