STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525412	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Hill Health Services	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)
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** Based on staff and resident representative interview and record review, the facility did not notify a Guardian of a fall and change in condition for 1 resident (R) (R5) of 5 sampled residents.R5 had a fall with injury on 10/30/25. R5's Guardian was not notified of the fall or change in condition.Findings include:The facility's Fall Prevention and Management Guidelines policy, dated 7/2024, indicates: .7. When any resident experiences a fall, the facility will: .c. Notify the physician and family/responsible party .On 11/10/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including acute metabolic encephalopathy, myxedema coma, hypothyroidism, and urinary tract infection (UTI). R5's Minimum Data Set (MDS) assessment, dated 11/4/25, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R5 had severe cognitive impairment. R5 had a Guardian for healthcare decisions. On 11/10/25 at 12:40 PM, Surveyor observed R5 in a wheelchair in R5's room. R5 had a dark bruise on the right temporal region. Surveyor attempted to interview R5; however, R5 was unable to answer questions. R5's medical record, fall report, and Interdisciplinary Team (IDT) clinical review indicated on 10/30/25 at 4:45 AM, R5 was found on the floor next to R5's bed. R5 was snoring and entangled in the bedding. There was stool on R5's chest and bed. R5 would not speak or open R5's eyes and refused to open R5's mouth for AM medications. Neuro checks were completed as able with no concerns. On 11/10/25 at 12:55 PM, Surveyor interviewed R5's Guardian ((GRD)-C) who was appointed to R5 on 10/27/25 upon R5's admission to the facility. GRD-C visited R5 on 11/3/25 and noticed a bruise on R5's forehead. GRD-C assumed the bruise occurred prior to admission. GRD-C was not informed of R5's fall or injury on 10/30/25. GRD-C indicated GRD-C expects to be notified of any falls or injuries. On 11/10/25 at 4:10 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated Guardian notification depends upon the Guardian's preferences. DON-B verified GRD-C should have been notified of R5's fall and change in condition.

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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Birch Hill Health Services	1475 Birch Hill Lane Shawano, WI 54166

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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	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 staff interview and record review, the facility did not ensure an injury of unknown origin was reported to the State Agency (SA) for 1 resident (R) (R3) of 1 sampled resident. On 11/7/25, a fracture was discovered in R3's right arm under a cast and above where R3 had a previous fracture repaired on 10/22/25. The facility did not report the injury of unknown origin to the SA.Findings include:The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: .IV. Identification of Abuse, Neglect, and Exploitation: .B. Possible indicators of abuse include, but are not limited to: .3. Physical Injury of a resident, of unknown source .VII. Reporting/Response: Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services (APS), and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. On 11/10/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] from home and had diagnoses including Alzheimer's disease with late onset, dementia-severe with agitation, unspecified fracture of lower end of right humerus, chronic pain, weakness, other osteoporosis with current pathological fracture, and polyosteoarthritis. R3's Significant Change Minimum Data Set (MDS) assessment, dated 11/5/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R3 had severe cognitive impairment. R3 had a Guardian who was R3's spouse.R3's medical record indicated R3 had an X-ray related to right elbow pain and swelling on 10/18/25. The X-ray indicated R3 had an acute transverse supracondylar fracture of the distal right humerus with posterior displacement. On 10/19/25, R3 was transferred to the emergency room (ER) and admitted to the hospital. On 10/22/25, the fracture was surgically repaired. On 10/29/25, R3 returned to the facility with a cast wrapped in an Ace bandage. A progress note, dated 11/3/25, indicated R3 received oxycodone for pain but continued to have right arm pain. The physician was notified and gave an order to change oxycodone to every 6 hours as needed.A progress note, dated 11/7/25, indicated R3 was given scheduled and as needed pain medication for right arm pain but continued to call out in pain and had significant pain with movement. R3's care team stated R3's splint could be adjusted for comfort. The nurse removed the Ace wrap; however, R3 had a hard cast that could not be adjusted. The orthopedist stated to send R3 to the ER for an X-ray. The X-ray indicated R3 had an additional fracture in the right humerus above the repaired site. R3 was scheduled for surgery on 11/11/25 and sent back to the facility pending an appointment on 11/10/25. Surveyor noted the injury of unknown origin was not reported to the SA despite the fact R3 did not have a documented fall or other injury to account for the additional fracture.On 11/11/25 at 1:19 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A via phone regarding how the second fracture occurred. Surveyor indicated the fracture was considered an injury of unknown origin that should have been reported to the SA since the fracture could not be linked to an event. NHA-A verified the statement by asking questions regarding the timeliness of the self-report (within 2 hours).