STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015013	A. BUILDING: _____ B. WING _____	C 10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING EAGLES RIDGE	224 22ND AVENUE W ASHLAND, WI 54806

(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 09/30/2025, Surveyor conducted 3 complaint investigations and a self-report review along with a standard licensure survey. Data was collected through 10/07/2025. One of 3 complaints were substantiated. Ten deficiencies were identified. Three of 10 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) E6XC11, dated 10/25/2024. Census: 7	N 000		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days after Resident 1's whereabouts were unknown.	N 163		

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

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N 163	Continued From page 1 Findings include: On 09/30/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/24/2024 with diagnoses of Down syndrome, dementia, depression, and anxiety. On 05/16/2025, Registered Nurse (RN) B documented: "Resident eloped from the facility this morning. This writer had the caregiver call the police department and then left to see if [s/he] could be located. [S/he] was found a few blocks away walking down the side walk [sic] and was unharmed. This writer brought [him/her] back to the facility. The police were notified of this. [Managed care organization] was updated and Message [sic] left for resident's [mother/father]." On 10/01/2025, Surveyor reviewed the Department's electronic file containing self-reports from the provider. The provider reported Resident 1 eloped on 01/04/2025 and 04/20/2025. The Department's electronic file did not contain a report of Resident 1's elopement on 05/16/2025. On 10/01/2025, Surveyor emailed Administrator A and asked if Resident 1's elopement from 05/16/2025 was reported to the Department. On 10/02/2025, Administrator A replied, via email, which read, in part: "I did not send this over to the state for review. From what I can see, neither did our nurse. I will remedy this and send this off today." On 10/02/2025, Administrator A emailed Surveyor a self-report on Resident 1's elopement from	N 163		

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N 163	Continued From page 2 05/16/2025.	N 163		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3 received prompt and adequate treatment when s/he sustained a laceration to his/her arm. Findings include: On 06/30/2025, the Department received a self-report for a fall Resident 3 had that resulted in an injury with emergency room treatment. The report read, in part: "Resident reports that [s/he] got out of bed at approx.(approximately) 0558 (5:58 a.m.) on 6/21/2025 to use the bathroom. [S/he] walked into the bathroom and [his/her] feet slipped out from underneath [him/her]. [S/he] fell on [his/her] buttocks and [his/her] left arm causing a skin tear ... Staff noticed [his/her] arm during shift change rounds. [Caregiver G] cleaned [his/her] arm and bandaged it as directed by Nurse on-call... Resident's [guardian] took [him/her] to the ER (emergency room) on Sunday 6/22/2025 to have [his/her] arm assessed due to the extent of the skin tear. It was reported that resident has a small wound that needed to be sutured, but because of the time that passed they were not able ... paperwork from the hospital	N 353		

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N 353	Continued From page 3 states that a referral to wound care was completed and that they will be calling to schedule ... " On 07/14/2025, the Department received a complaint that alleged staff did not provide prompt and adequate treatment to a resident after the resident fell and sustained a laceration to his/her arm. On 09/30/2025 at approximately 11:40 a.m., Surveyor interviewed Resident 3. Resident 3 told Surveyor his/her left arm split open from a fall s/he had. Resident 3 showed Surveyor his/her left forearm, a scar was visible from a previous laceration. On 09/30/2025 at approximately 11:50 a.m., Surveyor interviewed Registered Nurse (RN) B. RN B told Surveyor Caregiver G discovered Resident 3's wound on shift change. RN B said Caregiver G called to report the incident to the on-call, which was Licensee F, who is also a licensed practical nurse. RN B said Caregiver G reported it as a skin tear and Caregiver G cleaned the wound, wrapped the wound and taped it. It was reported Caregiver G used making tape as s/he could not locate medical tape to adhere the bandage. RN B said this occurred on a Saturday and on Sunday, Resident 3's sibling visited, and s/he took Resident 3 to the emergency room. RN B said Resident 3's wound would have required stitches, but since it was longer than 24 hours, the emergency department staff were unable to stitch the wound. Resident 3 went to wound care, and the wound is now closed. On 09/30/2025, Surveyor reviewed Resident 3's record.	N 353		

