

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Birch Hill Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1475 Birch Hill Lane Shawano, WI 54166	

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 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 report an allegation of abuse to the State Agency (SA) in a timely manner or the local police department for 1 resident (R) (R1) of 5 sampled residents.</p> <p>Certified Nursing Assistant (CNA)-E reported to Nursing Home Administrator (NHA)-A that CNA-C barricaded R1 in the nurses' station on 4/15/25. The allegation of abuse was not reported to the SA until 4/23/25. The facility also did not report the allegation of abuse to the local police department.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention Program, dated March 2018, indicates: .Involuntary seclusion refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's representative .7. Reporting/Responding: Allegations must be reported to the Administrator/designee immediately. The Administrator/designee will ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported no later than 2 hours after the allegation is made if events that cause the allegation involve abuse or result in serious bodily injury; or not later than 24 hours if events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the SA and other officials/authorities as needed.</p> <p>On 5/20/25, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the SA on 4/23/25. The FRI stated Registered Nurse (RN)-D reported to NHA-A that CNA-C was abusive to residents. On 4/22/25, NHA-A and Director of Nursing (DON)-B suspended CNA-C and initiated an investigation into the allegation of abuse. The facility's final investigation was submitted to the SA on 4/28/25.</p> <p>On 5/20/25, Surveyor reviewed staff statements that were included in the facility's investigation:</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>~ A statement by CNA-E, dated 4/15/15, indicated CNA-E came in at 2:00 AM on 4/15/25 and found CNA-C completing documentation at the nurses' station while R1 was at the CNA desk with a treatment cart next to R1. When CNA-E asked CNA-C why R1 was positioned like that, CNA-C stated it was because R1 kept going into other residents' rooms. CNA-C then exited the nurses' station and CNA-E took R1 to R1's room for toileting and cares. When CNA-E pulled down R1's pants, CNA-E noted blood and bruising on R1's left lower leg. CNA-E reported the skin concerns to Registered Nurse (RN)-F who assessed R1's leg and provided first aide. RN-F thought the bruising and skin tear were related to a recent fall. CNA-E reported concerns about CNA-C possibly barricading R1 behind the nurses' station desk to RN-D (the AM shift nurse) on 4/15/25 at approximately 10:15 AM.</p> <p>~ A statement by CNA-C, dated 4/16/25, indicated CNA-C was assigned the the D/E wing but was answering lights on the A wing with residents reporting R1 was going into their rooms. CNA-C brought R1 to the nurses' station and moved the treatment cart behind the CNA desk so R1 would be able to move around the entire area of the nurses' station. While CNA-C was charting, R1 wheeled behind the CNA desk and laid R1's head down on the desk. CNA-C indicated there was enough space for R1 to get between the treatment cart and the CNA desk. CNA-C indicated R1 was in the nurses' station from approximately 12:00 AM until 2:00 AM. CNA-E came in at 2:00 AM and took R1 to the bathroom. CNA-C returned to CNA-C's assigned wing.</p> <p>Surveyor reviewed staff education, dated 4/15/25, related to involuntary seclusion that indicated all residents have the right to freely move about the facility or unit despite behavior and/or diagnoses. Not allowing a resident to move about freely can be a form of abuse. The education included a review of the facility's abuse policy. The education was not signed by CNA-C.</p> <p>On 5/20/25 at 9:41 AM, Surveyor interviewed CNA-E who verified when CNA-E came into work at 2:00 AM, CNA-E observed R1 at the CNA desk in the nurses' station with the treatment cart between R1 and CNA-C. When CNA-E asked why R1 was sitting like that, CNA-C stated it was because R1 kept going into other residents' rooms. CNA-E brought R1 to R1's room and observed blood dripping down R1's left lower leg. CNA-E reported the blood to RN-F at approximately 2:20 AM. RN-F applied a dressing and indicated the wound and bruising were from a previous fall. CNA-E was still concerned and reported the information to RN-D (the AM shift nurse) at approximately 10:15 AM. CNA-E stated R1 would have been unable to wheel R1's self out from behind the CNA desk because CNA-E had to move the treatment cart to wheel R1 out of the nurses' station.