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	01/29/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not prepare and distribute food in accordance with professional standards for food service safety. This has the potential to affect all 91 residents. Surveyor observed a cook take the temperatures of food without properly cleaning the food thermometer probe. Evidenced by: Facility policy, entitled Food Temping, dated 10/8/25, states, in part: Purpose: To provide every resident adequate nutrition in a safe environment. Store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Policy: Rock Haven will provide residents with meals that are safe. following infection prevention measures. Procedure: Service: . 9. [NAME] food to proper temperature. 10. Use a clean thermometer. On 1/26/26 at 12:16 PM, Surveyor observed [NAME] D taking the temperatures of the food in the steam table prior to lunch being served in the dining room. Surveyor observed [NAME] D cleaning the food thermometer probe off with a napkin prior to inserting the thermometer probe into the various foods. Surveyor interviewed [NAME] D about her food temping process. [NAME] D stated that she cleans the food thermometer probe after she is done temping all the food and in between foods if the food could be an allergen like seafood. On 1/28/26 at 10:50 AM, Surveyor interviewed FSM E (Food Service Manager). Surveyor shared with FSM E the observations of food temping in the dining room before meal service. FSM E indicated that she would expect that the cooks would clean the food thermometer probe properly between each food by using a cleaning wipe and allowing it to dry for 10 seconds before inserting the food thermometer probe into the next food item.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not establish an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 4 of 4 supplemental residents (R79, R43, R17, and R27). R79, R43, R17, and R27 were treated with antibiotics without meeting Loeb Criteria. R79, R43, R17, and R27 did not have an antibiotic stewardship conversation with the Provider. This is evidenced by: The Facilities Antibiotic Stewardship Policy and Procedure dated 10/20/25 documents in part: .Antibiotic stewardship will include an assessment process, use of evidence-based criteria, efforts to identify the microbe responsible for disease, selecting the appropriate antibiotic along with documentation indicating the rationale for use, appropriate dosing, route, and duration of antibiotic therapy; and to ensure discontinuation of antibiotics when they are no longer needed. Example 1 R79 is on the line list for UTI (urinary tract infection), listed symptoms are cloudy urine with sediment and mucus, and foul odor. Per Loeb criteria for UTI with indwelling catheter: .One of the following: acute dysuria OR fever (temp >37.9 C/100 F or ˆ1.5 C/2.4 F above baseline); PLUS one or more of the following: fever (temp >37.9 C/100 F or ˆ1.5 C/2.4 F above baseline), rigors, new onset delirium OR new costovertebral angle tenderness . On 1/29/26 at 1:00 PM, Surveyor interviewed ADON/IP K (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP K if this met Loeb criteria for R79, ADON/IP K stated no. Surveyor asked ADON/IP K if R79's Provider was contacted regarding this to discontinue the antibiotic or give rationale for why to continue, ADON/IP K said no. Example 2 R43 is on the line list for UTI (urinary tract infection), there are no symptoms listed. Per Loeb criteria for UTI without indwelling urinary catheter: .One of the following: acute dysuria OR fever (temp >37.9 C/100 F or ˆ1.5 C/2.4 F above baseline); PLUS one or more of the following: urinary urgency, suprapubic pain, urinary incontinence, urinary frequency, gross hematuria, and costovertebral angle tenderness. On 1/29/26 at 1:00 PM, Surveyor interviewed ADON/IP K (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP K if this met Loeb criteria for R43, ADON/IP K stated no. Surveyor asked ADON/IP K if R43's Provider was contacted regarding this to discontinue the antibiotic or give rationale for why to continue, ADON/IP K said no. Example 3 R17 is on the line list for respiratory, listed symptom worsening cough. Per Loeb criteria for LRTI (lower respiratory tract infection): With temp >38.9 C (>102 F) and one or more of the following: productive cough or Respiratory rate >25 breaths per minute; With temp >37.9 C (>100 F) or ˆ1.5 C (ˆ2.4 F) above baseline and both of the following: cough AND One or more of the following: pulse rate >100 beats per minute, respiratory rate >25 breaths per minute, rigors, or new onset delirium; Afebrile with COPD (chronic obstructive pulmonary disease-progressive, treatable, yet incurable lung disease characterized by chronic inflammation, leading to