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N 353	Continued From page 4 Resident 3 was admitted to the facility on 07/23/2024 with a diagnosis of dementia. Resident 3 had an order for protective placement and was appointed a legal guardian. Surveyor reviewed an incident report, signed by RN B, dated 06/25/2025. The report read, in part: "Type of incident Alleged Fall Location of Incident OWN APARTMENT: Bathroom What did the resident tell you about what happened? Resident reported to this writer on 6/23, that [s/he] got out of bed to go to the bathroom and didn't know if there was some water on the floor of the bathroom, but [his/her] feet slipped out from under [him/her] and [s/he] fell. [S/he] states [s/he] landed on [his/her] left buttocks and left elbow which resulted in a large skin tear. [S/he] then got up, wiped up the urine from the floor, [s/he] had an accident when [s/he] fell, and then went back to bed. Describe what you saw and heard (just the facts): This writer was not in the facility at the time of the incident. Were there witnesses? No Were there apparent injuries? Yes: Skin Tear: Resident received a large sking [sic] tear and an open area on left arm, Puncture wound ... Did the resident receive medical care? Yes: Resident's [sibling] took resident to the ER on Sunday, 6/22/25, to have [his/her] arm assessed." On 10/06/2025, Surveyor reviewed documentation from the emergency department.	N 353		

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N 353	Continued From page 5 The emergency department provider note, dated 06/22/2025, read, in part: "History of Present Illness (HPI): HPI [Resident 3] is an [age] [fe/male] that presents to urgent care accompanied by [his/her] [sibling] for a wound check. [S/he] resides at an assisted living and reports that [s/he] got up to use the bathroom Saturday morning at approximately 0500 (5:00 a.m.) and they have a shared bathroom, [s/he] states [s/he] fell over the threshold of the door onto the floor which resulted in a skin tear/laceration to [his/her] left forearm. Denies hitting [his/her] head or LOC (loss of consciousness). [S/he] states the assisted living does not have a first-aid kit so the staff that was working at the time applied napkins and secured the napkins with masking tape. [Sibling] states that at approximately 2PM later that day a nurse seen [him/her] and removed the napkin which tore the skin more and at that time [s/he] cleaned the wound and applied a dressing. The same nurse changed the dressing again today and recommended that [s/he] come in to be evaluated ... Physical Exam: ... Large skin tear to left arm (extends to elbow) measuring 12 cm (centimeters), there is a laceration in the middle of the skin tear measuring 5 cm, skin surrounding wound is pink with mild swelling and some warmth noted ... Emergency Department Course: Patient evaluated for a wound check. Found to have a large skin tear/laceration to [his/her] left forearm. Wound is approximately 36 hours old, unable to suture as it is beyond the timeframe. Cleansed area, applied Steri-strips covered with nonadherent dressing and secured with kerlix. Prescription for kerlix provided. Referral to wound care sent for further evaluation and treatment ..."	N 353		

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N 353	Continued From page 6 Resident 3 was ordered an antibiotic, cephalexin 500 milligrams, 3 times a day for 5 days. On 06/26/2025, Resident 3 had a wound care appointment with debridement of the wound, which is the removal of dead, damaged tissue. The note read, in part: "Sharp selective debridement with canal knife to the level of subcutaneous to remove a moderate amount of devitalized tissue. Pick ups and iris scissors to remove unattached flap ... Expect to see patient once weekly for sharp debridement and skilled wound care ..." On 10/06/2025 at approximately 3:30 p.m., Surveyor interviewed Administrator A on the phone. Surveyor explained concerns that Resident 3 was not sent for a medical assessment for his/her injuries s/he sustained after his/her fall. Resident 3's wound could not be sutured, s/he had to go to weekly wound care with skin debridement due to not being assessed timely. Administrator A told Surveyor Licensee F would not be on the on-call rotation anymore. Administrator A told Surveyor that staff have been re-educated. Administrator A said s/he told staff, "When in doubt, send them out." Resident 3 did not receive prompt and adequate treatment for a skin tear and laceration to his/her arm. The wound was bandaged with non-medical supplies. S/he did not receive a medical assessment until over 24 hours after staff observed the wound. Resident 3 was unable to have the wound sutured, s/he was prescribed an antibiotic and underwent weekly wound care with sharp debridement until the wound was healed.	N 353		

