

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Maryhill Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Madison Ave Niagara, WI 54151	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff interview and record review, the facility did not ensure the resident environment remained free from abuse for 2 residents (R) (R2 and R4) of 5 sampled residents.</p> <p>R2 reported to Activity Aide (AA)-D on 6/6/24 that R1 had touched R2's breast in the hallway that morning. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B reviewed camera footage on 6/6/24, interviewed both residents, and determined the allegation did not occur. Monitoring interventions were not implemented for R1. On 6/7/24, Social Services Director (SSD)-C informed NHA-A and DON-B that SSD-C had seen R1 and R2 in the lounge after lunch on 6/6/24. NHA-A and DON-B again reviewed camera footage and determined R1 had touched R2 inappropriately on 6/6/24 at approximately 1:04 PM. NHA-A and DON-B completed a subsequent investigation during which another resident, R4, reported that R1 had touched R4's breast on 6/5/24. R4 stated R4 did not report the allegation sooner because R4 felt ignorant. SSD-C verified a previous facility had provided paperwork prior to R1's admission that indicated R1 had a history of inappropriate sexual behavior and had been accused of sexual abuse by a former roommate, however, staff did not read the paperwork and did not put monitoring interventions in place to supervise R1 and protect other residents.</p> <p>The facility's failure to read admission documentation and supervise a resident with a history of sexually inappropriate behavior and a previous accusation of sexual abuse and its failure to keep residents free from sexual abuse created a finding of immediate jeopardy that began on 6/5/24. Surveyor notified NHA-A of the immediate jeopardy on 6/14/24 at 2:28 PM. The immediate jeopardy was removed on 6/14/24, however, the deficient practice continues at a scope/severity level D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.</p> <p>Findings include:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse, Neglect, and Exploitation policy, revised 5/1/24, states: I. Screening .B. Prospective residents will be screened to determine whether the facility has the capability and capacity to provide the necessary care and services .an assessment of the individual's functional and mood/behavioral status, medical acuity, and special needs will be reviewed prior to admission .III. Prevention of abuse, neglect, and exploitation .The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, and misappropriation of resident property, and exploitation that achieves: B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is likely to occur .and assure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms .D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict .</p> <p>On 6/14/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including history of stroke, type 2 diabetes, chronic pain, and insomnia. R1's most recent Minimum Data Set (MDS) assessment, dated 6/7/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 had moderate cognitive impairment. R1 was R1's own decision maker. R1's care plan did not contain any sexually inappropriate behavior concerns until 6/7/24.</p> <p>On 6/14/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dementia, dysphasia, epilepsy, and depression. R2's most recent MDS assessment, dated 4/11/24, had a BIMS score of 8 out of 15 which indicated R2 had moderate cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC).</p> <p>On 6/14/24, Surveyor reviewed R5's medical record. R5 is R1's spouse. R5 was admitted to the facility on [DATE] with diagnoses including dementia, pneumonia, and chronic obstructive pulmonary disorder (COPD). R5's most recent MDS assessment, dated 5/29/24, had a BIMS score of 14 out of 15 which indicated R5 had no cognitive impairment. R5 was R5's own decision maker.</p> <p>On 6/14/24, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] with diagnoses including stroke, kidney disease, dementia, depression, and cognitive communication deficit. R4's most recent MDS assessment, dated 5/31/24, had a BIMS score of 8 out of 15 which indicated R4 had moderate cognitive impairment. R4 had an activated POAHC.</p> <p>On 6/14/24, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency (SA) on 6/7/24. The FRI indicated:</p> <p>On 6/6/24 at 6:20 PM, R2 reported to AA-D that R1 had touched R2's breast. When AA-D asked when the incident occurred, R2 stated the incident occurred that morning while R2 was sleeping in R2's wheelchair in the C wing (secured dementia unit) hallway.</p> <p>On 6/6/24 at 6:25 PM, AA-D reported the allegation to NHA-A. At 6:45 PM, NHA-A and DON-B arrived at the facility to investigate the allegation.</p> <p>On 6/6/24 at 7:15 PM, NHA-A interviewed R2 regarding the allegation of abuse. R2 verified R1 touched R2's breast in the hallway that morning while R2 was half asleep. DON-B reviewed the facility's camera footage from the C wing hallway. DON-B reviewed the footage from when staff assisted R2 to the dining room at 6:42 AM until R2 was brought to the dining room for lunch at approximately 11:47 AM. DON-B determined R2 did not have any unsupervised male contact on the morning of 6/6/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/6/24 at 7:45 PM, NHA-A and DON-B interviewed R1 regarding the allegation of abuse. R1 denied touching R2's breast. R1 stated R1 did not know who R2 was and understood that touching someone without their consent was wrong.