limited airflow and breathing difficulties) and >[AGE] years old, Both of the following: new or increased cough AND purulent sputum production; Afebrile without COPD, All of the following: new onset cough AND purulent sputum production AND one or more of the following: respiratory rate >25 breaths per minute or new onset delirium. On 1/29/26 at 1:00 PM, Surveyor interviewed ADON/IP K (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP K if this met Loeb criteria for R17, ADON/IP K stated no. Surveyor asked ADON/IP K if R17's Provider was contacted regarding this to discontinue the antibiotic or give rationale for why to continue, ADON/IP K said not at the time but now I'm told these (R17 was prescribed two antibiotics) were ordered for inflammation. Example 4 R27 is on the line list for UTI (urinary tract infection), listed symptoms are urine odor and nausea. Per Loeb criteria for UTI without indwelling urinary catheter: .One of the following: acute dysuria OR fever (temp >37.9 C/100 F or ˆ1.5 C/2.4 F above baseline); PLUS one or more of the following: urinary urgency, suprapubic pain, urinary incontinence, urinary frequency, gross hematuria, and costovertebral angle tenderness. On 1/29/26 at 1:00 PM, Surveyor interviewed ADON/IP K (Assistant Director of Nursing/Infection Preventionist). Surveyor asked ADON/IP K if this (continued on next page)

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	525390	A. Building B. Wing	01/29/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	met Loeb criteria for R27, ADON/IP K stated no. Surveyor asked ADON/IP K if R27's Provider was contacted regarding this to discontinue the antibiotic or give rationale for why to continue, ADON/IP K said no. On 1/29/26 at 3:39 PM, Surveyor interviewed DON B (Director of Nursing). Surveyor asked DON B would you expect residents that are treated with an antibiotic that they have signs and symptoms to support the antibiotic use, DON B stated yes. Surveyor asked DON B if they do not have the signs and symptoms to support the antibiotic, is it your expectation that the staff have a conversation with the Provider for rationale to continue the antibiotic, DON B explained they would review documentation first and then if there isn't any to support the continuation, then a discussion with the Provider would be the next step.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility did not ensure to develop and implement written policies and procedures that: S483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 8 staff reviewed for background checks.MT C (Maintenance Tech) did not have a background check completed every 4 years.This is evidenced by:The facilities Policy and Procedure for Background Checks states in part. Wisconsin law requires caregiver background checks using a Background Disclosure Form mandating completion at hire and every four years. MT C (Maintenance Tech) hire date was 12/14/20. His last completed background check was completed on 1/28/26. MT C should have had a background check completed by 12/14/24.On 1/28/26 at 4:45 PM surveyor interviewed NHA A (Nursing Home Administrator) and asked if background checks are supposed to be completed every 4 years. NHA A replied yes.On 1/29/27 at 8:26 AM surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if background check information be accessible? NHA A replied yes, the regulation states that all the information should be in the nursing home because we are responsible. NHA A reported that she has been trying to get access to background checks for 5 years, but since this is a county building, they keep records in HR (Human Resources) which is in a totally different building downtown.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 22 sampled residents (R53). R53 has a diagnosis of Congestive Heart Failure and the facility failed to recognize R53's severe weight gain as a significant change in condition, and the PCP was not notified. Staff failed to re-weigh, conduct assessments, and put appropriate interventions into place regarding R53's weight gain and increased edema. This is evidenced by: Facility policy titled, Weight Management, dated 6/10/15, states, in part, Procedure: . Residents will be weighed monthly unless otherwise ordered by the Physician or deemed necessary by the Interdisciplinary Team. Re-Weights will be obtained as soon as possible for any resident with a +/- five (5) lb. change from the previous weight. This weight should be documented in the residents record as a re-weight. Nursing staff will notify the physician and responsible parties of any significant unexpected and/or unplanned weight changes. The notification will be documented in the resident's chart. Each resident's weight will be monitored regularly by the Interdisciplinary Team. All