Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

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 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 12679

Based on review of facility policy, record review, and interview, the facility failed to ensure two residents (R) (R16 and R43) out of 22 residents reviewed for abuse/neglect were protected from potential physical abuse. The facility failed to ensure R16 was protected from potential physical abuse by Certified Nurse Aide (CNA) 2 by continuing to schedule CNA2 on the same unit that R16 resides. As a resident, R16 continued to be fearful. The facility failed to prevent physical and verbal abuse of R43 in which CNA3 prevented R43 from rising from a chair and was potentially verbally abusive during this same interaction by CNA3. (Cross Reference F610 and F730)

Findings include:

Review of a facility polity titled Abuse, Neglect, Mistreatment dated 01/26/24 indicated .The facility will strive to educate staff and other applicable individuals in techniques to protect all parties.

1. Review of a facility document for R16 titled Face Sheet provided by the facility indicated the resident was admitted to the facility on [DATE].

Review of R16's admission Minimum Data Set (MDS) provided by the facility with an Admission Reference Date (ARD) of 04/05/24 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15 revealed the resident was cognitively intact. The assessment indicated the resident had no behaviors directed towards others. The assessment indicated the resident required moderate assistance from staff for toileting.

Review of a facility document titled Interview with [R16] provided by the facility dated 05/14/24 indicated R16 voiced she was still scared of CNA2. The document indicated the resident voiced that CNA2 did not assist her with cares such as: will leave her walker away from her and then CNA2 will just stand, wait, and not offer the resident assistance. The document revealed the resident asked that CNA2 not provide her care since she was scared of CNA2. This note was written by (Interim) Director of Nursing (DON).

(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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document untitled and dated 05/14/24 provided by the facility indicated the Social Worker (SW) was told R16 wanted to speak with her. The SW stated the resident voiced she no longer wanted CNA2 to provide her care. The note went on to state the resident stated CNA2 did not want to provide her assistance and would [sic] too rough when CNA2 would wipe her. SW wrote that the resident voiced she was terrified of CNA2. Review of a facility document untitled and dated 05/14/24 provided by the facility indicated the Infection Preventionist (IP) wrote the note which indicated R16 wanted to speak with her. The IP wrote R16 voiced to her she was afraid of CNA2 and alleged the staff member was rude and did not understand the level of care she needs. The IP wrote R16 claimed she would tremble when CNA2 was present. Review of facility document titled Daily Schedule provided by the facility revealed CNA2 worked on the following dates on the Limestone [NAME] Unit: 05/14/24, 05/21/24, 05/24/24, 05/27/24, 05/28/24, 06/01/24, 06/02/24, 06/06/24, 06/10/24, 06/11/24, 06/13/24, 06/14/24, 06/15/24, 06/16/24, 06/17/24, 06/19/24, 06/23/24, 06/24/25, 06/25/24, 06/27/24, 07/01/24, 07/02/24, 07/05/24, 07/07/24, 07/08/24,07/09/24, 09/11/24, 07/12/24, 07/13/24, 07/14/24, 07/16/24, 07/18/24, 07/20/2407/22/24, 07/23/24, 07/26/24, 07/27/24, 07/28/24, 07/29/24, 07/30/24, 08/01/24, 08/05/24, 08/06/24, 08/09/24, 08/10/24, 08/11/24, 08/15/24, 08/19/24, 08/20/24, 08/21/24, 08/22/24, 08/23/24, 08/24/24, 08/27/24, 08/28/24, 09/01/24, 09/02/24, 09/03/24, 09/06/24, 09/08/24, 09/09/24, and 09/10/24. Review of a facility document titled Administrative Leave provided by the facility dated 05/15/24, indicated CNA2 was placed on administrative leave. Review of a facility document titled Regarding Reportable Incident dated 05/17/24 provided by the facility indicated the letter was directed to CNA2 and specifically stated .Communication between residents and CNAs needs to be person-centered. It's important for you to work on improving your communication skills as a professional. This is not the first time concerns have been raised about your gestures and tone. CNA2 refused to sign this document. During an interview with the Administrator and Interim DON on 09/17/24 at 1:35 PM, the Administrator stated CNA2 no longer provides care to R16. The Administrator and Interim DON were asked if they had any additional monitoring/auditing of CNA2 and her performance since the initial allegation was made on 05/14/24. The Administrator stated they provide a weekly customer service tool and would be able to determine if there were problems. The Administrator stated R16 continues to make