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	02/11/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure court-ordered protective placement was obtained for 1 resident (R) (R36) of 3 sampled residents. R36 had a Guardian. The facility did not ensure court-ordered protective placement in the least restrictive environment was obtained after R36's nursing home stay exceeded 60 days. R36 also did not receive an annual review to determine appropriate placement. Findings include: From 2/9/26 to 2/11/26, Surveyor reviewed R36's medical record. R36 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, chronic obstructive pulmonary disease (COPD), anxiety, and major depression. R36's Minimum Data Set (MDS) assessment, dated 12/3/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R36 had severely impaired cognition. R36 had a Guardian that was activated on 4/17/20. R36's medical record did not contain protective placement paperwork. On 2/10/26 at 8:15 AM, Surveyor interviewed Director of Memory Care (DMC)-C who indicated the facility did not have protective placement paperwork for R36. On 2/11/26 at 12:21 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who stated the facility does not have a Guardianship policy and follows Chapter 54 and 55. NHA-A indicated the facility did not obtain protective placement for R36 but will contact Adult Protective Services (APS) to start the process.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 allegation of sexual abuse was reported to the State Agency (SA) for 2 residents (R) (R42 and R8) of 2 sampled residents.Staff witnessed R42 kiss R8 in the hallway on 1/24/26. R42 then followed R8 into R8's room. Licensed Practical Nurse (LPN)-F entered R8's room and observed R42 unzipping R42's pants in front of R8 who was lying on the bed with a book and appeared confused. The allegation of sexual abuse was not reported to the SA. Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. An immediate investigation is warranted when an allegation or suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. The facility will report all alleged violations to the Administrator, State Agency .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 not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.From 2/9/26 to 2/11/26, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, heart failure, dementia, depression, and cognitive communication deficit. R42's Minimum Data Set (MDS) assessment, dated 1/14/26, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R42 had moderately impaired cognition. From 2/9/26 to 2/11/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, and anxiety. R8's MDS assessment, dated 12/16/25, had a BIMS score of 6 out of 15 which indicated R8 had severely impaired cognition.R42's medical record contained a progress note, dated 1/24/26 and written by LPN-F, that indicated R42 and (R8) were observed consensually kissing in the hallway by an unnamed housekeeping staff. The staff watched R42 and R8 enter R8's room then left the area to inform LPN-F. LPN-F verified with the housekeeping staff that the kiss was consensual and went to R8's room. LPN-F observed R8 lying on R8's bed holding a book. R42 was standing in front of R8 and unzipping R42's pants. LPN-F indicated R8 looked confused and LPN-F stopped R42 from unzipping R42's pants. LPN-F stated to R42 that R42's actions were inappropriate and asked R42 to zip R42's pants and leave the room. LPN-F stated R8 thanked LPN-F for asking R42 to leave. LPN-F notified R42's activated Power of Attorney for Healthcare (POAHC) who wondered if R42's sexual behavior was due to a medication that was discontinued a year ago. R42's POAHC indicated when the medication was discontinued, there was a warning that sexual behavior could reappear or worsen. R42's POAHC indicated R42 had increased incidents of this nature with various females since the medication was discontinued. LPN-F answered all questions and faxed the provider about the previously discontinued medication per R42's POAHC's request. R42's POAHC found the situation distressing since it was recurrent. The progress note indicated Director of Nursing (DON)-B was aware of the incident.On 2/10/26 at 11:05 AM, Surveyor interviewed LPN-F who indicated a housekeeper saw R42 and R8 kissing on 1/24/26 and verified