</p> <p>On 5/20/25 at 9:56 AM, Surveyor interviewed RN-D who verified R1 fell on [DATE] but had no skin concerns. RN-D felt the bruises were new based on the dark color (versus green or yellow which indicated older bruising). RN-D asked other staff questions to try to figure out the origin of R1's skin tear. CNA-E reported that when CNA-E came in at 2:00 AM, CNA-C had barricaded R1 behind the CNA desk with the treatment cart. RN-D stated DON-B started an investigation into the cause of R1's skin tear on 4/15/25 and it was determined the skin tear/bruising could have resulted from R1 bumping against the treatment cart. RN-D stated DON-B was aware of RN-D and CNA-E's concerns regarding CNA-C on 4/15/25. On 4/22/25, RN-D discovered CNA-C was still working despite the allegations and reported the concerns again to NHA-A and DON-B.</p> <p>(continued on next page)</p>		

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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>On 5/20/25 at 10:55 AM, Surveyor interviewed CNA-C who verified R1 regularly wandered and indicated in the early morning hours of 4/15/25, several residents complained that R1 entered their rooms. CNA-C brought R1 to the nurses' station for 1:1 supervision per R1's care plan. CNA-C indicated R1 could wheel R1's self around the nurses' station and wheeled behind the CNA desk. CNA-C stated when CNA-E came in at 2:00 AM, CNA-C returned to the D/E wing for the rest of the shift. CNA-C verified CNA-C was not suspended from work regarding the allegation until 4/22/25.</p> <p>On 5/20/25 at 12:15 PM, Surveyor interviewed NHA-A and DON-B regarding reporting the allegation of abuse. DON-B stated statements were obtained from RN-F, CNA-C, and CNA-E on 4/15/25 and 4/16/25 while they investigated the skin tear on R1's leg. NHA-A and DON-B confirmed they were aware of the allegation that CNA-C barricaded R1 behind the CNA desk with the treatment cart on 4/15/25. NHA-A and DON-B also verified involuntary seclusion was a form of abuse. NHA-A and DON-B indicated they did not immediately report the allegation of abuse because it did not happen based on re-enactment and staff interviews. NHA-A stated when RN-D reported the same concerns regarding CNA-C on 4/22/25, they suspended CNA-C and initiated a full abuse investigation. NHA-A indicated the allegation was not reported to the local police department because they do not respond to calls like that, especially with residents on the memory care unit.</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>Respond appropriately to all alleged violations.</p> <p>38793</p> <p>Based on staff interview and record review, the facility did not thoroughly investigate an allegation of abuse and prevent further potential abuse for 1 resident (R) (R1) of 5 sampled residents.</p> <p>Certified Nursing Assistant (CNA)-E reported to Nursing Home Administrator (NHA)-A that CNA-C barricaded R1 in the nurses' station on 4/15/25. CNA-C was not removed from or supervised during resident care until 4/22/25.</p> <p>Findings include:</p> <p>The facility's Abuse Prevention Program, dated March 2018, indicates: .Involuntary Seclusion refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's representative .6. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include: responding immediately to protect the alleged victim, staffing changes to protect the resident(s) from the alleged perpetrator .7. Reporting/Response: .d. Analyzing the occurrence to determine why abuse occurred and what changed may be needed to prevent further occurrences.</p> <p>On 5/20/25, Surveyor reviewed a facility-reported incident (FRI) that was submitted to the State Agency (SA) on 4/23/25. The FRI stated Registered Nurse (RN)-D reported to NHA-A that CNA-C was abusive to residents. On 4/22/25, NHA-A and Director of Nursing (DON)-B suspended CNA-C and initiated an investigation into RN-D's allegations of abuse. The facility's final investigation was submitted to the SA on 4/28/25.