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	08/01/2025

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 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. (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:	(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, facility document and policy review, the facility failed to reassess the risk of elopement and identify interventions to prevent a resident from exiting the facility through the bedroom window for 1 (Resident #1) of 5 residents reviewed for accidents. Resident #1 was observed by staff packing their belongings in a bag and saying they were leaving the facility but was not reassessed for the risk of elopement. Resident #1 exited the facility on 07/03/2025 at 12:05 AM, unnoticed and unsupervised by staff, and was found after approximately ten minutes in the bushes outside the resident's bedroom window. Findings included: The facility policy titled, Elopements, revised 07/09/2025, indicated, III. Definitions: Elopement behavior: Making verbalizations about wanting to leave, talking about going home, packing belongings, opening windows, and opening doors. IV. Elopement: When a resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired wanders away, walks away, runs away, escapes, or otherwise leaves a caregiving facility unsupervised, unnoticed, and/before to [sic] their scheduled discharge. The section of the policy titled, Procedure: specified, 2. Staff should promptly assess elopement behavior for initiation of Code Alert [departure alert system], window alarms, or other care planning interventions to prevent elopement. A Face Sheet, printed on 07/10/2025, revealed the facility admitted the Resident #1 on 01/17/2025. According to the Face Sheet, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease (COPD). The Face Sheet indicated the resident was receiving hospice services and was not at risk of elopement. An Elopement Risk Assessment, dated 02/14/2025, indicated Resident #1 ambulated with an assistive device, was alert, had no cognitive impairment, and no history of elopement. The Elopement Risk Assessment revealed the resident scored a 4, which indicated the resident was not at risk of elopement. The medical record revealed no documented evidence of subsequent Elopement Risk Assessments until 07/03/2025. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2025, indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #1 was independent with sit to stand transfers, chair/bed-to-chair transfers, and walking 10 feet and did not exhibit wandering behavior during the seven-day assessment look-back period. A Behavior note, dated 06/24/2025 at 12:34 AM, indicated Resident #1 was pacing, rummaging, and packing all [their] belongings in bag, saying [they were] leaving. The note indicated the resident demonstrated very anxious and agitated, noncompliant behavior after the supper meal until midnight, when staff tried to redirect the wandering behaviors. There was no documented evidence that staff completed a new elopement risk assessment. A Behavior note, dated 06/25/2025 at 11:24 PM, indicated Resident #1 demonstrated chronic behavior: Continues to sort out alot [sic] of items in room and ‘packing some up.' There was no documented evidence that staff completed a new elopement risk assessment. A Behavior note, dated 06/29/2025 at 7:39 AM, documented as a late entry for 06/28/2025 at 7:49 PM, indicated Resident #1 had wandering behaviors, was rummaging through their belongings, and was more confused than normal. There was no documented evidence that staff completed a new elopement risk assessment. A Behavior note, dated 07/03/2025 at 1:43 AM, documented as a late entry for 07/02/2025 at 10:31 PM, indicated Resident #1 demonstrated chronic behavior: to include pacing/rummaging and was difficult to redirect. The note indicated the resident got upset when staff attempted to redirect. Per the note, a hospice nurse was notified. There was no documented evidence that staff completed a new elopement risk assessment.A Behavior note, dated 07/03/2025 at 5:32 AM, revealed a nurse attempted to administer Resident #1's medications, but the resident refused and told the nurse to get out. According to the note, when the nurse left the resident's room, the resident was pacing back and forth. The note indicated that at 12:05 AM, shortly after Resident #1 refused their medications, the resident opened their window, punched the screen out, and was found lying outside on top of the bushes. According to the note, Resident #1 sustained a 3-centimeter (cm) by 2-cm bruise to the left upper buttocks, a 2-cm scratch to the left shin, and scattered abrasions to their bilateral knees. The note indicated hospice was notified, and the resident was placed on one-to-one (1:1) supervision until further evaluation. An Alleged Nursing Home Resident Mistreatment, Neglect, And Abuse Report, completed by Administrator (ADM) F on 07/03/2025 at 10:33 AM, indicated Resident #1 opened their bedroom window, pushed the screen out, and was found in the bushes right outside the resident's bedroom window. The report indicated Resident #1 was last observed by a nurse within ten minutes prior to the incident. A Misconduct Incident Report, completed by Interim Director of Nursing (IDON) F on 07/10/2025 at 4:34 PM, revealed Resident #1 was transferred to the