to LPN-F that it was consensual because neither pulled back from the kiss. The housekeeper then saw R8 and R42 enter R8's room and informed LPN-F of the incident. LPN-F went to R8's room and observed R42 start to unzip R42's pants while R8 was lying on the bed holding a book and looked confused. LPN-F redirected R42 from unzipping R42's pants. R42 pulled up the zipper, left room, and appeared frustrated. LPN-F informed R42 that R42 could not kiss residents or unzip R42's pants. R42 appeared to understand. LPN-F stated situations can be consensual and then become non-consensual depending on a resident's cognitive status. LPN-F notified DON-B and R42 and R8's POAHCs. LPN-F indicated R8's POAHC was (continued on next page)

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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	understanding; however, R42's POAHC was concerned the incident was related to a medication that was discontinued a year ago. LPN-F indicated the facility did not have a formal assessment for determining consensual sexual behavior. LPN-F contacted R42's physician on the day of the incident regarding the previously discontinued medication and was not sure the result of the physician update.On 2/10/26 at 11:17 AM, Surveyor interviewed DON-B who indicated R42 had kissed and groped residents in the past and R42's family and physician were aware. DON-B stated DON-B was not present when the incident occurred but thought LPN-F had ensured the safety of R42 and R8 and updated each resident's POAHC. DON-B indicated R42's physician was notified and would review R42's medication and plan of care during a scheduled meeting on 2/17/26. The physician indicated psychiatry should be involved. DON-B indicated the facility does not have a formal assessment to determine consensual sexual behavior and indicated LPN-F stopped the situation before it became non-consensual. DON-B indicated staff know to watch residents for distress and if a resident is distressed, the behavior is considered non-consensual. DON-B indicated the incident was not reportable to the SA because abuse did not occur.On 2/11/26 at 12:23 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware of the incident and was away from the facility when the incident occurred. NHA-A indicated NHA-A contacted the Ombudsman for information about identifying consensual sexual behavior and was planning to implement more staff education.

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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 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 thoroughly investigate an allegation of sexual abuse for 2 residents (R) (R42 and R8) of 2 sampled residents.Staff witnessed R42 kiss R8 in the hallway on 1/24/26 then follow R8 into R8's room. Licensed Practical Nurse (LPN)-F entered R8's room and observed R42 unzipping R42's pants in front of R8 who was lying on the bed with a book and appeared confused. The allegation of sexual abuse was not thoroughly investigated.Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. An immediate investigation is warranted when an allegation or suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur.From 2/9/26 to 2/11/26, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, cognitive communication deficit, and depression. R42's Minimum Data Set (MDS) assessment, dated 1/14/26, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R42 had moderately impaired cognition.From 2/9/26 to 2/11/26, Surveyor reviewed R8's medical record. R8 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, dementia, and anxiety. R8's MDS assessment, dated 12/16/25, had a BIMS score of 6 out of 15 which indicated R8 had severly impaired cognition.R42's medical record contained a progress note, dated 1/24/26 and written by LPN-F, that indicated R42 and (R8) were observed consensually kissing in the hallway by an unnamed housekeeping staff. The staff watched R42 and R8 enter R8's room and then left to inform LPN-F. LPN-F verified with the housekeeping staff that the kiss was consensual then went to R8's room. LPN-F observed R8 lying on R8's bed holding a book and R42 standing in front of R8 and unzipping R42's pants. LPN-F indicated R8 appeared confused. LPN-F told R42 that R42's actions were inappropriate, and asked R42 to zip R42's