allegations against CNA2 and stated there have been grievances made. The Administrator and the Interim DON were asked why CNA2 continued to work on the same unit as R16. The Administrator stated they did not look at this from the perspective of the resident continuing to be triggered. The Interim DON confirmed there was no documentation to show that the facility continued to monitor CNA2. The Interim DON stated CNA2 continues to work 24 hours a week and typically on the Limestone [NAME] Unit. During an interview with R16 on 09/17/24 at 1:50 PM, the resident stated she was aware that CNA2 was working today, even though the resident remains in her room to keep her legs elevated. R16 stated CNA2 was quite abusive to her. The resident stated she asked the CNA to be more careful and she continued to be rough. She said that CNA2 did not enter her room but again was aware she was still working on the unit. The resident stated that the CNA2 continues to make her nervous on the off chance that the staff member might provide her care. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/17/24 at 1:58 PM, CNA2 confirmed she continued to work on Limestone [NAME] Unit and confirmed that R16 lived on the unit. CNA2 confirmed she was placed on administrative leave and returned to the Limestone [NAME] unit. CNA2 stated she did not enter R16's room and denied the abuse allegations made by R16. During an interview on 09/17/24 at 2:52 PM, the Administrator and the Interim DON were asked if CNA2 was still on the Limestone [NAME] Unit. The Administrator stated CNA2 needed to be removed from the unit immediately. The Administrator stated CNA2 did not go into R16's room. During an observation on 09/17/24 at 3:00 PM, CNA2 was in a resident room providing care while on the Limestone [NAME] Unit. During an interview on 09/17/24 at 4:19 PM, the Interim DON stated she could not locate any additional grievances made by R16 against CNA2. The Interim DON stated even though there were continued complaints made by R16 regarding CNA2 there were no additional investigations. During an interview on 09/17/24 at 4:42 PM, Assistant Director of Nursing (ADON) confirmed she was the Nurse Manager for the Limestone [NAME] Unit. The ADON stated she was not directed by the facility to monitor CNA2 after the 05/14/24 abuse allegation. During an interview on 09/18/24 at 8:05 AM, R16 stated she was aware CNA2 was on the same unit as her since she could see CNA2 in the hallway next to her room on a regular basis. 37590 2. Review of R43's quarterly MDS, with an ARD of 8/20/24 and located in the Electronic Medical record (EMR) under the MDS tab, revealed R43 was admitted to the facility on [DATE], had diagnoses that included Alzheimer's disease, and had a BIMS score of one out of 15, which indicated the resident was severely cognitively impaired. Review of R43's Care Plan, located under the Care Plan tab of the EMR, revealed that the resident had a diagnosis of Alzheimer's dementia, resulting in increased disorientation and need for reminders. Review of a facility reported incident, dated 07/17/24, revealed that at approximately 12:00 PM, Activities Therapy Assistant (ATA) 1 expressed to Registered Nurse (RN) 2 that during meal service in the lower 300-unit dining room, Certified Nursing Assistance (CNA) 3 was verbally aggressive and physically prevented R43 from standing by placing her knee in the back of R43's chair to prevent the resident from sliding her chair and standing. Per the facility provided abuse investigation documentation, a written statement by ATA1 advised that she told RN2 that R43 would not stay seated during the meal service. The written statement continued, advising that CNA3 could be heard saying [R43] stop that right now in a way that made ATA1 uncomfortable, and she felt she needed to report it. ATA1 added that she also witnessed CNA3 put her knee on the back of [R43]'s chair so she couldn't move. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/17/24 at 12:00 PM, the Administrator was asked about the facility's investigation into R43's facility-initiated abuse allegation, and she initially stated their investigation found the allegation was a misunderstanding between staff members and reported hearsay. In a subsequent interview on 09/17/24 at 3:00 PM, the Administrator was asked about the witness statements and how they were written as if they were eyewitness testimony. The Administrator stated that after discussing the incident with the team, she confirmed that the statements alleging abuse were not hearsay. She was asked if there was any additional investigation conducted. The Administrator stated that her goal for their investigation was to safeguard the resident, educate the staff, and report it if necessary. She stated that the incident involving R43 was reported on 07/17/24 at 3:16 PM, and CNA3 was immediately put on administrative leave.