resident with patterned or significant weight changes will be assessed by the team as indicated. Interventions to address medical or nutritional issues that might contribute to weight change will be initiated and incorporated into the plan of care and re-evaluated on a timely and periodic basis. R53 was admitted to the facility on [DATE] with diagnoses that include, in part: Atherosclerotic heart disease of native coronary artery without angina pectoris, Hypertensive heart disease with heart failure, Lymphedema, and Heart failure, unspecified. R53's most recent Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 1/21/26 indicates that R53 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating that R53 is cognitively intact. Section GG of R53's MDS states R53 needs partial/moderate assist with lower body dressing and putting on footwear. R53s Comprehensive Care Plan, states, in part:Need/Preference: I have unintended weight gain. Because I have a history of CAD (Coronary Artery Disease)/ASHD (Atherosclerotic Heart Disease), CHF (Congestive Heart Failure), DVT (Deep Vein Thrombosis). I take Lasix as diuretic. My Mini Nutritional Assessment score is 11, indicating that I am at risk for malnutrition.Approach: I need my nurses to keep an eye on how much I drink and eat, monitor my serum protein level, check me for signs of dehydration, such as dry gums and poor skin turgor. I need my aides to record how much I drink and eat, weigh me every week, setup my meal so I can eat, remind me and encourage me, offer something else if I don't like the meal, offer me a snack.Start Date: 1/22/26. No revision date. R53's Physician Orders state, in part: --Furosemide 40 mg tablet. Dose: (1 tablet/40 mg) by mouth daily AM for edema. Start Date: 10/17/25. No end date.--Treatment: Weights/Heights/Vitals: Measure weight one time per month 1st Thursday PM. Start Date: 10/17/25. No end date. Of note, R53's care plan indicates R53 is to be weighed weekly, however R53's physician orders indicate monthly weights, despite R53's complex cardiac history. R53's recent weights were documented as follows:10/23/25: 268 lbs. (pounds)10/30/25: 268.3 lbs.11/6/25: 266.2 lbs.12/2/25: 265.6 lbs. 1/1/26: 290 lbs. (Note: this is almost a 25-pound weight gain in one month, which is a 9.1% severe unintended weight gain). Of note: Despite R53 having a nearly 25-pound weight gain in one month, there is no indication that R53's weight was rechecked for accuracy, no nurse assessment was completed, the physician was not notified, nor was R53's care plan updated with any new interventions. R53's unintentional weight gain could be a symptom of worsening edema due to his history of congestive heart failure. On 1/28/26 at 9:25 AM, Surveyor interviewed R53 in his room and observed R53 sitting in his wheelchair with his legs dependent and appearing edematous (swollen). Surveyor observed R53 wearing Velcro tennis shoes without socks, and the Velcro straps were not all the way closed on the tennis shoes. Surveyor asked R53 about his swollen legs. R53 stated that more recently his legs have been hurting upon standing, and that he is unable to wear socks due to his shoes being too tight. On 1/28/26 at 9:30 AM, Surveyor interviewed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN H (Licensed Practical Nurse) about the facility's weight management process. LPN H indicated the MAR (Medication Administration Record) lets them know who needs to be weighed each day, and that the CNAs are the ones who get the weights and then let the nurses know so they can be entered into the computer. LPN H indicated that if there was a discrepancy in the weight, such as 2 pounds or more, the resident should be re-weighed. LPN H stated that if a resident has a physician's order to notify the doctor if there is a 3-pound weight change, then the nurses let NM G (Nurse Manager) know, and she will notify the doctor to see if they have any new orders or recommendations. LPN H indicated that she will call the doctor personally right away if there is a 5-pound or greater weight loss or weight gain. LPN H stated that residents with CHF (Congestive Heart Failure) should have doctor's orders for daily weights and for notification if there is a daily or weekly weight change within certain parameters. LPN H stated that NM G asked her to re-weight R53 this morning before breakfast, because his monthly weight was 290 pounds and it had been 266 pounds the month prior. Surveyor asked LPN H if R53 should have been re-weighed three weeks ago at the time of his severe unintended weight gain. LPN H replied that is typically how it is done. LPN H stated that she was not sure what happened with R53, but that he should have been re-weighed and the doctor notified of the weight change. On 1/28/26 at 9:39 