pants and leave the room. LPN-F stated R8 thanked LPN-F for asking R42 to leave. LPN-F notified R42's activated Power of Attorney for Healthare (POAHC) who wondered if R42's sexual behavior was due to a medication that was discontinued a year ago. R42's POAHC indicated when the medication was discontinued, there was a warning that sexual behavior could reappear or worsen. R42's POAHC indicated R42 had increased incidents of that nature with various females since the medication was discontinued. LPN-F answered all questions and faxed the provider regarding the previously discontinued medication per R42's POAHC's request. R42's POAHC found the situation distressing since it was recurrent. The progress note indicated Director of Nursing (DON)-B was aware of the incident.On 2/10/26 at 11:05 AM, Surveyor interviewed LPN-F who indicated a housekeeper saw R8 and R42 kissing on 1/24/26 and told LPN-F that it was consensual because neither pulled back from the kiss. When the housekeeper saw R8 and R42 enter R8's room, the housekeeper informed LPN-F. LPN-F went to R8's room and observed R42 start to unzip R42's pants while R8 was lying on the bed and holding a book. LPN-F stated R42 appeared confused. LPN-F stopped R42 from unzipping R42's pants. R42 pulled up the zipper, left the room, and appeared frustrated. LPN-F informed R42 that R42 could not kiss residents or unzip R42's pants. R42 appeared to understand. LPN-F indicated situations can be consensual then become non-consensual depending on a resident's cognitive status. Following the incident, LPN-F notified DON-B and R42 and R8's POAHCs. LPN-F stated R8's POAHC was understanding of the incident; however, R42's POAHC was concerned the incident was related to a medication that was discontinued a year ago. LPN-F indicated the facility did not have a formal assessment for determining consensual sexual behavior. LPN-F notified R42's physician on the day of the incident but was not sure the result of the update.On 2/10/26 at 11:17 AM, Surveyor interviewed DON-B who was not present when the incident occurred but thought LPN-F had ensured the safety of R8 and R42 and updated R8 and R42's POAHC. DON-B (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated R42's physician was notified and would review R42's medication and plan of care during a scheduled meeting on 2/17/26. The physician also wanted psychiatry involved. DON-B indicated the facility does not have a formal assessment to determine consensual sexual behavior and stated LPN-F stopped the situation before it became non-consensual. DON-B indicated staff know to watch residents for distress and indicated if a resident is distressed, the behavior is considered non-consensual. DON-B indicated abuse did not occur.On 2/11/26 at 12:23 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who was not aware of the incident and was away from the facility when the incident occurred. DON-B was present during the interview indicated staff were not certain that R42 unzipped R42's pants. When Surveyor indicated a thorough investigation would have helped the facility determine if R42 unzipped R42's pants and if other residents or staff had similar concerns, NHA-A nodded in agreement.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure appropriate weight monitoring was provided for 2 residents (R) (R9 and R29) of 4 sampled residents.R9's provider and Power of Attorney for Healthcare (POAHC) were not notified of weight loss or gain greater than 3 pounds (lbs) from 11/4/25 to 1/30/26. In addition, R9 was not re-weighed for weight loss or gain greater than 3 lbs. R9's daily weights were not documented as ordered and were not obtained with a consistent device.R29's provider and Guardian were not notified regarding weight loss or gain greater than 3 lbs from 9/1/25 to 2/1/26. In addition, R29 was not re-weighed for weight loss or gain greater than 3 lbs.Findings include:The facility's Weight Monitoring policy, revised 12/21/22, indicates: The Interdisciplinary Team (IDT) will strive to prevent, monitor, and intervene for undesirable weight changes for residents .Weight Monitoring .5. Team members will follow a consistent approach to weighing and use an appropriately calibrated and functioning scale (e.g., wheelchair scale or bed scale). Since weight varies throughout the day, a consistent process and technique (e.g., weighing the resident wearing a similar type of clothing, at approximately the same time of day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, and verifying scale accuracy) can help make weight comparisons more reliable. 