</p> <p>On 6/6/24 at 8:00 PM, NHA-A and DON-B discussed the camera footage and interviews with R1 and R2. NHA-A and DON-B determined the camera footage did not show any interaction between R1 and R2 during the timeframe of R2's allegation. NHA-A and DON-B reviewed R2's care plan which indicated R2 had behavioral symptoms, including accusations toward staff (particularly male staff), making inappropriate sexual comments, delusions, and paranoia. Due to R1's recent admission, the facility had not yet completed a comprehensive care plan. R1's baseline care plan did not indicate R1 had sexually inappropriate behavior. NHA-A and DON-B stated R1 was courteous, pleasant, and always appropriate during a previous stay at the facility.</p> <p>On 6/6/24 at 8:15 PM, NHA-A and DON-B determined R2's allegation of sexual abuse was unsubstantiated and left the facility. The allegation of abuse was not reported to local law enforcement or the SA at that time.</p> <p>On 6/7/24 at 7:30 AM, NHA-A and DON-B notified SSD-C of the allegation involving R2 and R1 from 6/6/24. SSD-C stated SSD-C had seen R1 and R2 together in the C wing lounge on the afternoon of 6/6/24.</p> <p>On 6/7/24 at 8:30 AM, NHA-A, DON-B, and SSD-C reviewed camera footage for the C wing lounge on the afternoon of 6/6/24 and noted at approximately 1:04 PM, R1 and R2 were in the lounge with no other residents present. R2 appeared to be asleep and R2's head hung down toward R2's chest. R1 watched AA-D leave the lounge and then watched R2 for approximately 17 seconds. R1 put R1's left hand on R2's leg for approximately 30 seconds and then moved R1's left hand up the side of R2's body toward the collar of R2's shirt. R1 then put R1's right hand inside R2's shirt. R2 woke up and made a T (timeout) signal with R2's hands. R1 removed R1's hand from R2's shirt and left the lounge at approximately 1:21 PM.</p> <p>On 6/7/24 at 8:30 AM, R1 was placed on 1:1 supervision. Staff were informed of the incident and R1's increased supervision. R1 was moved off the secured dementia unit to a private room on another wing. At 9:56 AM, the facility notified local law enforcement of the incident.</p> <p>On 6/7/24 at 10:01 AM, a police officer arrived at the facility and reviewed the camera footage. The officer interviewed R2 regarding the incident and R2 stated R2 felt insulted when R1 touched R2 inappropriately. The officer interviewed R1 regarding the incident and R1 denied the incident occurred. R1 was shown the camera footage and denied it was R1 but stated the resident in the video looked like R1.</p> <p>On 6/7/24 at 10:30 AM, NHA-A interviewed R5 (R1's roommate/spouse). R5 stated that R1 was never sexually inappropriate with R5.</p> <p>On 6/7/24, SSD-C and DON-B spoke with R5 who was upset about the allegation against R1 and that R1 was moved to another room. When SSD-C brought R5 to visit R1 in R1's new room, R5 asked R1, Did you do this? and Did you do this again, like at that other place? When SSD-C asked R5 what R5 meant, R5 stated the same thing happened at another facility, but nothing came of it.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>From 6/7/24 through 6/10/24, the facility completed staff interviews. Certified Nursing Assistant (CNA)-G reported that R1 made sexually inappropriate comments to CNA-G during R1's shower on 6/3/24. Hospitality Aide (HA)-E reported that R1 made sexually inappropriate comments to HA-E on 6/5/24. CNA-I reported while CNA-I was getting R2 ready for bed on the evening of 6/6/24, R2 stated R2 was scared but could not verbalize why. CNA-J reported that R1 made sexually inappropriate comments to CNA-J on 6/9/24. None of the comments or behavior were reported to administrative staff prior to the interviews.</p> <p>On 6/10/24, all residents were interviewed as part of the investigation. At 8:15 AM, R4 reported to staff that R1 had touched R4 inappropriately approximately 1 week prior. R4 stated R4 did not report the incident because R4 felt ignorant.</p> <p>On 6/14/24, Surveyor reviewed a FRI submitted to the SA on 6/10/24 regarding R4's allegation of sexual abuse involving R1. The FRI indicated:</p> <p>On 6/10/24 at 8:15 AM, R4 reported to SSD-C that R1 acted like a doctor and felt inside R4's shirt and touched R4's breast approximately 4-7 days ago in the C wing lounge when no one else was present. R4 stated R4 did not report the incident to anyone because R1 felt ignorant.</p> <p>On 6/10/24 at 8:41 AM, the facility notified the local police department.</p> <p>Surveyor reviewed the police report and noted the following:</p> <p>On 6/10/24 at 12:27 PM, an officer arrived at the facility and interviewed R4 regarding the allegation. R4 reported that R1 stated R1 really liked R4 and shoved R1's hand down R4's shirt and touched R4's breast. R4 stated R4 told R1 no and R1 stopped. R4 verified R4 did not give R1 permission to touch R4's breast. R4 also stated R1 stared at R4 in the dining room and made R4 uncomfortable the day before the incident. SSD-C showed the officer the camera footage from the C wing lounge on 6/5/24 at approximately 8:40 PM. The footage showed R4 working on a puzzle while talking to another resident while R1 was in the lounge. After the other resident left the lounge, R1 talked to R4, touched R4's chest, pulled on R4's shirt while looking down, and moved R1's hand around R4's chest.