AM, Surveyor interviewed CNA I (Certified Nursing Assistant), who stated that when they get a resident's weight, the wheelchair weight is already pre-weighed and then they subtract the wheelchair weight from the total scale weight and give it to the nurse as the resident's weight. CNA I stated that typically it is the nurses who will compare that weight to the previous month's weight. On 1/28/26 at 9:52 AM, Surveyor interviewed CNA J about R53's weight gain. CNA J stated that she doesn't always work on R53's unit, but that she did notice that R53's legs and feet were significantly more swollen than they normally were the last time I worked over here a month ago. CNA J indicated that she noticed that the Velcro straps on R53's tennis shoes couldn't be all the way fastened this morning, and that she had let the nurse know so that they could find out what was going on. On 1/28/26 at 11:04 AM, Surveyor interviewed NM G (Nurse Manager) about R53's severe unintentional weight gain and the facility's weight management process. NM G stated that normally significant weight changes are caught by RD F (Registered Dietician) and she would add the resident to the NAR (Nutrition at Risk) list and they would be discussed at the NAR meetings and do a follow-up. NM G indicated that if a resident had an off weight, NM G would ask the staff to do a re-weigh. NM G stated that the EHR (Electronic Health Record) system that the facility uses will flag if there is a significant weight decrease or gain. NM G stated that the PCP (Primary Care Provider is called as soon as there is a significant weight loss or gain of 5% or more, and it is usually the floor nurses' responsibility to notify the PCP. Surveyor asked NM G if they had a CHF protocol. NM G stated that they don't have a standing order for re-weights or notifying the PCP because usually the residents who need that would have a notification order or weight parameters on their discharge paperwork when they are admitted to the facility. Surveyor asked NM G about R53's recent unintentional weight gain. NM G stated that she had staff re-weigh him today and his weight was back to normal. Surveyor asked NM G if R53 should have been re-weighed immediately after an almost 25-pound weight gain was indicated. NM G stated that generally if a resident had a weight that is off like that significantly then they do a re-weigh right away. NM G indicated that significant weight changes are usually caught by RD F, who keeps track of the monthly weights. NM G stated that yes, R53 should have been re-weighed sooner than today. Surveyor asked if any interventions had been put into place to monitor or mitigate R53's edema in his feet and legs. NM G stated that she would have to look on R53's care plan to see what the interventions were. Of note: R53 was re-weighed on 1/28/26 with a weight of 266 pounds. However, R53 was not re-weighed until Surveyor started asking questions and asking for documentation regarding his severe unintended weight gain. On 1/28/26 at 11:17 AM, Surveyor interviewed RD F (Registered Dietician) about R53's severe unintended weight gain. RD F stated that she keeps a list of all the residents' weights by the week and reviews them on a weekly basis. RD F stated that if she notices there is a weight change, she will ask for a re-weigh (continued on next page)

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	525390	A. Building B. Wing	01/29/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and also look to see if the resident had any other changes like medication or meal intake changes. RD F stated that she will then notify the nursing supervisors and put the resident on the NAR list for 4 weeks of monitoring. RD F indicated that if the resident was not already on weekly weights, they would be put on weekly weights for the time they were on the NAR list. Surveyor asked RD F if R53 should have been re-weighed after his severe unintended weight gain of nearly 25 pounds. RD F stated that she did send out a notice to get a re-weigh on him and she never got a re-weigh from nursing. RD F stated that she sent an email to the nursing staff on the 14th initially and then reminded them again on the 20th asking for a re-weigh. Surveyor asked RD F if she would expect that the staff would re-weigh a resident with a 25-pound weight change in one month. RD F stated yes, she would have expected the staff to get a re-weigh on R53. RD F stated she thought that R53's weight gain was discussed at the NAR meeting but he wasn't added to the NAR list because she was waiting for a re-weight to see what was going on with him. RD F provided Surveyor with a copy of the email she sent to the nursing staff. On 1/14/26 at 1:53 PM, RD F (Registered Dietician) sent an email to the nurse managers asking that R53 