6. Any weight change of 5 pounds or more since the last weight assessment will be taken for confirmation .8. The threshold for significant weight change will be based on the following criteria where percentage of body weight change = (usual weight-actual weight)/(usual weight) x 100: a. 1 month - 5% weight change is significant; greater than 5% is severe. b. 3 months - 7.5% weight change is significant; greater than 7.5% is severe. c. 6 months - 10% weight change is significant; greater than 10% is severe. 9. If the weight change is desirable, it will be documented by the Registered Dietitian (RDN)/designee and no change in the care plan will be necessary. 10. Nursing staff will notify the individual or responsible party, physician and RDN/designee of any individual with an unintended significant weight change .Interventions: .2. The undesired weight change will be discussed with the resident and/or responsible party.1. From 2/9/26 to 2/11/26, Surveyor reviewed R9's medical record. R9 was admitted to the facility on [DATE] and had diagnoses including unspecified severe protein calorie malnutrition, dysphagia, hypothyroidism, type 2 diabetes, metabolic encephalopathy, myxedema coma, and sequelae of cerebral infarction. R9's Minimum Data Set (MDS) assessment, dated 1/20/26, had a Brief Interview for Mental Status (BIMS) score of 00 out of 15 which indicated R9 had severly impaired cognition. R9 had an activated POAHC.A care plan, initiated 10/29/25, indicated R9 was at risk for nutritional status change related to self-care deficit, type 2 diabetes, chronic obstructive pulmonary disease, obesity, and metabolic encephalopathy. The care plan contained goals that R9's skin would show signs/symptoms of healing and R9 would maintain weight as evidenced by no significant weight changes (>/= 5% in 30 days, >/= 7.5% in 90 days, or >/= 10% in 180 days). The care plan contained interventions (dated 10/29/25) to provide diet as ordered (CCHO diet, L2/mechanical-alterterd texture, regular/thin consistency), record weight per facility protocol/Medical Doctor (MD) orders, and review weights and notify Registered Dietitian (RD), MD, and responsible party of significant weight change.R9's medical record indicated R9 was being monitored by cardiology and had been on a heart monitor.R9's medical record contained the following orders:~ Magic cup at bedtime once daily for supplement (dated 10/30/25)~ Med Plus 2.0 120 milliliters (ml) three times daily for supplement between meals and after dinner (dated 11/26/25)~ Consistent carbohydrate (CCHO) diet mechanical-altered texture with regular/thin consistency (dated 12/26/25)~ Mirtazapine 7.5 milligrams (mg) give 1 tablet by mouth once daily for depression and appetite stimulation (dated 11/20/25)~ Daily weights and vital signs once daily (dated 10/29/25)On 2/11/26, Surveyor reviewed the facility's standing orders with Director of Nursing (DON)-B. Standing orders signed by the provider on 6/23/25 indicated: Weight: If diagnosis of heart failure, notify provider if there is a 3 pound gain in 1 day or 5 pound gain in 7 days.Surveyor reviewed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's weights and noted the following:~ On 1/31/26 at 12:10 PM, R9 weighed 173.8 lbs (wheelchair scale) ~ On 1/30/26 at 9:01 AM, R9 weighed 174.4 lbs (wheelchair scale) (There was no re-weigh. R9's weight up 3 lbs.) ~ On 1/29/26 at 12:06 PM, R9 weighed 171.4 lbs (wheelchair scale) ~ On 1/21/26 at 1:30 PM, R9 weighed 176.6 lbs (wheelchair scale) ~ On 1/20/26 at 10:14 AM, R9 weighed 177.0 lbs (wheelchair scale) (There was no re-weigh. R9's weight was down 9.6 lbs.) ~ On 1/19/26 at 1:10 PM, R9 weighed 186.6 lbs (wheelchair scale) ~ On 1/18/26 at 8:44 AM, R9 weighed 187.8 lbs (wheelchair scale) (There was no re-weigh. R9's weight up 6.4 lbs.)~ On 1/17/26 at 10:25 AM, R9 weighed 181.4 lbs (wheelchair scale) (There was no re-weigh. R9's weight was up 5.8 lbs.)