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N 356	Continued From page 7	N 356		
N 356	83.32(3)(l) Rights of Residents: Least restrictive env In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Least restrictive environment. Have the least restrictive conditions necessary to achieve the purposes of the resident ' s admission. The CBRF may not impose a curfew, rule or other restriction on a resident ' s freedom of choice. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3's right to the least restrictive environment was honored. Staff members observed Resident 3 consume his/her allowed 2 ounces of an alcoholic beverage at bedtime. Findings include: On 09/30/2025 at approximately 11:40 a.m., Surveyor interviewed Resident 3 in his/her room. Resident 3 told Surveyor s/he was allowed to have 2 ounces of scotch at bedtime. S/he said some of the staff will stay in his/her room and watch him/her consume his/her 2 ounces of scotch. Resident 3 said s/he would like to put on his/her pajamas, sit and watch television, and sip on his/her scotch, but s/he has to drink it in front of staff. On 09/30/2025 at approximately 11:50 a.m., Surveyor interviewed Registered Nurse (RN) B. Surveyor asked about staff watching Resident 3 consume his/her alcoholic beverage in the	N 356		

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N 356	Continued From page 8	N 356		

evening. RN B told Surveyor this has been an ongoing complaint from Resident 3. RN B said Resident 3 was only allowed 2 ounces and s/he would report it would spill and have staff get him/her more, so staff watch him/her consume the alcohol.

On 09/30/2025 and 10/06/2025, Surveyor reviewed Resident 3's record.

Resident 3 was admitted to the facility on 07/23/2024 with a diagnosis of dementia. Resident 3 was under protective placement and had a legal guardian.

Resident 3's behavioral evaluation, dated 09/15/2025, signed by RN B, read, in part: "Resident does get frustrated when [s/he] wants to go places like 'downtown' by [him/herself] and is not allowed to do so. [S/he] does somewhat understand when told why [s/he] can not [sic] go by [him/herself]. Resident also drinks a shot of whiskey every night and has in the past stated that [s/he] spilled [his/her] shot in an attempt to get more. Staff are to not give more unless witnessing it being spilled."

Resident 3's August 2025 medication administration record included the following: "Alcoholic Beverage Resident is to have 2 ounces only of Whiskey [sic] at bedtime. Measure out in the plastic med (medication) cup. 30 ML (milliliters) = 1 ounce. May have no more beer can or bottle on occasion."

Resident 3's individual service plan (ISP), with a report date of 09/30/2025, indicated Resident 3 was capable of self supervision, independent in self-care, and could make his/her own decisions. The ISP read, in part: "[Resident 3] is legally blind

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N 356	Continued From page 9	N 356		

in [his/her] right eye and only has 20% vision in [his/her] left eye. [S/he] will need help navigating and locating objects [s/he] may desire/need. Staff will stand by to assist while allowing [him/her] to navigate safely through the building ... [Resident 3] displays good self concepts, [s/he] is aware of past, present, and future. [S/he] is able to communicate [his/her] needs wants and desires." The ISP did not include any restrictions related to his/her alcohol consumption or history of intoxication/behaviors while consuming alcohol. Resident 3's limited vision may have contributed to Resident 3 spilling drinks.

Resident 3's care plan, with a print date of 10/02/2025, read, in part: "[Resident 3] has not had any behavioral issues. 01/06/2025 [Resident 3] has been increasingly demanding about getting more that the 2 oz (ounces) of Whiskey that was prescribed by the doctor. Caregivers were instructed to only give 2 oz. 06/16/25 Since [Resident 3's] alcohol doses have been documented in the narcotic book and marked on the bottle when given, [s/he] has not been attempting to get more than [s/he] is prescribed to receive."

On 10/07/2025 at approximately 4:00 p.m., Surveyor interviewed Administrator A on the phone. Surveyor asked about staff observing Resident 3 consume his/her 2 ounces of alcohol in the evening. Administrator A said Resident 3 would tell staff s/he did not get the whiskey and request more. Staff document the whiskey like a narcotic medication, ensure s/he drinks it, like other medications. Surveyor explained Resident 3's concerns that were brought up to Surveyor and Resident 3's right to relax and sip on his/her alcoholic beverage. Administrator A said s/he would talk to Resident 3, his/her legal

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N 356	Continued From page 10 representative, and managed care organization team to come up with a plan everyone agrees with. Resident 3's right to the least restrictive environment was not honored when staff observed him/her drinking his/her 2 ounce alcoholic beverage at night.	N 356		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident, and their legal representatives were involved in developing their individual service plans (ISP), when their ISPs were not signed by the resident or their legal representative, acknowledging their involvement	N 387		