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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** 12679 Based on interview, record review, and policy review, the facility failed to ensure a Certified Nurse Aide (CNA) 1 reported allegations of physical abuse by Licensed Practical Nurse (LPN) 3 against Resident (R) 93 immediately to the Administrator for 1 out of a sample of 22 residents reviewed for abuse. This failure increased the risk of other vulnerable residents for further physical abuse. Findings include: Review of a facility polity titled Abuse, Neglect, Mistreatment dated 01/26/24 indicated .It is the policy of this facility that all allegations of abuse, neglect, exploitation, mistreatment .are reported per Federal and State Law.The facility will ensure that all alleged violations as noted will be reported immediately, but no later than two hours after the allegation is made. Review of a facility document for R93 titled Face Sheet provided by the facility indicated the resident was admitted to the facility on [DATE] with a diagnosis of dementia. Review of a facility document for R93 titled quarterly Minimum Data Set (MDS) provided by the facility with an Assessment Reference Date (ARD) of 06/11/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 which revealed the resident was moderately cognitively impaired. The assessment indicated the resident had no behaviors directed to self or to others. Review of facility document titled Misconduct Incident Report dated 06/25/24 provided by the facility indicated at 3:30 AM, CNA1 alleged she observed LPN3 enter R93's room and grabbed the back of the resident's neck and forcibly gave her medication in which the resident then spit out. The report indicated CNA1 delayed in reporting her observation to the night shift supervisor Registered Nurse (RN)3. The report revealed CNA1 then reported the observation to RN2 who was the day shift nurse supervisor. The report indicated CNA1 was provided additional training on reporting timely concerns on alleged abuse. The investigation indicated LPN3 was an agency nurse, and the facility requested that LPN3 not return back to the facility due to other professionalism concerns. The report revealed RN3 interviewed R93, and the resident denied any allegations of abuse. The facility concluded the allegation of abuse was unsubstantiated. In addition, the facility interviewed staff and other residents as part of their investigation. On 09/17/24 at 11:15 AM, an attempt was made to contact CNA1, and it was not successful. During an interview on 09/17/24 at 11:16 AM, RN3 confirmed she was the night nursing supervisor who worked on 06/25/24. RN3 stated that CNA1 never shared any concerns of potential abuse with her which involved RN1 and R93. RN3 stated if CNA1 had reported any potential abuse allegations, she would have immediately removed RN1, gathered a statement from RN1, and then sent her home. RN3 stated this process was to be done to protect the resident(s). RN1 stated staff were to report all allegations of potential abuse immediately. During an interview on 09/17/24 at 11:33 AM, LPN3 stated she was not suspended on 06/25/24. LPN3 denied the allegations of potential abuse against R93. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/17/24 at 12:20 PM, RN2 confirmed she was the staff member CNA1 reported the potential abuse allegations to on 06/25/24 sometime between 6:30 AM and 7:00 AM. RN2 stated she remembered asking CNA1 why the delay in reporting and was told by CNA1 that she believed RN3 and LPN1 were friends. RN2 stated as part of her investigation she gathered a statement from CNA1 and R93. RN2 stated the resident has advanced dementia and could not remember anything about the incident. RN2 stated the reason allegations of potential abuse need to be reported immediately was to be able to protect the resident. During an interview on 09/17/25 at 12:54 PM, the Administrator stated staff were to report all allegations of potential abuse immediately.

