Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013540	A. BUILDING: _____ B. WING _____	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE PATH	503 S WATER SPARTA, WI 54656

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 04/15/2026, Surveyor conducted 2 self report investigations for Bridge Path. Data collection continued through 04/28/2026. Two deficiencies were identified. Census: 37	N 000		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the resident's legal representative within 72 hours when there was an allegation of misappropriation of property. Findings include: On 04/06/2026, a self-report was received from Nurse Care Coordinator (NCC) B indicating on 03/31/2026 they were first made aware of Resident 1 missing 60 tablets of oxycodone from the medication cart along with the narcotic sign-out sheets. The self-report indicated on 04/06/2026 it was discovered Resident 2 was missing 84 tablets of oxycodone and Resident 3 was missing 60 tablets of narcotic medication from the medication cart along with the narcotic sign-out sheets. Law enforcement was contacted, and an internal investigation was conducted.	N 170		

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

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N 170	Continued From page 1 On 04/15/2026 at 09:15 AM, Surveyor interviewed Chief Executive Officer (CEO) A. CEO A confirmed it was discovered they were missing approximately 200 narcotic medications since becoming aware of it on 03/31/2026 for multiple residents. CEO A stated law enforcement was involved, and they were following their investigation guidance. On 04/15/2026 at 10:09 AM, Surveyor interviewed NCC B. NCC B stated s/he was first made aware on 03/31/2026 that Resident 1 was missing his/her oxycodone medication. NCC B stated s/he called law enforcement and started his/her investigation. On 04/06/2026, NCC B discovered Resident 2 and Resident 3 were also missing oxycodone medication. On 04/28/2026 at 12:49 PM, Surveyor interviewed Power of Attorney (POA) D. POA D stated s/he was not aware Resident 2 had medication misappropriated and was not informed by the provider. On 04/28/2026 at 2:00 PM, Surveyor interviewed POA E. POA E stated s/he was not aware Resident 3 had misappropriated medication and was not informed by the provider. On 04/28/2026 at 2:40 PM, Surveyor interviewed POA C. POA C stated s/he was not aware Resident 1 had misappropriated medication and was not informed by the provider. On 04/28/2026 at 3:00 PM, Surveyor interviewed CEO A and NCC B. CEO A stated they had not notified Resident 1's, Resident 2's, and Resident 3's legal representatives about the medication misappropriation due to the police advising them	N 170		

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N 170	Continued From page 2 to minimize the number of people they spoke to about it.	N 170		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure residents were free from misappropriation of property. Resident 1 had 60 oxycodone tablets missing from the facility. Resident 2 had 84 oxycodone tablets missing from the facility. Resident 3 had 60 oxycodone tablets missing from the facility. Resident 4 had one tramadol tablet missing from the facility. Resident 5 had 2 morphine syringes missing from the facility. Findings include	N 348		

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N 348	Continued From page 3 On 04/06/2026, a self-report was received from Nurse Care Coordinator (NCC) B indicating on 03/31/2026 they were first made aware of Resident 1 missing 60 tablets of oxycodone from the medication cart along with the narcotic sign-out sheets. The self-report indicated on 04/01/2026, staff reported a missing tramadol tablet from a medication card. The self-report indicated on 04/06/2026 it was discovered Resident 2 was missing 84 tablets of oxycodone and Resident 3 was missing 60 tablets of narcotic medication from the medication cart along with the narcotic sign-out sheets. Law enforcement was contacted, and an internal investigation was conducted. On 04/15/2026 at 09:15 AM, Surveyor interviewed Chief Executive Officer (CEO) A. CEO A confirmed it was discovered they were missing approximately 200 narcotic tablets and approximately 3 morphine syringes since becoming aware of it on 03/31/2026 for multiple residents. CEO A stated law enforcement was involved, and they were following their investigation guidance. On 04/15/2026 at 10:09 AM, Surveyor interviewed NCC B. NCC B stated s/he was first made aware on 03/31/2026 that Resident 1 was missing his/her oxycodone medication when hospice contacted him/her questioning why Resident 1 needed more oxycodone when it had recently been refilled. NCC B stated s/he called law enforcement and started his/her investigation the same day. NCC B stated staff reported on 04/01/2026, Resident 3 had one tablet of tramadol missing. NCC B stated s/he discovered Resident 3's missing medications on 04/06/2025 when a discontinued order for his/her oxycodone came through and s/he went to remove	N 348		

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medication from the medication cart. On 04/06/2026, NCC B also discovered Resident 2 was also missing their PRN (as needed)oxycodone medication. NCC B stated s/he also discovered Resident 5 was missing 2 morphine syringes. NCC B stated s/he did not know the exact dates when the medications had gone missing and staff would not have known due to the narcotic sign-off sheets also missing. NCC B explained two staff counted narcotics, psychotropic medications, and controlled substances at each change of shift and documented them on paper in a narcotic binder. Staff were to exchange the keys to the medication cart at that time and only the medication passer would have access to the keys. NCC B also explained narcotics and controlled substances were signed off by the medication passer administering them during their shift in the paper narcotic binder.

Surveyor reviewed the five resident's records that had medications missing.

Resident 1 was admitted on 12/03/2025 and had an activated Power of Attorney (POA). Resident 1's April 2026 Medication Administration Record (MAR) indicated s/he had an order for oxycodone 5 mg to be given every 6 hours as needed for acute pain with a start date of 12/02/2025.

Resident 2 was admitted on 11/10/2025 and had an activated POA. Resident 2's April 2026 MAR indicated s/he had an order for oxycodone 5 mg to be given every 6 hours as needed for chronic pain with a start date of 01/28/2026.

Resident 3 was admitted on 07/15/2025 and had an activated POA. Resident 3's April 2026 MAR indicated s/he had an order for oxycodone 5 mg

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N 348	Continued From page 5 to be given every 8 hours as needed for chronic pain with a start date of 02/10/2026. Resident 4 was admitted on 01/13/2022 and was his/her own decision maker. Resident 4's January 2026 MAR indicated s/he had an order for tramadol 100 mg to be given 2 tablets every 6 hours PRN for pain with a start date of 07/12/2023. Resident 5 was admitted on 12/03/2021 and had an activated POA. Resident 5's 2026 Psychotropic Drug Review indicated s/he had an order for concentrated sublingual morphine 0.5 ml/5 mg to be given every 2 hours PRN for pain and restlessness. On 04/28/2026 at 3:00 PM, Surveyor interviewed CEO A and NCC B. NCC B stated none of the residents with missing medications had a delay in receiving medication and they were able to refill all the medications timely. NCC B stated after the police investigation was completed, they would be working to improve their current monitoring and auditing system for narcotics to prevent misappropriation in the future. The provider did not ensure residents were free from misappropriation of property when it was discovered in March and April 2026, five residents were missing approximately 200 doses of narcotic medication. CROSS REFERENCE N0170 DHS 83.12(5)(b) Notification: Abuse And Neglect Allegations	N 348		