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N 387	Continued From page 11 in, understanding of, and agreement with the plan for 2 of 2 residents reviewed (Resident 1 and Resident 3). Findings include: On 09/30/2025, Surveyor reviewed Resident 1 and Resident 3's records. Resident 1 was admitted to the facility on 09/24/2024 with diagnoses of Down syndrome and dementia. Resident 1 had an activated health care power of attorney (HCPOA). Resident 1's ISP, with a report date of 09/30/2025, did not contain any signatures. Resident 3 was admitted to the facility on 07/23/2024 with a diagnosis of dementia. Resident 1 was under protective placement and had a legal guardian. Resident 3's ISP, with a report date of 09/30/2025, did not contain any signatures. On 10/01/2025, Surveyor emailed Administrator A and requested ISPs for Resident 1 and Resident 3 with signatures. On 10/02/2025, Administrator A responded, via email, which read, in part: "We sign [managed care organization's] ISP. With our new program we are getting these signed as we meet with family/guar (guardian)/HCPOAs." Administrator A did attach an ISP for Resident 3 that was signed by Resident 3 and Administrator A on 10/01/2025.	N 387		

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N 404	Continued From page 12	N 404		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for a pharmacist or a physician to review each resident's medication regimen within 30 days before or 30 days after the resident's admission and at least every 12 months for 2 of 2 resident's reviewed (Resident 1 and Resident 3). This is a repeat deficiency. See Statement of Deficiency (SOD) E6XC11, dated 10/25/2021. Findings include:	N 404		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING EAGLES RIDGE	224 22ND AVENUE W ASHLAND, WI 54806

(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 404	Continued From page 13 On 09/30/2025, Surveyor reviewed Resident 1 and Resident 3's record. Resident 1 was admitted to the facility on 09/24/2024 with multiple diagnoses including: Down syndrome, dementia, depression, and anxiety. Resident 1's primary care provider (PCP) was identified as Nurse Practitioner (NP) D. Resident 1's medication administration record (MAR) for August 2025 indicated Resident 1 was prescribed multiple scheduled medications including: acetaminophen, cetirizine, donepezil, famotidine, olanzapine, omeprazole, quetiapine, sertraline, and a multivitamin. S/he also had as needed (PRN) orders for an albuterol inhaler and ipratropium inhaler. Resident 3 was admitted to the facility on 07/23/2024 with a diagnosis of dementia. Resident 3's PCP was identified as NP E. Resident 3's MAR for August 2025 indicated Resident 3 was prescribed the following scheduled medications: acetaminophen, amlodipine, Breo Ellipta inhaler, clonidine, cyanocobalamin injection, Flonase, guaifenesin, ketoconazole cream, lisinopril, loratadine, melatonin, omeprazole, paroxetine, psyllium fiber, Spiriva inhaler and Vitamin D2. S/he also had the following PRN orders: acetaminophen, albuterol inhaler, benzonatate, capsaicin cream, diclofenac gel, magnesium oxide, meclizine, senna, and a sore throat spray. On 10/01/2025, Surveyor emailed Administrator A	N 404		

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N 404	Continued From page 14 and requested the most recent medication regimen reviews for Resident 1 and Resident 3. On 10/07/2025, Administrator A emailed Surveyor which read, in part: "I have asked pharmacy to send over medication reviews for [Resident 1] and [Resident 3]. They are working on that." On 10/07/2025, the provider emailed Surveyor medication regimen reviews signed and dated 10/07/2025 by the pharmacist. The reviews for Resident 1 and Resident 3 included recommendations.	N 404		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide supervision appropriate to meet Resident 1's needs. Resident 1 eloped from the facility 5 times in the last year. Findings include:	N 426		

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N 426	Continued From page 15 On 09/30/2025 at approximately 11:00 a.m., Surveyor interviewed Caregiver D. Caregiver D told Surveyor there was 1 staff per shift scheduled for the facility. On 09/30/2025 at approximately 11:15 a.m., Surveyor interviewed Administrator A and Care Staff manager (CSM) M. Surveyor explained the purpose of the survey, which included reviewing self-reports related to Resident 1's elopements. Administrator A told Surveyor Resident 1 had been doing good until recently. S/he said the change of seasons seems to affect Resident 1. Administrator A confirmed there was 1 staff per shift and they also use the activity staff, nurse and care staff managers to assist with Resident 1. From 09/30/2025 - 10/06/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 09/24/2024 with diagnoses of Down syndrome, dementia, depression, and anxiety. Resident 1's individual service plan (ISP), with a report date of 09/30/2025, indicated s/he required 24-hour supervision. The ISP, read, in part: "Elopement Resident is at a moderate risk for elopement has eloped in the past 3 months. Requiring 30 min (minute) checks. Toilet Resident every 2 hours... General Health Resident is a high elopement risk and wears a GPS (global positioning system) tracker on [his/her] ankle that is linked to the Ashland Police Department. Staff will need to check the battery once a month, The instructions for the tracker are in [his/her] chart. Battery was last changed on 6/20/25 when changed next update care plan with new date of when it was changed..."	N 426		