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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** 12679 Based on interviews and record reviews, the facility failed to ensure that allegations of abuse were thoroughly investigated for two residents (Resident (R)16 and R43) out of a sample of 22 residents reviewed for abuse. This lack of investigation had the potential to lead to continued episodes of physical and verbal abuse. Findings include: Review of a facility polity titled Abuse, Neglect, Mistreatment dated 01/26/24 indicated . To comply with the eight-step approach to abuse and neglect detection and prevention. The abuse policy will be reviewed on an annual basis and will be integrated into the Facility Assurance and Performance Improvement program. The eight components are composed of screening, training, prevention, identification, investigation, protection, reporting and response . designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed . 1. Review of a facility document for R16 titled Face Sheet provided by the facility indicated the resident was admitted to the facility on [DATE]. Review of a facility document titled Interview with [R16] provided by the facility dated 05/14/24 indicated R16 voiced she was still scared of CNA2. The document indicated the resident voiced that CNA2 did not assist her with cares such as will leave her walker away from her and then CNA2 will just stand, wait, and not offer the resident assistance. The document revealed the resident asked that CNA2 not provide her care since she was scared of CNA2. This note was written by (Interim) Director of Nursing (DON). Review of a facility file referred to as an investigative file for R16 provided by the facility contained documents titled Customer Service Questions, all dated 05/14/24 all collected on the date of the potential abuse allegation made by R16. There were no specific questions directed to each resident interviewed which asked if they had been abused by any staff member during their stay at the facility. During an interview on 09/18/24 at 10:01 AM, the Administrator stated the issue with R16 was a customer service issue and not potential abuse. The Interim Director of Nursing (DON) was present during the interview. 37590 2. Review of R43's quarterly MDS, with an ARD of 8/20/24 and located in the EMR under the MDS tab, revealed R43 was admitted to the facility on [DATE], had diagnoses that included Alzheimer's disease, and had a BIMS score of one out of 15, which indicated the resident was severely cognitively impaired. Review of R43's Care Plan, located under the Care Plan tab of the EMR, revealed that the resident had a diagnosis of Alzheimer's dementia, resulting in increased disorientation and need for reminders. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility reported incident, dated 07/17/24, revealed that at approximately 12:00 PM, Activities Therapy Assistant (ATA)1 expressed to Registered Nurse (RN) 2 that during meal service in the lower 300-unit dining room, Certified Nursing Assistance (CNA) 3 was verbally aggressive and physically prevented R43 from standing by placing her knee on the back of R43's chair to prevent the resident from sliding her chair away from the table. Per the facility provided abuse investigation documentation, a written statement by ATA1 advised that she told RN2 that R43 would not stay seated during the meal service. The written statement continued, advising that CNA3 could be heard saying [R43] stop that right now in a way that made ATA1 uncomfortable, and she felt she needed to report it. ATA added that she also witnessed CNA3 put her knee on the back of [R43]'s chair so she couldn't move. There was no documentation the incident had been investigated as an allegation of abuse. During an interview on 09/17/24 at 12:00 PM, the Administrator was asked about the facility's investigation into R43's facility-initiated abuse allegation, and she initially stated their investigation found the allegation was a misunderstanding between staff members and reported hearsay. In a subsequent interview on 09/17/24 at 3:00 PM, the Administrator was asked about the witness statements and how they were written as if they were eyewitness testimony's. The Administrator stated that after discussing the incident with the team, she confirmed that the statements alleging abuse were not hearsay. She was asked if there was any additional investigation conducted. The Administrator stated that her goal for their investigation was to safeguard the resident, educate the staff, and report it if necessary. She stated that the incident involving R43 was reported on 07/17/24 at 3:16 PM, and CNA3 was immediately put on administrative leave.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, interview, and facility policy review, the facility failed to notify the resident and resident's representative (RR) of a transfer or discharge in writing for one of one resident (Resident (R) 6) reviewed for hospitalization . This created a potential for the resident or their resident representative to have incomplete information, misunderstand the reason, and process for transfer or discharge, and the discharge appeal process. Findings include: Review of a facility policy titled Involuntary Transfer/Discharges 01/26/24, indicated .When discharging to another facility or continuum of care documentation in the resident's medical record must include.The facility will notify the residents and the resident's representative(s) of the transfer or discharge in writing and in a language and manner they understand. The Facility will also send a notice to the Office of the State Long Term Care Ombudsman.The state's department of protection and advocacy for the mentally ill or those with developmental disabilities will also be notified if applicable. The resident has 7 days from the notice to appeal the discharge or transfer.The facility policy failed to address the following aspects: 1. The transfer notice must be in writing and in a language that the resident and/or the representative understands. 