~ On 1/16/26 at 1:10 PM, R9 weighed 175.6 lbs (wheelchair scale) (There was no re-weigh. R9's weight was down 6 lbs.) ~ On 1/14/26 at 1:38 PM, R9 weighed 181.6 lbs (wheelchair scale) ~ On 1/13/26 at 10:48 AM, R9 weighed 179.9 lbs (wheelchair scale) ~ On 1/12/26 at 9:31 AM, R9 weighed 179.4 lbs (wheelchair scale) (There was no re-weigh. R9's weight was up 11.6 lbs.) ~ On 1/11/26, there was no weight recorded for R9.~ On 1/10/26 at 1:43 PM, R9 weighed 167.8 lbs (wheelchair scale) ~ On 1/9/26, there was no weight recorded for R9.~ On 1/8/26 at 11:33 AM, R9 weighed 167.6 lbs (wheelchair scale) (There was no re-weigh. R9's weight was down 8 lbs.) ~ On 1/7/26 at 8:52 AM, R9 weighed 175.6 lbs (wheelchair scale) (There was no re-weigh. R9's weight was down 5.4 lbs.) ~ On 1/5/26 at 11:27 AM, R9 weighed 181.0 lbs (wheelchair scale) ~ On 1/4/26 at 12:37 PM, R9 weighed 182.6 lbs (wheelchair scale) ~ On 1/3/26 at 8:21 AM, R9 weighed 183.4 lbs (wheelchair scale) (There was no re-weigh. R9's weight up 4.6 lbs.)~ On 1/2/26 at 10:10 AM, R9 weighed 178.8 lbs (wheelchair scale) ~ On 12/28/25 at 12:46 PM, R9 weighed 183.2 lbs (wheelchair scale) ~ On 12/27/25 at 11:11 AM, R9 weighed 182.0 lbs (wheelchair scale) ~ On 12/26/25 and 12/25/25, there was no weight recorded for R9. ~ On 12/24/25 at 11:51 AM, R9 weighed 180.6 lbs (wheelchair scale)~ On 12/17/25 at 8:31 AM, R9 weighed 180.6 lbs (wheelchair scale) ~ On 12/16/25, there was no weight recorded for R9. ~ On 12/15/25 at 1:22 PM, R9 weighed 179.6 lbs (wheelchair scale) ~ On 12/14/25 at 12:51 PM, R9 weighed 178.8 lbs (mechanical lift scale) ~ On 12/13/25 at 10:18 AM, R9 weighed 178.2 lbs (wheelchair scale) ~ On 12/12/25, no weight was recorded for R9.~ On 12/11/25 at 12:31 PM, R9 weighed 178.6 lbs (wheelchair scale)~ On 12/7/25 at 12:24 PM, R9 weighed 181.8 lbs (wheelchair scale) ~ On 12/6/25 at 11:33 AM, R9 weighed 182.3 lbs (wheelchair scale) (There was no re-weigh. R9's weight was up 7.7 lbs.)~ On 12/5/25 and 12/4/25, there was no weight recorded for R9.~ On 12/3/25 at 12:54 PM, R9 weighed 174.6 lbs (wheelchair scale) ~ On 12/2/25 at 11:56 AM, R9 weighed 175.9 lbs (mechanical lift scale) ~ On 11/29/25 at 12:18 PM, R9 weighed 175.5 lbs (wheelchair scale) ~ On 11/28/25 at 11:34 AM, R9 weighed 174.0 lbs (mechanical lift scale) (There was no re-weigh. R9's weight was down 8 lbs.)~ On 11/27/25 at 9:04 AM, R9 weighed 182.0 lbs (wheelchair scale) (There was no re-weigh. R9's weight was up 6.5 lbs.)~ On 11/26/25 at 9:43 AM, R9 weighed 175.5 lbs (mechanical lift scale)~ On 11/19/25 at 10:48 PM, R9 weighed 182.4 lbs (wheelchair scale) ~ On 11/18/25 at 11:28 AM, R9 weighed 184.4 lbs (wheelchair scale) (There was no re-weigh. R9's weight was down 4 lbs.)~ On 11/17/25 at 1:58 PM, R9 weighed 188.4 lbs (wheelchair scale) ~ On 11/16/25 at 12:48 PM, R9 weighed 187.4 lbs (wheelchair scale) ~ On 11/8/25 at 8:48 AM, R9 weighed 189.4 lbs (wheelchair scale) ~ On 11/7/25 at 9:30 AM, R9 weighed 189.5 lbs (wheelchair scale) (There was no re-weigh. R9's weight was down 6.7 lbs.) ~ On 11/6/25 at 10:02 AM, R9 weighed 196.2 lbs (wheelchair scale) ~ On 11/5/25 at 10:14 AM, R9 weighed 198.0 lbs (wheelchair scale) ~ On 11/4/25 at 1:40 PM, R9 weighed 198.8 lbs (mechanical lift scale) (There was no re-weigh. R9's weight was up 4.8 lbs.) ~ On 11/3/25 at 9:48 AM, R9 weighed 194.0 lbs (wheelchair scale) ~ On 11/2/25 at 7:28 AM, R9 weighed 195.5 lbs (mechanical lift scale) ~ On 11/1/25 at 1:41 PM, R9 weighed 196.5 lbs (mechanical lift scale) ~ On 10/30/25 at 10:46 AM, R9 weighed 195.5 lbs (wheelchair scale)~ On 10/29/25 at 11:13 AM, there was a disputed value by the Registered Dietitian (RD)-G. ~ On 10/29/25 at 11:08 AM, R9 weighed 193.5 lbs (wheelchair scale) ~ On 10/28/25 at 11:51 AM, R9 weighed 238.0 lbs (mechanical lift scale) (There was no re-weigh. R9's weight was up 47 lbs.)