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N 426	Continued From page 16 A care plan, with a print date of 10/02/2025, read, in part: Start date 12/09/24, "Vulnerability, Safety and Risk [Resident 1] has a GPS tracking device on [his/her] ankle that is linked to the Ashland Police department. Battery is to be checked once a month, instructions for the tracker is in [Resident 1's] chart. [Resident 1] is high risk for elopement. [His/her] last elopement was 9/27/24 in which [s/he] left the building and was found walking down the street. [Resident 1] is on every 15 minute safety checks. [Resident 1] has not had any episodes of elopement since. [S/he] does like to go outside and walk close to the building." Start date 6/20/25 "15 minute safety checks [Resident 1] had eloped on 12/10/2024. [S/he] was brought back to the facility by the Ashland police department with no injury noted. 1/4/24 [sic] [Resident 1] eloped and walked to Quik [sic] Trip. [S/he] was returned by APD (Ashland Police Department) - no injury. Care plan and orders updated. When a door alarm goes off staff will go do a visual on [Resident 1's] where abouts [sic]." Start date 6/20/25 "Mental Status: Behaviors: Elopement Risk [Resident 1's] location bracelet will remain in good working order and will be checked monthly by staff to ensure battery is adequately charged. 6/20/25 [Resident 1's] bracelet is to be checked monthly by APD." Surveyor reviewed the following incident reports and self-reports to the Department: On 12/10/2024, Resident 1 eloped. The report read, in part: "[Resident 1] left the facility on [his/her] own while staff was providing care to another resident. Resident was noted missing from the facility at approximately 1630 (4:30	N 426		

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p.m.). Staff searched grounds and home, then contacted the administrator. Administrator assisted in the search while contacting Ashland Sheriff's Department. That call was made at 17:04 (5:04 p.m.). Resident was returned to the facility by Ashland FD (fire or [sic] department) at approximately 1740 (5:40 p.m.), Uninjured [sic] and unharmed. [Resident 1's] guardian was notified of staff unable to locate [him/her], and when [s/he] was returned to the house. Staff completed vitals, provided cares to ensure there was no injuries. Resident was placed on 15 - minute checks. [Managed care organization (MCO)] and RN (registered nurse) were notified via email of resident eloping... [Resident 1] was placed on 15-minute checks. Facility is working with [MCO] to obtain a wanderguard provided by the Sheriff's department. Staff has [sic] been educated on the importance of monitoring and ensuring the residents needs are met."

On 01/04/2025, Resident 1 eloped. The report read, in part: "[Resident 1] eloped from Eagles Ridge on January 4, 2025, at approximately 11:30AM... the resident was not harmed and showed no injury... Caregiver was instructed to call the dispatch number in [Resident 1's] file as [s/he] does have a location device that [s/he] now wears. Caregiver left message for guardian, contacted administrator and [RN K]."

On 04/20/2025, Resident 1 eloped. The report read, in part: "At approximately 1700 (5:00 p.m.), [Resident 1] left the Eagles Building [sic] while staff was assisting another resident. [Resident 1] had gone out with family for the day, and when [s/he] returned, family identified that [s/he] was tired and needed to rest. The caregiver assisted [Resident 1] to [his/her] room. The caregiver did [his/her] safety checks and went to assist another

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resident with cares. It was at this time [Resident 1] left the building. [Resident 1] is very alert to staff routines, and watches staff going into rooms and them shutting doors. This is generally the time [s/he] chooses [sic] exit the building. The sheriff's department was contacted. An attempt to contact [Resident 1's] [legal representative] x3 with no response. The Sheriff made contact with [Resident 1] at approximately 1817 (6:17 p.m.) and [s/he] was returned to the facility. [Resident 1] was located at [name] Public library walking... [Resident 1] returned to the facility via Sheriff's department. [Resident 1] has no noted injuries, and was wearing a long sleeved jacket and pants. Resident is unable to identify why [s/he] left, or where [s/he] was going...Action that will be taken are as follows: Continue to ensure that [Resident 1's] needs are being met, such as toileting, liquids, clean clothing. Offer tasks that interest [him/her] and invite [him/her] to stay with staff or sit and wait close to door where cares are being provided. continue with frequent safety checks and ensuring all door bells are working properly. The Activity Coordinator will also assist in taking [Resident 1] for walks and spending 1:1 when [s/he] is available to do so. A request for family/friends to visit more frequently if able."