2. The transfer notice must identify the location and the reasons for the transfer. 3. If the facility has a resident with an intellectual disability or related disability, the transfer notice must include the name, mailing address, email address, and telephone number for the agency for the protection and advocacy of people with developmental disabilities. 4. If the facility has a resident with a mental disorder or a related disability, the transfer notice must include the name, mailing address, email address, and the telephone number for the protection and advocacy of people with mental illness. Review of a facility document for R6 titled Face Sheet provided by the facility indicated the resident was admitted to the facility on [DATE]. Review of a facility document for R6 referred to as the Nursing Progress Notes dated 08/21/24 provided by the facility revealed the resident sustained a change in her condition and sent to the local hospital for evaluation and treatment. There was no evidence the facility provided the resident and/or her representative with a written transfer notice. On 09/16/24 the Progress Note indicated the resident sustained a change in her condition and was sent to the local hospital for evaluation and treatment. There was no evidence the facility provided the resident and/or the representative with a written transfer notice. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/24 at 11:21 AM, Licensed Practical Nurse (LPN) 1 stated when a resident was sent to the hospital a written bed hold notice was sent with the resident and a transfer notice was given to the hospital. LPN 1 stated the family was always notified, by phone, when a resident was sent to the local hospital when there was a change in their condition. During an interview on 09/18/24 at 1:41 PM, the Administrator was asked when a resident was transferred to the local hospital for a medical emergency, was a written transfer notice sent with them. The Administrator confirmed there was no written transfer notice given to the resident and/or the RR.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review and interview, the facility failed to ensure one of one Resident (R) (R34's) clinical records out of a sample of 22 residents contained evidence the resident and/or her representative participated in the development or revision of her care plan. Findings include: Review of a facility document for R34 titled Face Sheet provided by the facility indicated the resident was admitted to the facility on [DATE]. Review of a facility document referred to as a Nursing Progress Notes provided by the facility dated 03/19/24 revealed the clinical record contained evidence R34 participated in the development/revision of her Care Plan. Review of a facility document untitled referred to a care plan invite, provided by the facility dated 05/23/24 indicated R34 was invited to participate in her care conference which was scheduled on 06/21/24. Review of R34's record failed to contain evidence the resident and/or her representative participated in her care conference scheduled on 06/21/24. Review of a facility document for R34 titled annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/12/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident had no behaviors. During an interview on 09/16/24 at 10:16 AM, R34 stated she did not get invited to participate in her care conference. During an interview on 09/18/24 at 1:50 PM, the Social Worker (SW) stated each resident receives an invitation to participate in their care conferences. SW stated the electronic medical record (EMR) would have documentation to support the resident and/or their representative participated in the care plan meeting. During this interview, SW reviewed the EMR and confirmed the last entry was dated 03/19/24 which showed the resident had participated in her care plan meeting. During an interview on 09/19/24 at 10:17 AM, the Administrator stated the facility had no care plan policy. During an interview on 09/19/24 at 10:33 AM, the Interim Director of Nursing (DON) stated her expectation was for the care plan meetings to be documented in the clinical record and to identify the resident and/or representative and the disciplines who participated in these quarterly meetings.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36461 Based on observation, interview, and record review the facility did not ensure that residents with an indwelling catheter received the appropriate care and services to prevent a urinary tract infection (UTI) for 3 of 5 Residents (R90, R243, R89) reviewed for catheters as catheter bags were observed to be uncovered and resting/touching on the floor. Findings include: Review of the facility's Infection Prevention and Control Program, dated 01/26/24, revealed that the . primary mission is to establish and maintain an Infection Prevention and Control Program (IPCP) designed to provide a safe, sanitary and comfortable environment and to help prevent, treat, and control the development and transmission of communicable diseases and infection . 