</p> <p>On 5/20/25, Surveyor reviewed staff statements that were included in the facility's investigation:</p> <p>~ A statement by CNA-E, dated 4/15/15, indicated CNA-E came in at 2:00 AM on 4/15/25 and observed CNA-C completing documentation at the nurses' station while R1 was at the CNA desk with a treatment cart next to R1. When CNA-E asked why R1 was positioned like that, CNA-C stated it was because R1 kept going into other residents' rooms. CNA-C exited the nurses' station and CNA-E brought R1 to R1's room for toileting and cares. When CNA-E pulled down R1's pants, CNA-E observed blood and bruising on R1's left lower leg. CNA-E reported the skin concerns to RN-F who assessed R1's leg and provided first aide. RN-F thought the bruising and skin tear were related to a recent fall. CNA-E reported the concern about CNA-C possibly barricading R1 behind the desk in the nurses' station to RN-D (the AM shift nurse) on 4/15/25 at approximately 10:15 AM.</p> <p>~ A statement by CNA-C, dated 4/16/25, indicated CNA-C was assigned to the D/E wing but answered several lights on the A wing with residents reporting R1 was going into their rooms. CNA-C brought R1 to the nurses' station and moved the treatment cart behind the CNA desk so R1 would be able to move around the entire area of the nurses' station. While CNA-C was charting, R1 wheeled R1's self behind the CNA desk and laid R1's head down on the desk. CNA-C indicated there was enough space for R1 to get between the treatment cart and the CNA desk. CNA-C indicated R1 was in the nurse's station from approximately 12:00 AM until 2:00 AM. CNA-E came in at 2:00 AM and took R1 to the bathroom. CNA-C returned to CNA-C's assigned wing.</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>Surveyor reviewed staff education, dated 4/15/25, related to involuntary seclusion that stated all residents have the right to freely move about the facility or unit despite behavior and/or diagnoses. Not allowing a resident to move about freely can be a form of abuse. The education included a review of the facility's abuse policy. The education was not signed by CNA-C.</p> <p>On 5/20/25 at 9:41 AM, Surveyor interviewed CNA-E who verified when CNA-E came in at 2:00 AM, CNA-E observed R1 at the CNA desk in the nurses' station with a treatment cart between R1 and CNA-C. When CNA-E asked why R1 was sitting like that, CNA-C stated it was because R1 kept going into other residents' rooms. CNA-E brought R1 into R1's room and observed blood dripping down R1's left lower leg. CNA-E reported the concern to RN-F at approximately 2:20 AM. RN-F applied a dressing and indicated the wound and bruising were from a previous fall. CNA-E was still concerned and reported the concern to RN-D (the AM shift nurse) at approximately 10:15 AM. CNA-E stated R1 would have been unable to wheel R1's self out from behind the CNA desk because CNA-E had to move the treatment cart to wheel R1 out of the nurses' station.</p> <p>On 5/20/25 at 9:56 AM, Surveyor interviewed RN-D who indicated CNA-E reported that when CNA-E came in at 2:00 AM, CNA-C had barricaded R1 behind the CNA desk with the treatment cart. RN-D stated DON-B was aware of RN-D and CNA-E's concerns regarding CNA-C on 4/15/25. On 4/22/25, RN-D found out CNA-C was still working despite the allegations and reported the concerns again to NHA-A and DON-B.</p> <p>On 5/20/25 at 10:55 AM, Surveyor interviewed CNA-C who verified CNA-C was not removed from or supervised during resident care until 4/22/25. CNA-C stated DON-B provided education via phone regarding abuse and involuntary seclusion.</p> <p>On 5/20/25, Surveyor reviewed CNA-C's timecard punches from 4/13/25 to 4/28/25 and noted CNA-C worked on 4/16/25, 4/17/25, 4/18/25, 4/20/25, 4/21/25, and 4/22/25. CNA-C returned to work on 4/28/25.</p> <p>On 5/20/25 at 12:15 PM, Surveyor interviewed NHA-A and DON-B regarding the investigation. NHA-A and DON-B indicated they were aware of the allegation of CNA-C barricading R1 behind the CNA desk with the treatment cart on 4/15/25. NHA-A and DON-B verified involuntary seclusion is a form of abuse. NHA-A and DON-B stated they did not immediately suspend CNA-C related to the allegation of abuse because it did not happen based on re-enactment and staff interviews. NHA-A stated when RN-D reported the same concerns regarding CNA-C again on 4/22/25, they suspended CNA-C and initiated a full investigation. DON-B verified CNA-C was suspended from work starting on 4/22/25 pending the results of the investigation and returned to work on 4/28/25.</p>		