STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019249	A. BUILDING: _____ B. WING _____	C 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE SENIOR LIVING	**3172 OLD TOWN ROAD EAU CLAIRE, WI 54701**

(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 12/18/2025, Surveyor conducted 3 complaint investigations at Cambridge Senior Living. Data collection continued through 12/23/2025. Two of 3 complaints were substantiated. Three deficiencies were identified. Census: 59	N 000		
N 169	83.12(5)(a) Notification: incident, injury, changes. The CBRF shall immediately notify the resident's legal representative and the resident's physician when there is an incident or injury to the resident or a significant change in the resident's physical or mental condition. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2's legal representative was notified when Resident 2 experienced changes in condition. Findings include: On 11/24/2025, the Department received a complaint regarding the provider's lack of communication when residents experienced a change in condition. On 12/18/2025, Surveyor reviewed Resident 2's	N 169		

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

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N 169	Continued From page 1	N 169		

record.

Resident 2 was admitted on 07/30/2024 and had a guardian.

Staff progress from October 2025 through November 2025 included the following:

-On 10/17/2025, Resident 2 was prescribed Deep Sea .065% Nose Spray to be instilled 4 times daily as needed for dry nasal passages and Nasal Decongestant .05% SP to be instilled once daily as needed for bloody nose.
-On 11/04/2025, "Resident was taken to ER (Emergency Room) by [his/her] [Family Member] due to reoccurring nose bleeds."
-On 11/04/2025, "[Resident 2] was brought to the emergency room by family due to a bloody nose that wouldn't stop. We will notify you when [s/he] returns and if there are any changes in [his/her] meds (medications) or care."
-On 11/07/2025, a care team review took place with Administrator A, Nurse B, and Guardian C. Under a heading titled, "Changes/concerns addressed and discussed," section, it read, "Resident needs more frequent checks. Staff to wash bedding weekly. Concerns of medical issues with nose bleeds missed by staff and how to prevent future occurrences."

Resident 2's October 2025 Medication Administration Record (MAR) and November 2025 MAR reflected the 2 nasal sprays that were prescribed on 10/17/2025. The medications had not been signed as administered in October or November.

An "After Visit Summary" from Resident 2's medical provider, dated 11/04/2025, indicated Resident 2 was seen for a nosebleed. Under a

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N 169	Continued From page 2 "Lab Tests in Progress" section, it read, "Transfuse Red Blood Cells." A document titled, "Provider Concern Details" included the following: Under a "Domain of Concern" section, it read, "Dissatisfaction, Health/Safety, Failure to Notify." Under a "Concern Narrative" it read, "Guardian was never notified from facility of member going to the hospital and being admitted. [S/he] just started getting emails asking to be signed in for member in the ER." Under a "What new or different arrangement has been agreed upon" section, it read, "Facility leadership educated staff on the importance of ensuring Member returns from the ER/hospital to a clean room. Facility also updated Member's care plan to include more frequent checks from staff." Under a "Summary of Findings" it read, in part, "Substantiated failure to notify concern. Member was seen in the ER for a substantial nosebleed. Member's care team was not notified of the ER visit within the contractual day of notification... Tests indicated that member was anemic. Member had a transfusion and the impacted area in the member's nose was cauterized to stop the bleeding..." On 12/18/2025, at approximately 10:30 AM, Surveyor interviewed Administrator A. When asked about the provider's notification process related to resident changes in condition, Administrator A stated when a resident was sent to the ER, the provider tried to contact the resident's legal representative as soon as possible. Administrator A stated if they did not speak with the legal representative directly, they would leave a voicemail. When asked if Resident 2's guardian was immediately contacted with	N 169		

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N 169	Continued From page 3 his/her change in condition as it related to his/her nosebleeds and ER visit, Administrator A stated Resident 2's [Family Member] took Resident 2 to the ER and did not notify Resident 2's guardian. The provider was under the assumption Resident 2's family member was going to be notifying Resident 2's guardian. Administrator A stated Guardian C was made aware of Resident 2's ER visit after receiving a message in Resident 2's medical provider's portal. On 12/19/2025, at 12:10 PM, Surveyor received an email from Administrator A that included the following: "On the 4th when [his/her] [Family Member] took [him/her] out to see the doctor, [s/he] did not notify staff that [s/he] was leaving with [him/her.] We were able to determine this through the sign out book at the front, where we discovered [s/he] signed [him/her] out. This was following the phone call we received from [his/her] guardian, [Guardian C] that [s/he] was notified that [s/he] was checked into Mayo Emergency Department on [his/her] Mayo portal."	N 169		
N 328	83.31(4)(c) Involuntary discharge notice requirements. Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the	N 328		