~ On 10/27/25 at 4:20 PM, R9 weighed 191.0 lbs (mechanical lift scale) A progress note by RD-G, dated 2/9/26, indicated R9 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weighed 177.8 lbs. On 1/8/26, R9 weighed 167.8 lbs = 6% weight gain. On 11/4/25, R9 weighed 198.8 lbs = 10.6% weight loss. Significant weight gain x 1 month (6%). Significant weight loss x 3 months (10.6%). R9's weight gain was likely due to good meal and supplement intake. R9's weight loss since admission was likely due to not consuming excessive calories. RD-G recommended R9 continue with diet and supplements as ordered.A progress note by RD-G, dated 1/28/26, indicated R9 weighed 172.6 lbs. On 12/28/25, R9 weighed 183.2 lbs = 5.8% weight loss. On 10/29/25, R9 weighed 193.5 lbs = 10.8% weight loss. Significant weight loss x 1 month (5.8%). R9 took a multivitamin for wound healing, levothyroxine (which may cause weight loss), and mirtazapine (which may increase appetite). R9's weight loss was likely due to levothyroxine treatment with myxedema coma. RD-G recommendaed R9 start vitamin C 500 mg for wound healing.A progress note by RD-G, dated 1/21/26, indicated R9 weighed 177.0 lbs on 1/20/26. On 12/20/25, R9 weighed 179.6 lbs = 1.4% weight loss. A progress note by RD-G, dated 12/17/25, indicated R9 weighed 180.6 lbs. On 11/17/25, R9 weighed 188.4 lbs = 4.1% weight loss. On 11/4/25, R9 weighed 198.8 lbs = 9.2% weight loss. Significant weight loss x 3 months (9.2%). R9's weight loss was likely due to poor meal intake. RD-G recommended R9 continue with diet and supplements as ordered.A progress note by RD-G, dated 11/26/25, indicated R9 weighed 175.5 lbs. On 11/2/25, R9 weighed 195.5 lbs = 10.2% weight loss. Significant weight loss x 1 month (10.2%). R9's weight loss was likely due to poor appetite and poor intake of meals and supplements. R9 refused meals at times. RD-G recommended to increase Med Plus 2.0 120 ml to three times daily.On 2/11/26 at 10:22 AM at Surveyor interviewed RD-G who stated RD-G reviews residents' weights weekly and writes monthly notes. RD-G stated RD-G was not notified of R9's weight loss or gain. RD-G stated R9 received speech therapy who recommends diet types. RD-G recommends supplements and analyzes diet, intake, and weight. RD-G confirmed R9 took mirtazapine to stimulate R9's appetite. RD-G was not sure if the provider was aware of R9's significant weight fluctuations. RD-G stated RD-G notifies nursing staff of RD-G's recommendations and nursing staff obtain orders. On 2/11/26 at 11:45AM, Surveyor interviewed Director of Nursing (DON)-B who indicated a re-weigh is required if there is a difference in weight of 5 lbs since the previous weight. DON-B stated the facility has a standing order to call the provider if the resident has a 3 lb weight change in 1 day or a 7 lb weight change in 1 week for residents with heart failure. DON-B indicated cardiology followed R9 and staff should notify the provider of 3 lb weight changes. DON-B indicated daily weights were ordered due to R9's cardiac history. DON-B indicated nurses should re-weigh R9 if there is a 3 to 5 lb weight change and staff should document the re-weigh. DON-B indicated there should be two weights recorded if a re-weigh is obtained. DON-B indicated nurses enter weights but do not always compare them to the previous weight. DON-B stated nurses should write a progress note for weight loss or gain and update the provider. DON-B verified provider and POA notification was not documented in R9's medical record for weight losses or gains from 11/4/25 through 1/30/26. 2. From 2/9/26 to 2/11/26, Surveyor reviewed R29's medical record. R29 was admitted to the facility on [DATE] and had diagnoses including morbid obesity due to excess calories, type 2 diabetes, traumatic subdural hemorrhage with loss of consciousness, unspecified dementia, behavioral disturbance, and anxiety. R29's MDS assessment, dated 11/25/25, had a BIMS score of 7 out of 15 which indicated R29 had severely impaired cognition. R29 had a Guardian.A care plan, dated 8/27/25, indicated R29 was risk for nutritional status change related to dementia, dysphagia, obesity, hypertension and edema, R29 took diuretic medication and had a history of weight changes. The care plan contained a goal that R29 would maintain weight as evidenced by no significant weight changes (>/= 5% in 30 days, >/= 7.5% in 90 days, or >/= 10% in 180 days) and would accept the recommended diet for weight reduction through the next quarter as evidenced by weight loss of 1-2 pounds per week. The care plan contained the following interventions: Provide diet as ordered - CCHO diet, L2/mechanical-altered texture with pureed vegetables, thin consistency. Try to avoid thick bread products, may need to soften more or cut into smaller pieces; Record weight per facility protocol/MD orders; Review weights and notify RD, MD, and responsible party of significant weight change (7/18/22); See tray card for specific food (continued on next page)