1. Review of R90's Face Sheet, undated and located in the resident hard chart, revealed R90 was admitted to the facility on [DATE] with diagnoses that included UTI, chronic kidney disease, and hypertension. According to the admission Minimum Data Set Assessment (MDS), with an Assessment Reference date of 08/05/24 and located in the electronic medical record (EMR) under the MDS tab, R90 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident was moderately cognitively impaired. During an observation on 09/16/24 at 12:45 PM, R90 was observed lying in bed with the bed in the lowest position. R90's urinary catheter bag was observed lying directly on the carpeted floor, folded in half, with the tubing resting on the floor, and positioned above the level of the bladder. R90's bedspread was observed covering half of the catheter bag. Urine was observed in the tubing. During an observation on 09/16/24 at 2:00 PM, R90 was observed lying in bed with the bed in the lowest position. R90's urinary catheter bag was observed lying directly on the carpeted floor, folded in half, with the tubing resting on the floor, and positioned above the level of the bladder. R90's bedspread was observed covering half of the catheter bag. During an observation on 09/16/24 at 4:00 PM, R90 was observed lying in bed with the bed in the lowest position. R90's urinary catheter bag was observed lying directly on the carpeted floor, folded in half, with the tubing resting on the floor and wrapped around the wheels of the overbed table, and was positioned above the level of the bladder. During an observation on 09/17/24 at 10:15 AM, R90 was observed lying in bed, with the bed in the lowest position. R90's urinary catheter bag was observed lying directly on the carpeted floor, folded in half, with the tubing resting on the floor, and positioned above the level of the bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 09/18/24 at 12:40 PM, R90 was observed lying in bed with the bed in the lowest position. R90's urinary catheter bag was observed hooked to the bedframe, and the bottom half of the bag was folded in and touching the carpeted floor and positioned at the level of the bladder. Urine color was observed to be an amber color, no sediment but some mucous and no odor noted. During an observation and interview on 09/18/24 at 3:15 PM, the Interim Director of Nursing (IDON) and surveyor observed R90 in bed, with her catheter bag hooked to the bedframe. The bottom half of the bag was folded in on itself and touching the carpeted floor, and it was positioned at the level of the bladder. Urine color was observed to be amber colored. There was some mucous noted. The catheter bag was not covered with a dignity bag. The IDON acknowledged the urinary catheter bag should not be touching the floor or folded in on itself. The IDON was unable to confirm if urinary catheter bags should be contained in a dignity bag or protective bag, regardless of whether the resident was in or out of their room. 2. Review of R243's undated Face Sheet, located in the residents' hard chart, revealed R243 was admitted to the facility on [DATE] with diagnoses that included heart failure, urinary retention (lack of ability to urinate and empty the bladder), and hypertension. According to the admission MDS, with an ARD of 09/18/24 and located in the EMR under the MDS tab, R243 had a BIMS score of 11 out of 15, which indicated the resident was moderately cognitively impaired. During an observation on 09/16/24 at 1:00 PM, R243 was observed lying in bed, with his urinary catheter bag hanging from the bed frame, uncovered, and positioned above the level of the bladder. Urine color was observed to be deep golden yellow, and in the tubing. During an observation on 09/16/24 at 1:45 PM, R243 was observed lying in bed, and his catheter bag was observed hanging from the bed frame, uncovered, and positioned above the level of the bladder. Urine color was observed to be deep golden yellow, with no sediment noted. There was urine in the tubing. During an observation on 09/16/24 at 4:15 PM, R243 was observed lying in bed, and his catheter bag was observed hanging from the over bed table which placed the catheter bag above the level of his bladder. The catheter bag was uncovered. Urine color was observed to be deep golden yellow, with no sediment noted. There was urine in the tubing. During an observation on 09/17/24 at 10:10 AM, R243 was observed lying in bed, and his catheter bag was observed hanging from the bed frame even with the level of his bladder. The bag was uncovered, and the tubing was touching the floor. Urine color was observed to be deep golden yellow, with no sediment or odor noted. During an interview and observation of R90 and R243 on 09/18/24 at 2:05 PM, Certified Nursing Assistant (CNA) 5 stated Our policy is to have catheter bags covered when the resident was out of their room, but not when they are in their room He also stated catheter bags should not be resting on or touching the floor, should be below the level of the bladder, and not attached to items like the residents' over bed table. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/18/24 3:20 PM with the Interim Director of Nursing (IDON), R243 was observed in his bed, his urinary catheter bag was hooked to the bedframe, at the level of his bladder, and urine observed in the tubing, however the knees of the bed were approximately at a 30-degree angle, which placed the catheter tubing at risk for backflow of urine into his bladder. The catheter bag was not touching the floor. The IDON acknowledged the catheter bag should have been placed lower than the bladder level. During an interview on 09/19/24 at 10:54 AM, the Infection Preventionist (IP) stated she would conduct random walk throughs in the facility to observe residents with catheters. She stated she would be looking for proper placement or any potential infection control practices with care/maintenance. The IP further stated she was not aware of the observations made during the survey period of R90 and R243, and had she observed the catheters on the