On 05/16/2025, Resident 1 eloped. The report read, in part: "Caregiver reported to RN that [s/he] could not locate [Resident 1] in the facility. [Caregiver G] was instructed to call police, and report resident missing. Administrator was also contacted. Writer was traveling in vehicle to facility to help locate [Resident 1] when [s/he] saw [Resident 1] walking down the sidewalk. Writer picked [Resident 1] up and returned [him/her] to the facility and ensure [his/her] needs were met. [S/he] was provided a beveraged [sic] and toileting was offered. [Resident 1] did not appear

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to have any injuries... Door alarm placed on alternate door in building. Offering [Resident 1] bathroom, something to eat or drink, and ensuring all other needs are met. Staff are to have eyes on [Resident 1] at all times. Staff is to monitor [Resident 1] closely for behaviors and put interventions in place before elopement increases. Guardian [MCO], and administrator notified."

On 09/27/2025, Resident 1 eloped. The report read, in part: "[Resident 1] eloped out the front door around 1330 pm (1:30 p.m.) while caregiver was doing charting; caregiver noticed around 1400 (2:00 p.m.), called Searchlight program, resident was found by [Caregiver C] who called dispatch, and was returned by Ashland Police Department... Staff to continue with 15 minute checks on [Resident 1]. Staff to offer interventions: 1:1, toileting, activity programming, walking outdoors with staff..."

On 10/06/2025 at approximately 3:45 p.m., Surveyor interviewed Administrator A on the phone. Surveyor asked how often staff were to be completing safety checks on Resident as the ISP and care plan were not clear what interventions were in place. Administrator A said Resident 1 was on 15 minute safety checks. Surveyor requested documentation of Resident 1's safety checks on 09/27/2025.

On 10/07/2025, Administrator A emailed Surveyor documentation that staff were completing 30 minute safety checks on Resident 1 on 09/27/2025. The email read, in part: "In reviewing [Resident 1], [s/he] should have been on 15-minute checks according to [his/her] previous orders in our [electronic records] system since September 2024. (I will ask management team to

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N 426	Continued From page 20 update new system to match) We will fix this in our new charting system. We installed doorbells on all doors at Eagles (there was one that did not exist on the patio door and placed one). Also, staff are to call team leads, myself, or use [RN B] in that building to help monitor [Resident 1] if they need support. One big intervention we did have was having the tracking bracelet placed by the Sheriff's Department. Although this doesn't prevent [him/her] from eloping, it helps locate [him/her] quickly. we are now seeing a pattern of excessive elopement during seasons changing. We requested a refill on [his/her] hydroxyzine for the days [s/he] is anxious. [His/her] primary will not refill and doesn't feel it is necessary. So, we will continue with enforcing interventions." The provider did not provide appropriate supervision to prevent Resident 1 from eloping. Resident 1 eloped form the facility 5 times in the last year.	N 426		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an	N 431		

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advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not provide health monitoring of Resident 3 related to changes in his/her skin. The provider did not record changes in Resident 3's skin in his/her record.

Findings include:

On 06/30/2025, the provider submitted a self-report to the Department which read, in part: "Resident reports that [s/he] got out of bed at approx. (approximately) 0558 (5:58 a.m.) on 6/21/2025 to use the bathroom. [S/he] walked into the bathroom and [his/her] feet slipped out from underneath [him/her]. [S/he] fell on [his/her] buttocks and [his/her] left arm causing a skin tear ... Staff noticed [his/her] arm during shift change rounds. [Caregiver G] cleaned [his/her] arm and bandaged it as directed by Nurse on-call... Resident's [guardian] took [him/her] to the ER (emergency room) on Sunday 6/22/2025 to have [his/her] arm assessed due to the extent of the skin tear. It was reported that resident has a small wound that needed to be sutured, but because of the time that passed they were not

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able ... paperwork from the hospital states that a referral to wound care was completed and that they will be calling to schedule ... "

On 09/30/2025 at approximately 11:40 a.m., Surveyor interviewed Resident 3. Resident 3 told Surveyor his/her left arm split open from a fall s/he had. Resident 3 showed Surveyor his/her left forearm, a scar was visible from a previous laceration. Resident 3 also showed Surveyor his/her right arm that had bruise proximal to his/her shoulder. S/he also said the right side of his/her head hurt. Resident 3 told Surveyor s/he could not remember what happened.