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	525412	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preferences; Snack per R29's preference.R29's medical record contained the following orders:~ Consistent carbohydrate diet, Level 2/mechanical-altered texture, regular/thin consistency (dated 8/7/25) UPDATE (9/3/25): Diet texture - minced and moist. Pureed vegetables. Try to avoid thick bread products. May need to soften more or cut into smaller pieces. General swallow precautions. Small portions.Surveyor reviewed R29's weights and noted the following:~ On 2/1/26 at 9:11 AM, R29 weighed 193.4 lbs (standup scale) (There was no re-weigh. R29's weight was down 5.2 lbs.) ~ On 1/1/26 at 9:44 AM, R29 weighed 198.6 lbs (standup scale) (There was no re-weigh. R29's weight was down 3 lbs.)~ On 12/1/25 at 9:49 AM, R29 weighed 201.6 lbs (standup scale) (There was no re-weigh. R29's weight was down 12 lbs.)~ On 11/5/25 at 11:16 AM, R29 weighed 213.6 lbs (wheelchair scale) ~ On 10/1/25 at 8:01 AM, R29 weighed 211.6 lbs (wheelchair scale) ~ On 9/1/25 at 12:15 PM, R29 weighed 210.4 lbs (wheelchair scale) (There was no re-weigh. R29's weight was down 10.8 lbs.)~ On 8/1/25 at 10:35 PM, R29 weighed 221.2 lbs (wheelchair scale) ~ On 7/1/25 at 12:54 PM, R29 weighed 223.0 lbs (wheelchair scale)A progress note by RD-G, dated 1/7/26, indicated R29 weighed 198.6 lbs. On 12/1/25, R29 weighed 201.6 lbs = 1.5% weight loss. On 10/1/25, R29 weighed 211.6 lbs = 6.1% weight loss. On 7/1/25, R29 weighed 223 lbs = 10.9% weight loss. Significant weight loss x 6 months (10.9%). R29 followed a CCHO diet, level 2/mechanical-altered texture with intakes of 51-100%. R29 accepted snacks at times with 100% intake of those accepted and did not take supplements. No edema was documented x 30 days. The note indicated furosemide can cause weight fluctuations and R29's weight loss was likely due to desired gradual weight loss with morbid obesity. R29's intake was adequate to meet needs. RD-G recommended that R29 continue with diet as ordered and continue to monitor weight/intake.A progress note by RD-G, dated 12/22/25 at 5:56 PM, indicated R29 weighed 201.6 lbs. On 11/5/25, R29 weighed 213.6 lbs = 5.6% weight loss. On 9/1/25, R29 weighed 210.4 lbs = 4.2% weight loss. On 6/1/25, R29 weighed 223.6 lbs = 9.8% weight loss. Significant weight loss x 1 month (5.6%). The note indicated furosemide can cause weight fluctuations and indicated R29's weight loss was likely due to weight fluctuations from diuretic treatment.A progress note by RD-G, dated 11/19/25 at 1:52 PM, indicated R29's average meal intake was 50-100%. On 11/5/25, R29 weighed 213.6 lbs. On 10/1/25, R29 weighed 211.6 lbs = 0.9% weight gain. On 8/1/25, R29 weighed 221.2 lbs = 3.4% weight loss. On 5/1/25, R29 weighed 224 lbs = 4.6% weight loss. R29 had the potential for weight fluctuation related to fluid shifts. R29's weight fluctuations were likely due to diuretic therapy. R29 was on a texture-modified diet with L2/mechanical-altered texture and pureed vegetables. Small portions were added as well as avoid thick bread products/soften or cut into smaller pieces. The note indicated RD-G would monitor and coordinate care with the IDT. R29's care plan was reviewed and updated.A nutrition assessment note by RD-G, dated 8/27/25 at 8:33 AM, indicated R29's average meal intake was 50-100% and R29 ate 2-3 meals per day. On 8/1/25, R29 weighed 221.2 lbs. R29's weight was stable. R29 consumed adequate calories to maintain weight. The note indicated R29 had potential for weight fluctuation related to fluid shifts and diuretic therapy.On 2/11/26 at 11:11 AM, Surveyor interviewed RD-G who stated RD-G received a weight loss triggered/notification on 2/1/26 for R29 whose weight will be discussed at an upcoming quarterly meeting. RD-G confirmed R29 had weight loss over the last year and thought R29 had a weight loss goal due to R29's high BMI. RD-G reviewed R29's intakes with Surveyor and stated RD-G thought R29's weight loss was planned because R29 was obese. RD-G had not discussed R29's weight loss with the provider and verified R29 had lost more weight over the last 3 months. RD-G stated Nursing Home Administrator (NHA)-A or the MDS nurse contact RD-G if they have concerns. RD-G