floor, or touching the floor, she would have spoken with the staff and corrected the situations. She further stated it was not appropriate for urinary catheter bags to be placed/lying directly on the floor, shoved under the bed, tubing wrapped around the over bed tables, catheter bags hooked to the over bed table, or placed above the level of the resident's bladder. The IP stated those practices increased the potential risk of infection of UTIs for residents. Multiple requests were made during the survey period for policies regarding infection control practices with care/maintenance of urinary catheters, and the IDON, IP and Administrator were unable to provide any. 37590 3. Review of R89's EMR revealed that she was readmitted to the facility on [DATE] with diagnoses that included urinary retention. Review of R89's Care Plan, dated 09/12/24 and provided by the facility, revealed a problem related to R89's urinary catheter, with interventions that included taking care of the catheter equipment and covering for privacy while outside the resident's room. R89 was observed on 9/16/24 at 12:11 PM, in the lower 300-unit dining room, seated in a wheelchair. R89's urinary catheter bag and tubing were touching the floor. During an observation on 09/16/24 at 2:35 PM, R89 was in her room, reclined in a chair, and with her legs and feet elevated. R89's catheter tubing was hanging from the elevated leg rest and came in contact with the floor. The catheter bag and the dignity cover, which was not covering the catheter bag, were both in contact with the floor. The catheter bag and dignity cover were attached to the lower bar on the resident's walker. During an observation on 9/17/24 at 5:28 PM, R89 was seated in her wheelchair in the lower 300 dining room. R89's catheter bag and tubing were touching the floor. During an interview on 09/17/24 at 5:30 PM, Registered Nurse (RN) 5 confirmed the observation and stated that the catheter bag and tubing should not be in contact with the floor, as this could lead to possible contamination and infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Infection Preventionist (IP) on 09/19/24 at 10:40 AM, the IP confirmed that it was not best practice for a catheter and/or accessories to come in contact with the floor. She added that she completed annual training and as needed training regarding infection control with all clinical staff, as well as conducting random walkthroughs to confirm that staff were following infection control best practices and facility protocols.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 12679 Based on interview, personnel file review, and policy review, the facility failed to ensure 1 of 2 Certified Nurse Assistant (CNA) (CNA2) reviewed was provided an annual performance review. This failure had the potential for decreased quality of life or quality of care for the residents. Findings include: Review of the personnel file of CNA2 revealed a copy of a document titled Performance Review and was date stamped 01/10/23. There was no current performance reviews contained in CNA2's employee record. During an interview on 09/18/24 at 3:28 PM, the Human Resource Director (HRD) stated the last performance review in CNA2's employee record was completed on 01/10/23. The HRD stated there were no current policies available for annual performance reviews of the nursing home staff. During an interview on 09/19/24 at 10:33 AM, the Interim Director of Nursing (DON) stated the county currently requires bi-annual employee performance reviews and prior to this current change it was the expectation for the facility to conduct performance reviews on an annual basis.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on interview and record review, the facility failed to ensure the medication regimen was free from unnecessary medications for one (Resident (R) 43) of five residents reviewed for unnecessary medications out of a total sample of 24. The facility failed to ensure staff did not administer as needed (PRN) lorazepam (Ativan, a psychotropic anxiolytic medication) to R43 without indication for use and failed to ensure the PRN lorazepam was not prescribed beyond 14 days without documented rationale. Findings include: Review of the facility's policy titled, Psychotropic Medication Policy and Procedure, last updated 01/26/24, revealed, . Psychotropics medication may be prescribed on a PRN basis in certain situations . When a PRN psychotropics medication is ordered, the medical record will include: indication/clinical need for medication, dose and frequency for use, non-pharmacological interventions to be identified, tried, documented before administering the medication. Review of R43's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/20/24 and located in the electronic medical record (EMR), revealed R43 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated the resident was severely cognitively impaired. Review of R43's Physician Orders, located in the EMR under the Physician Orders tab, revealed an order, dated 03/14/24, for Lorazepam 0.5mg [milligrams] . twice a day as needed For: Agitation associated with Dementia . There was no stop date for the order. Review of R43's Note to Attending Physician/Prescriber, dated 06/17/24, signed by the pharmacist, and provided by the facility, revealed, . PRN psychotropic orders to be written for more than 14 days. If PRN psychotropic orders are deemed necessary beyond this time, clinical rationale and a specific duration need to be provided by the prescriber . R43's physician returned a response on 06/23/24 that stated that discontinuing the medication is contraindicated. There was no rationale documented. Review of R43's Medication Administration Record (MAR), dated 07/19/24 through 09/19/24 and provided by the facility, revealed R43 received PRN lorazepam on 08/24/24, 09/03/24, 09/06/24, 09/08/24, and 09/11/24. Review of the corresponding nursing notes in the EMR did not reveal any associated behaviors for the use of the lorazepam or if any types of non-pharmacological interventions were attempted. During an interview on 09/19/24 at 11:39 AM, the Interim Director of Nursing (IDON) stated she had assumed the physician's response that discontinuing R43's lorazepam was contraindicated was sufficient to continue the PRN medication. She confirmed the nursing documentation related to the times R43 received PRN lorazepam was not adequate to show why the resident received the doses. The IDON stated she would educate the nursing staff on documenting behaviors in relation to administering PRN psychotropic medications.