On 09/30/2025 at approximately 11:50 a.m., Surveyor interviewed Registered Nurse (RN) B. RN B told Surveyor s/he was not on-call when Resident 3 fell and sustained a laceration to his/her arm on 06/21/2025. S/he said that wound was healed now. Surveyor asked about the bruise to Resident 3's right arm. RN B told Surveyor s/he was unaware Resident 3 had a bruise on his/her right arm.

From 09/30/2025 - 10/06/2025, Surveyor reviewed Resident 3's record.

An incident report, completed by RN B, dated 06/25/2025, indicated Resident 3 fell on 06/21/2025 and sustained a "large skin tear" to his/her left arm. The injury was described as: "Resident received a large sking [sic] tear and an open area on left arm, Puncture wound." The report indicated Resident 3's guardian took Resident 3 to the emergency room on Sunday (06/22/2025) to have his/her arm assessed.

A progress note dated 06/25/2025 by RN B read, "Late Entry for 6/23/2025 08:00: Resident got out

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N 431	Continued From page 23 of bed at approx. (approximately) 0558 (5:58 a.m.) on 6/21 to use the bathroom. [S/he] walked into the bathroom and [his/her] feet slipped out from underneath [him/her] and [s/he] fell on [his/her] left buttocks and [his/her] left arm causing a skin tear ... Staff noticed [his/her] arm during shift change. Care staff [Caregiver G] cleaned [his/her] arm and bandaged it. Resident 's [sibling] took [him/her] to the ER (emergency room) on Sunday 6/22 to have [his/her] arm assessed due to the extent of the skin tear. It was reported that resident has a small wound that needed to be sutured but because of the time that passed they were not able. This writer changed resident's dressing and assessed for any infection on Monday 6/23. After care paperwork from the hospital states that a referral to wound care was completed and that they will be calling to schedule. This writer will assess the wound again today ..." This was the only documentation from the provider in Resident 3's record related to the wound Resident 3 sustained to his/her left arm. There was no description of the wound other than large skin tear and puncture wound. Staff would not be able to notice if there was a change in condition to the wound (bigger, smaller, drainage, redness) without having some documentation to review. There was no documentation to indicate if the wound was healed. The emergency department documentation, dated 06/22/2025, read, in part: "Physical Exam: ... Large skin tear to left arm (extends to elbow) measuring 12 cm (centimeters), there is a laceration in the middle of the skin tear measuring 5 cm, skin surrounding wound is pink with mild swelling and some warmth noted."	N 431		

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N 431	Continued From page 24 Wound care notes from the hospital indicate Resident 3 had weekly wound care appointments with sharp debridement of the wound. On 10/06/2025, Surveyor emailed Administrator A, which read, in part: "Do you have any documentation from staff related to [Resident 3's] wound? ... Who changed the dressing on Sunday (06/22/2025) prior to her going to the ER. Is there any documentation of this? Did [Licensee F] or [Caregiver G] document the wound in [Resident 3's] record? ... Has there been any assessments/documentation of the bruise [Resident 3] showed me while I was onsite?" On 10/06/2025, Administrator A replied to Surveyor, via email, which read, in part: "[Caregiver L], 2nd Shift Staff changed dressing again before ER visit ... [Licensee F] did not document (this was a Saturday when [s/he] was called) [RN B] did document When [sic] [s/he] arrived. [Caregiver G] would have completed the IR (incident report)/notes, which then become part of the IR that [RN B] completes. We were using paper docs (documentation) for caregivers ..." Administrator A attached a note from RN B related to Resident 3's bruise. The note, dated 10/06/2025, read: "Writer had spoke with resident regarding a bruise [s/he] found on [his/her] right upper arm. [S/he] states that [s/he] has no idea where the bruise came from and that is [sic] never really hurt so [s/he] isn't sure when it happened either. The bruise is light yellow and is the shape of a half of a circle a little larger than a golf ball. [S/he] also states that [s/he] had a small bump on the right side of [his/her] head also that is just about gone and only had slight discomfort from it. This writer assessed resident's head and	N 431		

