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Form Approved OMB
No. 0938-0391

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	02/04/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, staff interview, and record review, the facility did not provide the appropriate care and treatment to prevent the development of pressure injuries and/or promote healing for 1 resident (R) (R4) of 1 sampled resident.R4 had a stage 2 pressure injury on the left buttock. During an observation of wound care, Registered Nurse (RN)-E did not remove gloves and cleanse hands appropriately. In addition, RN-E used a gloved finger to apply ointment to R4's wound.Findings include:The facility's Clean Dressing Change policy, revised 1/22/24, indicates: For wound cleaning and dressing applications, use a no-touch technique to remove ointments and cream from their containers (i.e., use tongue blade or applicator) .Cleanse the wound as ordered, taking care to not contaminate other skin surfaces or other surfaces of the wound (i.e., clean outward from center of the wound). Pat dry with gauze .Wash hands and put on clean gloves. Apply topical ointments or creams and dress the wound as ordered.On 2/4/26, Surveyor reviewed R4's medical record. R4 had diagnoses including pressure ulcer of unspecified buttock stage 2, opioid dependence, and non-displaced fracture of sacrum. R4's Minimum Data Set (MDS) assessment, dated 11/12/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 had intact cognition.R4's medical record contained the following order:~ Santyl ointment 250 unit/gram thin layer topical to left upper buttock. Cleanse with wound cleanser. Apply Santyl to wound and cover with Mepilex padded dressing. (The pressure injury was identified on 10/14/25 and was doucmented as a stage 2.)On 2/4/26 at 12:11 PM, Surveyor observed RN-E don gloves, wipe R4 after toileting, and remove gloves. Without cleansing hands, RN-E donned clean gloves, removed a dressing (dated 2/3/25) from R4's left buttock that contained yellow draingage, and removed gloves. Without cleansing hands, RN-E donned clean gloves, sprayed the wound with wound cleanser, and wiped with the wound with a washcloth. While wearing the same gloves, RN-E put Santyl on a gloved finger, applied the ointment to the wound, and removed gloves. Without cleansing hands, RN-E donned clean gloves, applied a Mepilex dressing to the wound, dated and initialed the dressing, and removed gloves. On 2/4/26 at 12:17 PM, Surveyor interviewed RN-E who indicated it made sense not to apply ointment to the wound bed with a soiled glove.On 2/4/26 at 1:30 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated staff should complete hand hygiene between glove changes. DON-B also indicated RN-E should have wiped the cleanser with a clean or sterile 4 x 4 gauze and applied Santyl with a clean or sterile cotton applicator.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Maryhill Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Madison Ave Niagara, WI 54151	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff and resident interview, and record review, the facility did not ensure enhanced barrier precautions (EBP) were implemented during high-contact cares for 2 residents (R) (R1 and R4) of 2 sampled residents. R1 had an order for EBP due to open wounds. The facility did not ensure EBP was implemented for R1 during a transfer and toileting.R4 had an order for EBP due to an open wound. The facility did not ensure EBP was implemented for R4 during wound care. Findings include: The facility's Enhanced Barrier Precautions policy, revised 7/17/25, indicates: It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of multidrug-resistant organisms (MDROs) .b. An order for EBP will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) .even if the resident is not known to be infected or colonized with an MDRO .3.Implementation of EBP: a. Make gowns and gloves available immediately near or outside the resident's room. Note: Face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). B. Personal protective equipment (PPE) for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room .4. High-contact resident care activities include the following: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, central line, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, peripherally inserted central catheter (PICC) lines, midline catheters, and wound care: any skin opening requiring a dressing . The facility's Hand Hygiene policy, revised 7/17/25, indicates: Hand hygiene will be performed under the conditions listed in, but not limited to, the attached hand hygiene table .Hand Hygiene Table: .Before applying and after removing personal protective equipment (PPE), including gloves .Before and after handling clean or soiled dressings, linens. 1.On 2/4/26, Surveyor reviewed R1's medical record. R1 had diagnoses including displaced intertrochanteric fracture of the right femur, subsequent encounter for closed fracture with routine healing, other osteoporosis with current pathological fracture right femur, subsequent encounter for fracture with routine healing, and venous insufficiency (chronic) (peripheral) with bilateral lower extremity (BLE) venous stasis ulcers requiring wound care. R1's Minimum Data Set (MDS) assessment, dated 1/6/26, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R1 had intact cognition. R1 made R1's own healthcare decisions. R1's medical record contained the following orders: ~ Cleanse venous ulcers right and left anterior lower leg with saline wash, pat dry, apply adaptic (non-adhesive dressing) to wound bed, cover with ABD pad (a highly absorbent dressing), and apply knee-high compression stockings to both legs. May leave on at night while dressings are in place two times per week on Tuesday and Friday (dated 1/14/26). ~ Enhanced barrier precautions (EBP) related to vascular ulcers to BLE every shift: day, evening, and night (dated 12/30/25). On 2/4/26 at 9:09 AM, Surveyor observed Certified Nursing Assistant (CNA)-D enter R1's room and close the door. CNA-D did not don PPE prior to entering the room. Surveyor observed CNA-D exit R1's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room at 9:13 AM. Surveyor interviewed CNA-D who stated CNA-D did not wear PPE because CNA-D assisted R1 with toileting and a transfer which did not require EBP. CNA-D indicated wound care was the only high-contact care that required staff to don PPE for EBP. On 2/4/26 at 9:48 AM, Surveyor interviewed R1 who stated R1 had wounds with dressings on both legs. R1 stated staff complete wound care twice weekly and wear gloves, but do not wear a gown or a face shield/mask. R1 also indicated staff transfer R1 on and off the toilet and assist with personal hygiene without wearing a gown. (See interview under example 2.) 2. On 2/4/26, Surveyor reviewed R4's medical record. R4 had diagnoses including pressure ulcer of unspecified buttock stage 2, opioid dependence, and non-displaced fracture of sacrum. R4's MDS assessment, dated 11/12/25, had a BIMS score of 15 out of 15 which indicated R4 had intact cognition. R4's medical record contained the following order: ~ Enhanced barrier precautions (EBP) related to pressure area to left buttock (dated 1/6/25.) On 2/4/26 at 12:11 PM, Surveyor observed Registiered Nurse (RN)-E provide wound care for R4 who was on EBP. RN-E donned gloves, but not a gown or a face shield/mask. RN-E removed a dressing (dated 2/3/25) from R4's left buttock that contained yellow drainage. RN-E sprayed the wound with wound cleanser, wiped the wound with a washcloth, and completed wound care. On 2/4/26 at 12:17 PM, Surveyor interviewed RN-E who confirmed R4 was on EBP and RN-E should have worn a gown during wound care. On 2/4/26 at 1:30 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed RN-E should have worn a gown during wound care for R4. On 2/4/26 at 1:20 PM, Surveyor interviewed Infection Preventionist (IP)-C confirmed R1 and R4 have orders for EBP and a gown and gloves are required for all residents on EBP. IP-C indicated a face shield/mask is required for cares (including wound care) where splash may occur. IP-C verified high-contact cares include bed changes, transfers, walking, toileting assistance, shaving, bathing, and wound care. IP-C indicated staff are educated on EBP during orientation, stand-up meetings, and annually. IP-C stated a binder at the nurses' station identifies residents who are on precautions. IP-C stated staff know the facility's policy/procedure for EBP and should adhere to it.