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on observation, interview and record review, the facility failed to ensure medical records were complete and accurate for 1 resident (R), R89, of 22 residents sampled. The facility failed to ensure R89 had orders for an indwelling urinary catheter. This had the potential to cause R89's care needs to go unmet. Findings include: Review of R89's electronic medical record (EMR) revealed R89 was readmitted to the facility on [DATE] following a hospitalization with diagnoses that included urinary retention. Review of R89's hospital records, provided by the facility, revealed R89 had a failed voiding trial, and an indwelling urinary catheter was inserted while the resident was in the hospital. Review of R89's Physician Orders, located under the Physician Orders tab of the EMR, revealed an order to measure R89's urinary output three times daily. There was no order for a urinary catheter. Review of R89's Care Plan, dated 09/12/24 and provided by the facility, revealed a problem related to R89's need for a urinary catheter. The goals included reporting concerns and having no signs or symptoms of urinary tract infections. Interventions included documenting urinary output and notifying the physician of any changes. During observations on 09/16/24 at 12:11 PM and 2:35 PM and 09/17/24 at 5:28 PM, R89 was observed to have an indwelling urinary catheter. During an interview on 09/19/24 at 10:33 AM, the Interim Director of Nursing (IDON) confirmed that hospital transfer orders should be reconciled and confirmed upon admission and readmission with the resident's physician. The IDON stated she was not aware of the missing orders for the urinary catheter for R89 but stated that she expected staff to confirm orders and for physicians to reconcile resident orders every 30 days. The Medical Director was interviewed on 09/19/24 at 12:52 PM. He confirmed that all transfer orders must be verified and confirmed with the resident's physician. He stated that he was not aware of the missing order for R89, but that staff could contact him if they were having an issue contacting any of the residents' primary care physicians. The facility was asked to provide a policy related to physician orders, and the IDON advised on 9/19/24 at 12:00 PM that they did not have a policy related to physician orders.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer one of five residents reviewed for flu/pneumonia vaccinations (Resident (R) 71) and/or their representatives, the opportunity for the residents to be vaccinated with Pneumococcal 20-valent Conjugate Vaccine PCV 20 or Pneumococcal polysaccharide vaccine 23 (PPSV23), in accordance with nationally recognized standards out of a total sample of 22 residents. Findings include: Review of the CDC website titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, effective 01/28/22, indicated . CDC recommends pneumococcal vaccination for all adults [AGE] years or older . For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you . Give 1 dose of PCV [Pneumococcal Conjugate Vaccine] 15 or PCV20 . If PCV15 is used, this should be followed by a dose of PPSV 23 [Pneumococcal polysaccharide vaccine] at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . If PCV20 is used, a dose of PPSV23 is NOT indicated . For adults [AGE] years or older who have only received a PPSV23, CDC recommends you . May give 1 dose of PCV15 or PCV20 . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults [AGE] years or older who have only received PCV13, CDC recommends you . Give PPSV23 as previously recommended . For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete . For adults who received PCV13 at any age and PPSV23 after age [AGE] years . use shared clinical decision-making to decide whether to administer PCV20 . Review of a facility policy titled Pneumococcal Vaccines dated 01/26/24 indicated .To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.Rock Haven will follow CDC recommendations for the administration of pneumococcal vaccine as directed by signed standing order from our Medical Director and in collaboration with contracted pharmacy and/or community physicians of our residents. Review of a facility document for R71 titled Wisconsin Immunization Registry printed 9/16/24 provided by the facility indicated the resident received the Prevnar 13 (PCV13) vaccine on 8/31/22 prior to her admission to the facility. Review of a facility document for R71 titled Face Sheet provided by the facility indicated the resident was admitted to the facility on [DATE]. The resident was over the age of 65 when she was admitted to the facility. During an interview on 09/19/24 at 10:27 AM, the Infection Preventionist (IP) stated R71 received the PCV13 prior to her admission to the facility. During this interview, she confirmed R71 should have been offered PCV20 one year after she was administered the PCV13.