be re-weighed. On 1/20/26, RD F sent another email to the nurse managers reminding them that R53 still needed to be re-weighed. On 1/28/26 at 11:24 AM, Surveyor interviewed NM G who verified that R53 did not have any weight parameters and no new nursing interventions were added to his care plan to monitor R53's weight or edema. On 1/28/26 at 1:36 PM, Surveyor interviewed DON B (Director of Nursing) about R53's severe unintentional weight gain. DON B stated that she would have expected staff to re-weigh R53 right away when there was a nearly 25-pound weight gain in one month. DON B indicated that R53 did not have a special physician's order for weights, so they just used the facility policy and procedure of monthly weights for him. DON B stated that she would follow-up with the clinical team right away to see about getting R53 on a program to reduce his edema. On 1/29/26 at 8:32, Surveyor again observed R53 in his room with his legs dependent, no socks on and tennis shoes without the Velcro straps completely closed On 1/29/26 at 3:38 PM, Surveyor interviewed DON B and asked if the facility had a CHF protocol. DON B stated that the facility did not have a CHF protocol. Surveyor asked DON B who was responsible for following up on significant weight changes. DON B stated that it was the nurse manager's responsibility to make sure that the nurses are following through on the re-weights that the dietician requests. Surveyor asked DON B what interventions had been put in place to manage R53's edema in his legs and feet. DON B indicated that R53 was not out of his baseline or showing increased symptoms so no new interventions had been put into place. Despite R53's severe unintentional weight gain, the facility failed to obtain reweights to ensure accuracy, failed to assess his edema, failed to evaluate his care plan and implement interventions to prevent further weight gain and edema. The facility failed to recognize R53's severe weight gain as a significant change in condition, and the PCP was not notified.

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	525390	A. Building B. Wing	01/29/2026

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 4 Sampled residents (R47) reviewed for trauma informed care. R47 did not have a Trauma Informed Care Assessment completed upon admission. Psychiatric notes written while admitted to the facility indicate R47 has a history of nightmares related to combat he experienced in Vietnam. R47's trauma was not identified, and no care plan approaches to mitigate triggers to prevent re-traumatization were put into place. This is evidenced by: The facility policy entitled, Trauma Informed Care, dated [DATE], states in part: . A Trauma Informed Care Information sheet will be provided in each new admission booklet. Social [NAME] will briefly review during admission and invite questions and conversation. Any information received from the resident/HCPOA (Healthcare Power of Attorney)/Guardian will be entered in the Social History/Trauma Informed Care folder by the Social Worker. The Social Worker will add any identified approaches to the care plan under the Trauma Informed Alert heading which is found in the Mental Wellbeing care plan. The approaches listed under the Trauma Informed Alert will also pull to the CNA Kardex (Care Summary). The Social Worker will email the Trauma Informed Care team and approaches. If specialized psychiatric rehabilitative services (SPRS) are required per the PASRR screen recommendations, this is to be included in the resident's comprehensive plan of care. The facility policy entitled, Comprehensive Person-Centered Care Planning, dated [DATE], states, in part: . A comprehensive care plan will be developed and implemented based on a comprehensive person-centered care plan for each resident, consistent with resident's rights that includes. Trauma informed-care interventions. The comprehensive care plan must describe the following. b) Interventions to ensure culturally competent care and trauma-informed care interventions as applicable. R47 was admitted to the facility on [DATE] with diagnose including Parkinson's disease (neurological disorder causing slow movement, tremors, balance problems, and cognitive impairment) with dyskinesia (uncontrollable and involuntary movements), secondary parkinsonism due to other external agents, contact with and (suspected) exposure to other hazardous substances - agent orange, dementia without behavioral disturbance, generalized anxiety disorder, and chronic post-traumatic stress disorder. R47's most recent Minimum Data Set with Assessment Reference Date of [DATE], indicates R47 has a Brief Interview for Mental Status score of 13 out of 15, indicating he is cognitively intact. Section I indicates R47 is diagnosed with anxiety