STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525467	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryhill Manor	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49563 Based on staff interview and record review, the facility did not notify a physician when 1 resident (R) (R2) of 4 sampled residents was physically aggressive toward another resident. R2 had a history of making threats to suffocate R1 with a pillow. On 2/20/25, R2 placed a pillow over R1's face in an attempt to quiet R2. R2's physician was not notified of the incident. Findings include: The facility's Clinical Change of Condition policy, dated 9/28/23, indicates: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a clinical change of condition .Procedure: 1. Upon identification of an actual or suspected change in resident status, the licensed nurse will assess the resident to determine their physical, emotional, or mental status change. 2. Notify the physician of the change and assessment. On 3/10/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, psychotic disturbance, mood disturbance, and anxiety. R2's Minimum Data Set (MDS) assessment, dated 1/16/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R2 had severely impaired cognition. R2 had an activated Power of Attorney for healthcare (POAHC). On 3/10/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, dementia, neurocognitive disorder with Lewy bodies, and anxiety. R1's MDS assessment, dated 12/26/24, had a BIMS score of 3 out 15 which indicated R1 had severely impaired cognition. On 3/10/25, Surveyor reviewed a facility-reported incident that indicated staff heard R1 yell that R1 could not breathe on 2/20/25 and discovered R1 had a pillow over R1's head. R2 (who was R2's roommate) was observed moving to R2's side of the room in a wheelchair. Interviews with staff indicated R2 had a history of making statements that R2 wanted to put a pillow on R1's head and was observed attempting to do so in the past. R1's physician was notified of the incident on 2/26/25, however, R2's physician was not notified of R2's change in behavior. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525467	A. Building B. Wing	03/10/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 1:51 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A indicated the facility was focused on R1 as the impacted resident and did not think to notify R2's physician. NHA-A and DON-B verified R2's physician should have been notified of R2's significant behavior change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525467	A. Building B. Wing	03/10/2025

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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 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** 49563 Based on staff interview and record review, the facility did not ensure a care plan was reviewed and revised for 1 resident (R) (R2) of 4 sampled residents. R2's care plan was not updated with interventions to address aggressive behavior, resident-to-resident altercations, and the impact of loud noise on R2. Findings include: The Facility's Abuse, Neglect and Exploitation policy, dated 3/5/25, indicates: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .VI. Protection of Resident: .G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse . On 3/10/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, psychotic disturbance, mood disturbance, and anxiety. R2's Minimum Data Set (MDS) assessment, dated 1/16/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R2 had severely impaired cognition. R2 had an activated Power of Attorney for Healthcare (POAHC). On 3/10/25, Surveyor reviewed a facility-reported incident (FRI) that involved an altercation between R2 and R1 (who were roommates) on 2/20/25 in which R2 was identified as the aggressor. The FRI indicated R2 placed a pillow over R1's head to silence R1 from yelling out. Staff separated the residents and moved R2 to a different room. On 3/10/25, Surveyor reviewed R2's plan of care which did not contain behavioral interventions to address aggressive behavior, resident-to-resident altercations, or the impact of loud noise on R2. On 3/10/25 at 12:11 PM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who indicated staff moved R2 to another room to separate R2 and R1 and promote safety. CNA-C was not aware of a care plan or Kardex (an abbreviated care plan used by nursing staff) that addressed R2's aggressive behavior. CNA-C stated staff just watch R2 consistently. On 3/10/25 at 1:51 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A and Director of Nursing (DON)-B. NHA-A indicated R2's POAHC informed staff that R2 becomes more agitated with loud noise. DON-B confirmed R2's plan of care did not include interventions to address noise reduction or provide a private room to reduce R2's aversion to loud noise. DON-B verified R2's plan of care should have been updated.