stated RD-G was not notified by staff of weight concerns for R29. RD-G verified R29's January 2026 note indicated R29 had a 10.9% weight loss from 6 months prior. On 2/11/26 at 11:45AM, Surveyor interviewed DON-B who stated a resident should be re-weighed if there is a difference in weight of 5 lbs since the previous weight. DON-B stated the facility has a standing order to call the provider if a resident has a 3 lb weight change in 1 day or a 7 lb weight change in 1 week. DON-B stated nurses should document a re-weigh and indicated there should be two weights documented if a re-weigh occurred. DON-B (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated nurses enter weights but do not always compare them to the previous weight. DON-B stated nurses should write a progress note for weight loss or gain and update the provider. DON-B stated R29's medical record did not indicate the provider and R29's POA were notified of R29's weight loss for 9/1/25 through 2/1/26.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 3 residents (R) (R41, R32, and R43) of 3 sampled residents.R41 was on enhanced barrier precautions (EBP) for an indwelling catheter. Certified Nursing Assistant (CNA)-D did not wear a gown while emptying R41's catheter.Registered Nurse (RN)-E did not complete proper hand hygiene during medication pass for R32 and R43.Findings include: The facility's Enhanced Barrier Precautions (EBP) policy, revised 8/8/24, indicates: EBP refer to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high-contact resident care activities. High-contact resident care includes if a resident has a wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with an MDRO. The facility's Hand Hygiene policy, dated 11/2/2022, indicates: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .3. Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations .Hand Hygiene Table: Either soap and water or alcohol-based hand rub .before preparing or handling medications. 1. From 2/9/26 to 2/11/26, Surveyor reviewed R41's medical record. R41 was admitted to the facility on [DATE] and had diagnoses including dementia, heart failure, and obstructive uropathy. R41's Minimum Data Set (MDS) assessment, dated 1/28/26, had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 which indicated R41 had severely impaired cognition. A care plan, dated 2/9/26, indicated R41 had an indwelling catheter related to obstructive uropathy and was on EBP. Surveyor observed an EBP sign and a personal protective equipment (PPE) cart which contained gowns and gloves outside R41's room. On 2/10/26 at 1:30 PM, Surveyor observed CNA-D enter R41's room, draw the curtain between R41 and R41's roommate, complete hand hygiene, and don gloves. CNA-D retrieved a graduated cylinder, removed R41's catheter bag from a dignity bag, and wiped the drainage spout with an alcohol pad. CNA-D unclamped the drainage spout and emptied urine from the bag into the graduated cylinder. CNA-D then clamped the drainage spout, wiped the spout with an alcohol pad, and put the catheter bag back in the dignity bag. CNA-D emptied the urine into the toilet and rinsed the cylinder. CNA-D then removed gloves and completed hand hygiene. On 2/10/26 at 1:34 PM, Surveyor interviewed CNA-D who, after reading the EBP sign outside R41's door, indicated CNA-D should have worn a gown while emptying R41's catheter. On 2/10/26 at 11:41 AM, Surveyor interviewed Director of Nursing (DON)-B who stated staff should follow precautions signs. 2. On 2/9/26 at 8:20 AM, Surveyor observed RN-E prepare medication for R32. RN-E did not complete (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand hygiene before medication preparation or prior to delivering medication to R32. (See interview under example #3.) 3. On 2/9/26 at 8:27 AM, Surveyor observed RN-E prepare medication for R43. RN-E did not complete hand hygiene before medication preparation or prior to delivering medication to R43. On 2/9/26 at 8:32 AM, Surveyor interviewed RN-E who stated hand hygiene should be performed between residents when preparing and providing medication. RN-E verified RN-E did not complete hand hygiene during the observations. On 2/11/26 at 8:04 AM, Surveyor interviewed DON-B who stated staff should complete hand hygiene between residents during medication administration.