disorder and post-traumatic stress disorder. R47's Physician Orders indicate:Mirtazapine (antidepressant) 15 MG (milligram) tablet by mouth at bedtime for Mood Changes. An initial evaluation conducted by a mental health provider on [DATE] indicates R47 has a military history of being a Vietnam veteran with agent orange exposure. A mental health provider visit note from [DATE] indicates R47 has historically experienced nightmares related to his military service. A mental health provider visit note from [DATE] indicates previously staff have reported R47 having increased nightmares related to his time in the military. On [DATE] at 3:39 PM, Surveyor observed the Plan of Care Summary posted on R47's bathroom door. This document did not include information related to R47's history of trauma, identified triggers, and interventions to prevent possible triggers. R47's Comprehensive Care Plan has a Need/Preference, dated [DATE], that states, I EXPERIENCED: Minor car accidents over the years. I had a couple surgeries. I had my esophagus operated on twice as well. I also was shot at while serving in the military in the Vietnam War. The Approach section for this Need/Preference, also dated [DATE], states I need the SW to --- Talk to me and let me know what is going on.(Of note: No further history of trauma, triggers, or interventions were added to R47's care plan related to his military service.) A document titled, Life Events Checklist (LEC) was provided to Surveyor as the tool that is (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to assess for trauma in newly admitted residents. This checklist lists several stressful events that may happen to people. Choices to respond to the assessment are: things that happened to you personally, you witnessed it happen to someone else, you learned about it happening to someone close to you, you're not sure if it fits, or it doesn't apply to you. The instructions note to consider your entire life as you go through the list of events. On [DATE] at 2:21 PM, a note was written by SW (Social Worker) O. This note indicates a trauma assessment was conducted on [DATE] with findings of fire or explosion, combat or exposure to a war-zone, life-threatening illness or injury, severe human suffering, sudden, unexpected death of someone close to you, and other stressful event or experience are all indicated to have happened to R47. The finding of a sudden, violent death is indicated that R47 learned about an overdose.(Of note: R47's severe human suffering finding is in relation to the recent loss of his wife. This is the only part of the assessment included on R47's comprehensive care plan). On [DATE] at 3:34 PM, Surveyor interviewed CNA (Certified Nursing Assistant) P. Surveyor asked CNA P how long she has worked at the facility. CNA P indicates, 3 years and she works all over the facility. Surveyor asked CNA P how she knows which residents have a history of trauma. CNA P indicates staff can always ask a nurse, it should be in the care plan, and that she usually checks the resident's chart. Surveyor asked CNA P how she knows which residents have triggers or interventions in place to prevent any triggers related to trauma. CNA P indicates, it is more on the nurses stuff for interventions, but they should be listed on the CNA Kardex (Plan of Care Summary) in the bathroom. On [DATE] at 3:47 PM, Surveyor interviewed CNA Q. Surveyor asked CNA Q how long she has worked at the facility. CNA Q indicated 13 years, and she mostly works on R47's section. Surveyor asked CNA Q how she knows which residents have a history of trauma. CNA Q indicates it is on the residents' charts. Surveyor asked CNA Q how she knows which residents have interventions in place to avoid any triggers related to trauma. CNA Q indicates the interventions and triggers are listed on the residents' Kardex (Plan of Care Summary). Surveyor asked CNA Q if she was aware if R47 has a history of trauma. CNA Q indicates he has a lot of history of trauma, especially with his wife passing. Surveyor asked CNA Q if she was aware if R47 had any triggers or interventions for his trauma. CNA Q indicates R47 likes his door shut and he gets up early for church. On [DATE] at 3:54 PM, Surveyor interviewed RN (Registered Nurse) R. Surveyor asked RN R how she knows which residents have a history of trauma. RN R indicates the Social Worker will evaluate the resident and then develop a care plan around it. RN R also indicates if changes are made to the care plan, the changes are highlighted in a book at the nurses station. Surveyor asked RN R how she knows which residents have interventions for triggers related to their trauma RN R indicates, the resident's care plan. Surveyor asked RN R if R47 has a history of trauma. RN R indicates she knows R47 