

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

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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 06/16/2026
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)		
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** Based on observation, interview, and record review, the facility did not ensure an allegation of abuse was reported to Nursing Home Administrator (NHA)-A or their designee for 1 resident (R) (R1) of 5 sampled residents. On 6/11/26, Certified Nursing Assistant (CNA)-C observed an incidence of verbal abuse directed toward R1 by CNA-E. The abuse was not reported to NHA-A. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 9/30/25, indicates: . Verbal abuse means the use of oral, written, or gestured communication or sounds that willfully include disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Reporting/Response: Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes; a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. R1 was admitted to the facility on [DATE] and had diagnoses including neurocognitive disorder with Lewy bodies, vascular dementia, unspecified with anxiety, and traumatic brain injury. R1's Minimum Data Set (MDS) assessment, dated 4/9/26, stated R1 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated the assessment could not be completed. A comment on the assessment indicated R1 stopped answering. The MDS assessment and R1's care plan indicated R1 required staff assistance for activities of daily living (ADLs). On 6/16/26, Surveyor reviewed R1's medical record. A progress note, dated 6/11/26 at 3:22 PM, indicated R1 slept most of the morning. At approximately 12:00 PM, R1 was combative during cares and hit/tried to kick staff. Following cares, R1 was adamant that they did not want to get out of bed. R1 remained in bed and slept the rest of the shift. On 6/16/26 at 10:50 AM, Surveyor interviewed CNA-C who indicated they were called to assist CNA-D and CNA-E in R1's room last Thursday (6/11/26) at approximately 12:00 PM. R1 was in bed and was combative toward CNA-D and CNA-E. CNA-C indicated R1 hit CNA-E whose eyeglasses flew off. CNA-C stated they saw CNA-E get down in (R1's) face and call R1 a motherfucker. CNA-C indicated they did not see CNA-E physically abuse R1; however, R1 later told CNA-C staff were forcing R1 to get up and broke R1's watch. R1 pointed to scratch marks on their wrist while talking about the incident. CNA-C confirmed they saw R1's broken watch. CNA-C indicated they did not report the abuse to the nurse on duty or management. CNA-C thought Registered Nurse (RN)-F knew about the broken watch because RN-F brought R1 a different watch. CNA-C saw a yellow bruise on R1's stomach after the incident in addition to the scratches on R1's wrist. CNA-C confirmed CNA-E continued to work scheduled shifts following the incident. Surveyor reviewed nursing schedules which indicated CNA-E worked until 2:00 PM on 6/11/26 and worked AM shifts (5:30 AM to 2:00 PM) on 6/13/26 and 6/14/26. On 6/16/26 at 11:40 AM, Surveyor interviewed RN-F who was aware that R1's watch was broken and R1 was given another watch. RN-F was also aware that R1 was combative with staff on the 6/11/26 AM shift. RN-F was not aware of the allegation of abuse or the scratches and bruise observed on R1's wrist (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stomach. On 6/16/26 at 1:06 PM, Surveyor observed R1's left wrist and noted 3 scratches (less than 1 inch). R1 was not wearing a watch. Surveyor observed a watch on R1's nightstand. On 6/16/26 at 1:14 PM, Surveyor observed CNA-G enter R1's room with a lift. When Surveyor asked if R1 had a bruise on their stomach, CNA-G was unsure and stated they would check during the transfer. Following the transfer, CNA-G confirmed R1 had a yellow bruise. Surveyor noted the bruise was above the waistband of R1's pants and was approximately 3 inches long and 1 inch wide. On 6/16/26 at 1:30 PM, Surveyor interviewed CNA-D who confirmed R1 was combative during cares on 6/11/26. CNA-D indicated they and CNA-E were trying to wash R1's bottom when R1 hit CNA-E in the face and bent their glasses. CNA-D told CNA-E to report the incident because CNA-E should not have to pay to get their glasses fixed. CNA-D stated R1's watch was broken during the incident and may have gotten caught on something or flipped off R1's wrist when R1 hit CNA-E. CNA-D did not recall scratches on R1's wrist. CNA-D used a pager to request additional help during the incident and CNA-C provided assistance. CNA-D denied observing verbal or physical abuse toward R1. On 6/16/26 at 2:09 PM, Surveyor interviewed Assistant Director of Nursing (ADON)-H whose office was near R1's room. ADON-H stated staff did not report abuse toward R1. ADON-H indicated RN-F reported during morning meeting on 6/12/26 that R1's watch was broken and they were being given another watch until it could be fixed. There was no mention of abuse or other incidents with staff. On 6/16/26 at 2:21 PM, Surveyor interviewed CNA-E who confirmed R1 was combative on 6/11/26 but denied that R1 hit them in the face or glasses. CNA-E indicated they were hit by another resident on the unit prior to caring for R1. CNA-E indicated R1 clawed CNA-E's arm. CNA-E confirmed R1's watch was broken during the incident and thought CNA-E's finger got stuck underneath the watch. CNA-E indicated R1 wanted to get up and was calm and in a good mood, however, R1 sometimes gets mad when staff roll or move them. CNA-E stated R1's mood changed when CNA-E was almost finished with incontinence cares. CNA-E stated staff could not step away because R1 was naked and they and their bed were soaked. CNA-E confirmed CNA-C provided assistance after being called to help. CNA-E denied swearing at R1 and denied any verbal or physical abuse toward R1. CNA-E was not aware of scratches or bruises on R1's wrist and stomach and verified R1 remained in bed after the incident. On 6/16/26 at 2:40 PM, Surveyor interviewed NHA-A who indicated they had not received any reports of abuse from R1 or staff. On 6/16/26 at 7:47 PM, Surveyor interviewed R1's Power of Attorney for Healthcare ((POAHC)-I) via phone. POAHC-I stated R1 had recently mentioned to them that R1's watch was upside down. POAHC-I did not know the watch was broken at the time. R1 also indicated three people held R1 down. POAHC-I stated they did not make sense of it at the time but wondered if it had something to do with the incident on 6/11/26.		