</p> <p>On 6/10/24, R1 was removed from the facility by the police and charged with fourth degree sexual assault.</p> <p>Surveyor reviewed pre-admission documents that were scanned into R1's medical record and noted a continuity of care document from a previous facility with a care plan goal that indicated R1 will be redirected from sexual comments/attempts to touch inappropriately. Progress notes from the previous facility indicated R1 was closely monitored for behaviors prior to discharge. R1's medical record also contained a physician progress note, dated 5/16/24 and written by Medical Director (MD)-H, that was scanned into R1's medical record on 5/30/24 (the day prior to R1's admission). The note stated MD-H was asked to re-evaluate R1 due to R1's inappropriate comments to staff and R1's roommate who accused R1 of inappropriate sexual contact.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/14/24 at 12:26 PM, Surveyor interviewed NHA-A regarding the allegations of abuse. NHA-A verified the facility did not have any concerns with R1 prior to 6/6/24 because R1 was pleasant during R1's previous stay at the facility. NHA-A verified if R2's allegation of abuse was thoroughly investigated when it was reported and if other residents were interviewed, the allegation would have been verified sooner. NHA-A also stated if R1's pre-admission paperwork was thoroughly reviewed, R1 would have not been placed on a unit with vulnerable residents and would have had a care plan for inappropriate sexual behavior.</p> <p>On 6/14/24 at 12:53 PM, Surveyor interviewed SSD-C regarding R1's admission documents and history of sexually inappropriate behavior. SSD-C verified the documents were in the facility's possession upon R1's admission to the facility. SSD-C stated the admission documents were read, but SSD-C did not recall reading about R1's sexually inappropriate behavior. SSD-C stated if SSD-C was aware of the behavior, R1 would not have been placed on the secured dementia unit with a vulnerable population of residents and would have had increased supervision and care planning to mitigate the risk to other residents.</p> <p>After Surveyor's investigation was completed on 6/14/24, the facility initiated facility-wide education regarding the admission of new residents, including review for inappropriate behaviors or concerns.</p> <p>The failure to supervise a resident with a history of inappropriate sexual behavior and an allegation of abuse from a former roommate created a reasonable likelihood for serious harm for R2 and R4 which created a finding of immediate jeopardy. The facility removed the jeopardy on 6/14/24 when it completed the following:</p> <ol style="list-style-type: none"> 1. Removed R1 from the secured dementia unit on 6/7/24 2. Initiated facility-wide education related to sexual behaviors/signs of predator beginning on 6/10/24 3. Initiated facility-wide education related to new admissions with inappropriate behaviors beginning on 6/14/24 		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff interview and record review, the facility did not ensure an allegation of sexual abuse was reported to the State Agency (SA) or local law enforcement in a timely manner for 2 residents (R) (R1 and R2) of 5 sampled residents.</p> <p>On 6/6/24, R2 told staff that R1 had touched R2 inappropriately without R2's consent. The facility did not report the allegation of sexual abuse to the SA or to local law enforcement within the accepted regulatory timeframe.</p> <p>Findings include:</p> <p>The facility's Compliance with Reporting Allegations of Abuse/Neglect/Exploitation policy, revised 5/1/24, states that the facility will report all allegations of abuse/neglect/exploitation or mistreatment .immediately to appropriate agencies in accordance with current state and federal regulations within prescribed timeframe .5. Alleged violation is defined as a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the federal requirements .8. Reporting/response: the facility will report all alleged violations and all substantiated incidents to the State Agency and to all other agencies as required. Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: .2. The Administrator, Director of Nursing (DON), or designee will: a. Notify the appropriate agencies immediately .In the case of an allegation of abuse, no later than 2 hours after discovery or forming the suspicion.</p> <p>On 6/14/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including history of stroke, type 2 diabetes, chronic pain, and insomnia. R1's most recent Minimum Data Set (MDS) assessment, dated 6/7/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 had moderate cognitive impairment. R1 was R1's own decision maker. R1's care plan did not contain any sexually inappropriate behavior concerns until 6/7/24.</p> <p>On 6/14/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dementia, dysphasia, epilepsy, and depression. R2's most recent MDS assessment, dated 4/11/24, had a BIMS score of 8 out of 15 which indicated R2 had moderate cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC).</p> <p>On 6/14/24, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the SA with a local police report. The FRI indicated on 6/6/24 at approximately 6:20 PM, R2 reported to Activity Aide (AA)-D that R1 had touched R2's breast without R2's consent. When AA-D asked when the incident occurred, R2 stated it occurred earlier that day while R2 was sleeping in R2's wheelchair.</p> <p>The police report indicated the allegation of sexual abuse was not reported to local law enforcement until 6/7/24 at 9:58 AM.</p> <p>The Misconduct Incident Report indicated the allegation of sexual abuse was not reported to the SA until 6/7/24 at 3:12 PM.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/24 at 11:43 AM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated NHA-A did not initially report the allegation of abuse because the facility did not substantiate the allegation after they reviewed camera footage and interviewed R1 and R2. NHA-A verified other resident and staff interviews were not completed before the facility determined R2's allegation was unsubstantiated. NHA-A stated after NHA-A and DON-B spoke with Social Services Director (SSD)-C and the incident was discovered on camera footage the next day (6/7/24), the allegation of sexual abuse was reported to the SA and local law enforcement.		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38793</p> <p>Based on staff interview and record review, the facility did not ensure an allegation of sexual abuse was thoroughly investigated for 2 residents (R) (R1 and R2) of 5 sampled residents.</p> <p>On 6/6/24, R2 told staff that R1 had touched R2 inappropriately without R2's consent. The facility did not thoroughly investigate the allegation of sexual abuse before they determined the allegation did not occur and later discovered the allegation did occur.</p> <p>Findings include:</p> <p>The facility's Abuse, Neglect, and Exploitation policy, revised 5/1/24, states that an immediate investigation is warranted when reports of abuse occur. Investigations will include identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation.</p> <p>On 6/14/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including history of stroke, type 2 diabetes, chronic pain, and insomnia. R1's most recent Minimum Data Set (MDS) assessment, dated 6/7/24, had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R1 had moderate cognitive impairment. R1 was R1's own decision maker. R1's care plan did not contain any sexually inappropriate behavior concerns until 6/7/24.</p> <p>On 6/14/24, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] with diagnoses including dementia, dysphasia, epilepsy, and depression. R2's most recent MDS assessment, dated 4/11/24, had a BIMS score of 8 out of 15 which indicated R2 had moderate cognitive impairment. R2 had an activated Power of Attorney for Healthcare (POAHC).</p> <p>On 6/14/24, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency (SA) with a local police report. The FRI indicated on 6/6/24 at approximately 6:20 PM, R2 reported to Activity Aide (AA) - D that R1 had touched R2 inappropriately and without consent. AA-D asked when the incident occurred and R2 stated the incident occurred earlier that day while R2 was sleeping in R2's wheelchair. The investigation included interviews with R1 and R2 and a review of the facility's video camera footage from when staff assisted R2 to the dining room at 6:42 AM until R2 was brought to the dining room for lunch at approximately 11:47 AM. Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B determined the allegation did not occur because they did not see the incident during the initial camera footage review.</p> <p>The investigation did not include interviews with other residents and staff.</p> <p>Upon review of the Misconduct Incident Report, the allegation of abuse was not reported to the SA until 6/7/24 at 3:12 PM. When NHA-A and DON-B notified Social Services Director (SSD)-C of R2's allegation on the morning of 6/7/24, SSD-C stated SSD-C had seen R1 and R2 together in the C wing lounge on the afternoon of 6/6/24. NHA-A, DON-B, and SSD-C reviewed the camera footage beyond 11:47 AM on 6/6/24 and witnessed the incident. The allegation was then reported to the SA and a subsequent investigation was initiated. During that investigation, another resident, R4, reported that R1 had touched R4's breast on 6/5/24. The incident was not previously reported to staff.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/14/24 at 11:43 AM, Surveyor interviewed NHA-A regarding the thoroughness of the investigation. NHA-A verified NHA-A and DON-B initially dismissed R2's allegation of abuse on the evening of 6/6/24 because they were not able to verify the incident with video camera footage and R1 denied the incident. NHA-A verified no further investigation (including staff and resident interviews) was going to be completed until after SSD-C reported that R1 and R2 were together in the C wing lounge on 6/6/24. NHA-A agreed if more camera footage was reviewed and additional interviews were completed, the facility may have been able to substantiate R2's allegation of abuse on 6/6/24 instead of 6/7/24 which resulted in a delayed report, a delayed investigation, and delayed interventions to prevent further abuse.</p>		