recently lost his wife, and they were together for a long time. Surveyor asked RN R if R47 has any triggers or interventions related to his trauma. RN R indicates she gets along good with R47, and he would tell RN R if something was bothering him. Surveyor asked RN R if she was aware R47 was a veteran who experienced combat. RN R indicates she is aware he was in the service, but he talks very proudly about his service. On [DATE] at 9:44 AM, Surveyor interviewed SW (Social Worker) N. Surveyor asked SW N what the process is for performing trauma assessments. SW N indicates she meets with and interviews the resident, interviews family, reviews the resident's History and Physical, meets with the nurses, and uses the assessment tool if needed. Surveyor asked SW N if she uses the assessment tool for all admitted residents. SW N indicates, no, it is on a per resident basis. Surveyor asked SW N if the trauma assessments indicate possible triggers for the residents. SW N indicates she uses the tool to identify possible triggers along with the comprehensive admission assessment. Surveyor asked SW N how this information is disseminated to staff. SW N indicates she communicates with staff verbally, by email, and speaks with the charge nurse and the Director of Nursing. Surveyor asked SW N how she arranges for needed mental and psychological counseling services. SW N indicates she asks every resident if they want to see a mental health provider. SW N acknowledges that a resident asking for counseling can be traumatic in and of itself, so she makes (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	01/29/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure to offer the service to all residents. Surveyor asked SW N what triggered the need for R47's psychological assessment in [DATE]. SW N indicates she was not employed at the facility at that time, and that she started around [DATE]. Surveyor asked SW N if R47 has a PTSD care plan. SW N reviewed R47's care plan and indicated she does not see one. Surveyor asked if R47 should have a PTSD care plan, especially related to his military services. SW N indicated yes. Surveyor asked SW N if she was employed at the facility at the time of R47's admission, how would she assess R47 related to his trauma. SW N indicates R47 should have a full trauma assessment related to his military service and it should be on his care plan. On [DATE] at 1:05 PM, Surveyor interviewed SW (Social Worker) O. Surveyor asked SW O if she knew R47. SW O indicates she knows him, but he is assigned to a different social worker. Surveyor asked SW O if she was aware if he had any history of trauma. SW O indicates she thinks he does from when his father died, SW O is also aware he was in the army and that his wife passing was very hard on him. Surveyor asked SW O if R47 should have had a trauma assessment completed on admission. SW O indicates, yes. Surveyor asked SW O who is responsible for reviewing psychiatric notes. SW O indicates social work and nursing reviews psychiatric notes, but she does not believe R47 is seeing a psychiatric provider. Surveyor asked SW O to review R47's electronic health record to see if R47 ever had a trauma assessment completed. On [DATE] at 1:30 PM, SW O returned to Surveyor and reported R47 did not have a previous trauma assessment on file. SW O also indicated she just went to complete a trauma assessment using the Life Events Checklist (LEC) tool which indicated the findings listed previously. On [DATE] at 3:54 PM, Surveyor interviewed DON (Director of Nursing) B. Surveyor asked DON B what assessments are included in the admission process for social services. DON B indicates BIMS, PHQ-9 (depression screening), social determinants, trauma assessment, mini mental exam, SLUMS (cognitive assessment), and discharge planning disposition. DON B also notes that social services are responsible for the trauma-informed care plan. Surveyor asked DON B if all residents who are admitted to the facility receive depression and trauma assessment. DON B indicates, yes. Surveyor asked DON B how the results of these assessments are disseminated to staff. DON B indicates positive findings on assessments are communicated to staff through the care plan, everyday communication with social services and nursing, and through IDT (Interdisciplinary Team) meetings. Surveyor asked DON B if these positive findings should be added to the care plan. DON B indicates, yes. Surveyor asked DON B if she was aware R47 has a history of PTSD along with nightmares associated with his military service. DON B indicates it is social services responsibility to review psychiatric notes and behaviors. Surveyor asked DON B if R47 has a care plan related to his PTSD and military service-related nightmares. DON B indicates, yes.