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	0015013	A. BUILDING: _____ B. WING _____	C 10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING EAGLES RIDGE	224 22ND AVENUE W ASHLAND, WI 54806

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N 431	Continued From page 25 felt a very slight bump barely palpable. [S/he] doesn't know if both happened at the same time or not. Writer reminded resident that if [s/he] notices any injury on [him/herself] to make sure [s/he] reports it to nursing or care staff. Resident states [s/he] understands the importance of notifying staff." On 09/30/2025, Surveyor notified RN B of Resident 3's bruise to his/her right arm. RN B did not assess or document on this change in Resident 3's skin until approximately 1 week later on 10/06/2025, after Surveyor requested documentation. The provider did not provide health monitoring related to changes in Resident 3's skin and document changes in Resident 3's record.	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure staff provided medication administration to meet the needs of each	N 432		

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N 432	Continued From page 26 resident. Resident 2's Lantus insulin pen that was open and in use was not stored according to the Food and Drug Administration (FDA) label. Findings include: The FDA label indicates proper storage for Lantus, which read, in part: "After first use o Keep your pen at room temperature below 86°F (30°C). o Keep your pen away from heat or light. o Store your pen with the pen cap on. o Do not put your pen back in the refrigerator. o Do not store your pen with the needle attached. o Keep out of the reach of children. o Only use your pen for up to 28 days after its first use. Throw away the LANTUS SoloStar pen you are using after 28 days, even if it still has insulin left in it." (Retrieved 10/07/2025 from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/021081s078s079lbl.pdf). On 09/30/2025 at approximately 12:45 p.m., Surveyor observed the medication storage system with Caregiver C. Resident 2's Lantus insulin pens were stored in the medication refrigerator. Caregiver C showed Surveyor the Lantus insulin pen that was in use, which was stored in the refrigerator. There was a sticker on the pen to write the open date on the pen. The date was not on the pen. Surveyor asked Caregiver C if they date the pens when they open them. Caregiver C said they did not. On 10/01/2025, Surveyor emailed Administrator A and explained my observation and interview with Caregiver C.	N 432		

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N 432	Continued From page 27 On 10/02/2025, Administrator A emailed Surveyor, which read, in part: "All meds (medications), including injectables, need to be dated upon opening. I am revising our Medication administration policy to identify insulin specifically. This also will be a re-education of our Staff [sic] that has started 10/02/2025."	N 432		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were completed at least quarterly in 2024. This is a repeat deficiency. See Statement of Deficiency (SOD) E6XC11, dated 10/25/2021.	N 525		

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N 525	Continued From page 28 Findings include: This provider is licensed to care for up to 8 residents in the client groups of: advanced age, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, traumatic brain injury, developmentally disabled, and physically disabled. On 09/30/2025, Surveyor reviewed the provider's safety reports. The provider conducted 3 fire drills in 2024 on the following dates: 01/25/2024, 04/18/2024, and 12/19/2024. On 10/01/2025, Surveyor emailed Administrator A and asked if there were any other fire drills completed in 2024 and if any of the fire drills were simulated conditions for sleeping hours. On 10/02/2025, Administrator A replied via email, which indicated the 12/19/2024 fire drill that was completed at 7:30 p.m., was the simulated sleep fire drill. S/he did not indicate there were any other fire drills for 2024.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct tornado, flooding, or other emergency or disaster evacuation drills at least semi-annually in 2024.	N 526		

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N 526	Continued From page 29 This is a repeat deficiency. See Statement of Deficiency (SOD) E6XC11, dated 10/25/2021. Findings include: This provider is licensed to care for up to 8 residents in the client groups of: advanced age, emotionally disturbed/mental illness, irreversible dementia/Alzheimer's disease, traumatic brain injury, developmentally disabled, and physically disabled. On 09/30/2025, Surveyor reviewed the provider's safety reports. The provider conducted a severe weather drill on 05/21/2024 and 04/22/2025. On 10/01/2025, Surveyor emailed Administrator A and asked if there were any other emergency evacuation drill conducted in 2024. On 10/02/2025, Administrator A replied via email. S/he did not indicate a response to the question related to the other emergency evacuation drills. On 10/06/2025 at approximately 3:45 p.m., Surveyor interviewed Administrator A on the phone. Administrator A told Surveyor they have completed one emergency evacuation drill in 2025 and will be completing another.	N 526		