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure an injury of unknown origin was thoroughly investigated for 1 resident (R) (R3) of 1 sampled resident.On 11/7/25, a fracture was discovered in R3's right arm under a cast and above where R3 had a previous fracture repaired on 10/22/25. The facility did not thoroughly investigate the injury of unknown origin.Findings include: The facility's Abuse, Neglect, and Exploitation policy, revised 7/15/22, indicates: .IV. Identification of Abuse, Neglect, and Exploitation: .B. Possible indicators of abuse include, but are not limited to: .3. Physical injury of a resident of unknown source. V. Investigation of Alleged Abuse, Neglect, and Exploitation: A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. On 11/10/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] from home and had diagnoses including Alzheimer's disease with late onset, dementia-severe with agitation, unspecified fracture of lower end of right humerus, chronic pain, weakness, other osteoporosis with current pathological fracture, and polyosteoarthritis. R3's Significant Change Minimum Data Set (MDS) assessment, dated 11/5/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R3 had severe cognitive impairment. R3 had a Guardian who was R3's spouse.R3's medical record indicated R3 had an X-ray related to right elbow pain and swelling on 10/18/25. The X-ray indicated R3 had an acute transverse supracondylar fracture of the distal right humerus with posterior displacement. On 10/19/25, R3 was transferred to the emergency room (ER) and admitted to the hospital. On 10/22/25, the fracture was surgically repaired. On 10/29/25, R3 returned to the facility with a cast wrapped in an Ace bandage. A progress note, dated 11/3/25, indicated R3 received oxycodone for pain but continued to have pain in the right arm. The physician was notified and gave an order to change oxycodone to every 6 hours as needed.A progress note, dated 11/7/25, indicated R3 was given scheduled and as needed pain medication related to right arm pain but continued to call out in pain and had significant pain with movement. R3's care team stated R3's splint could be adjusted for comfort. The nurse removed the Ace wrap; however, R3 had a hard cast that could not be adjusted. The orthopedist stated to send R3 to the ER for an X-ray. The X-ray indicated R3 had an additional fracture in the right humerus above the repaired site. R3 was scheduled for surgery on 11/11/25 and sent back to the facility pending an appointment on 11/10/25. Surveyor noted the facility did not have an investigation for the additional fracture that was discovered on 11/7/25. R3 could not state how the fracture occurred.On 11/11/25 at 1:19 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A via phone regarding R3's new fracture that was considered an injury of unknown origin which should have been investigated to determine the cause and rule out abuse. NHA-A confirmed the facility did not investigate R3's injury of unknown origin.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility did not ensure adequate supervision and assistance to prevent accidents was provided for 1 resident (R) (R5) of 3 sampled residents. R5 sustained a fall with injury on 10/30/25 when R5 fell out of bed and onto the floor. Staff did not complete neurological checks in accordance with the facility's policy. In addition, the Interdisciplinary Team (IDT) identified the need for a bolster mattress. The intervention was not added to R5's care plan.Findings include:The facility's Fall Prevention and Management Guidelines policy, dated 7/2024, indicates: .7. When any resident experiences a fall, the facility will: .2) Neuro checks for any unwitnessed fall or witnessed fall where the resident hits their head: initially, then hourly x 3, continue neuro checks every 4 hours x 6, then continue neuro checks every 8 hours x 6, or as indicated by the physician .8. Review each fall/fall investigation during the next morning meeting/clinical meeting with the Interdisciplinary Team (IDT). Action of the IDT may include: a. Review of investigation and determination of potential root cause of fall .c. Additional revision to the plan of care including any physical adaptation to room, furniture, wheelchair, and/or assistive devices .On 11/10/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including acute metabolic encephalopathy, myxedema coma, hypothyroidism, and urinary tract infection (UTI). R5's Minimum Data Set (MDS) assessment, dated 11/4/25, contained a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R5 had severe cognitive impairment. R5 had a Guardian for healthcare decisions. R5's medical record, fall report, and IDT clinical review indicated R5 was found on the floor next to R5's bed snoring and entangled in bedding on 10/30/25 at 4:45 AM. R5's chest and bed contained stool. Neurological checks were completed at 4:45 AM (as tolerated; R5 would not open R5's eyes or speak with staff); 6:48 AM; 10:21 AM; 11:55 AM; and 9:30 PM. Surveyor noted 5 of 15 neuro checks required to monitor for injury following an unwitnessed fall were completed.On 11/10/25 at 12:40 PM, Surveyor observed a dark bruise on R5's right temporal region incurred during the fall on 10/30/25. R5 was unable to communicate with Surveyor.Surveyor reviewed the IDT results for R5's fall on 10/30/25. The IDT recommended to put a bolster mattress on R5's bed so R5 is aware of the edges of the bed. (R5's care plan did not include an intervention for a bolster mattress.)On 11/10/25 at 4:10 PM, Surveyor interviewed Director of Nursing (DON)-B who verified neuro checks were not completed in accordance with the facility's policy. DON- B also indicated R5's care plan should have been updated in accordance with the IDT's recommendation for a bolster mattress.