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N 328	Continued From page 4 CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide an involuntary discharge notice to Resident 1 that included the following requirements: the reason and justification for discharge, a statement indicating the resident may ask for Department review, the contact information for the regional office's director, or the contact information for the regional office ombudsman program. Resident 1 was sent to the emergency room (ER) to be assessed for stroke-like symptoms and was not accepted back to the facility. Findings include: The provider is licensed to care for 72 residents in the client groups physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 09/22/2025, the Department received a complaint regarding involuntary discharges. On 12/18/2025, at approximately 10:30 AM,	N 328		

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N 328	Continued From page 5 Surveyor interviewed Administrator A regarding the provider's discharge practices. Administrator A stated they provided a written 30-day discharge notice to residents, but they gave leniency with the written notice if they felt they could no longer meet the needs of a resident. Administrator A stated if the resident was no longer fit for the community, they would not make the resident fulfil a 30-day notice. At approximately 11:00 AM, Surveyor requested to review Resident 1's record, including the discharge notice issued by the provider. Resident 1 had an admission date of 01/04/2025, and a discharge date of 08/30/82025. Resident 1's pre-admission health assessment, dated 12/27/2024, indicated s/he had falls within the last 6 months and had multiple neurological conditions including seizures, dizziness, and paralysis. At approximately 2:00 PM, Surveyor interviewed Administrator A. When asked if Resident 1 received a written 30-day involuntary discharge notice, Administrator A stated Resident 1 did not. Administrator A stated Resident 1 was sent to the ER to be evaluated for stroke-like symptoms. Resident 1 did not return to the facility after being sent to the ER. When asked why Resident 1 was not allowed to return to the facility, Administrator A stated the hospital social worker believed Resident 1 needed a higher level of care than what the facility could provide. The provider did not feel Resident 1 would be safe to return to the facility. When asked about what changed with Resident 1's condition, Administrator A stated there were a number of concerns related to Resident 1's history of falls. Administrator A stated they met with Resident 1's managed care	N 328		

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N 328	Continued From page 6 organization (MCO) regarding Resident 1's falls, and they had struggled to come up with interventions to prevent Resident 1's falls.	N 328		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on record review, and interview, the provider did not provide an environment that was safe, clean, comfortable, and homelike. Findings include: On 11/24/2025, the department received a concern alleging resident rooms were not being maintained. On 12/08/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 07/30/2024 and had a guardian. Staff progress from November 2025 included the following: -On 11/13/2025, a note read, in part, " ...I think the incident you were told about is [his/her] original return from [his/her] ER (Emergency Room) visit on the night of the4th [sic]. [Guardian	N 481		

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N 481	Continued From page 7 C] did come that morning and note that [his/her] sheets and pillow cases still had smears of blood and [his/her] trash can was not emptied of the bloody tissues. We discussed how [Resident 2] had refused to let staff wash [his/her] sheets but I did tell [him/her] that staff should have cleaned them while [s/he] was out as well as empty [his/her] trash can. I told [him/her] that we would provide education to staff to ensure rooms are being cleaned and set up nicely for the return of residents ..." -On 11/13/2025, a note read, in part, "Email form [sic] MCO (Managed Care Organization.) Hello [Nurse B], [Resident 2's] family has some questions, so I'm just reaching out to see what you and staff know. Sounds like [s/he] had the nosebleed on the 4th, and there is quite a bit of blood in [his/her] room per [his/her] family. Do you know how long staff were aware of any nosebleeds? Also, the room has blood in it today when [s/he] went back so it may be that no staff went into to clean since the 4th. Should someone be checking on [his/her] room to clean during that time, or do they leave it as is while someone is out to the hospital?" A document titled, "Provider Concern Details," with an incident date of 11/07/2025, included the following: Under a "Domain of Concern" section, it read, "Dissatisfaction, Health/Safety, Failure to Notify." Under a "Concern Narrative" it read, in part, " ...Guardian ended up going to member's room in the facility after member was hospitalized, and there were bloody sheets and bloody tissues all over the room." Under a "What new or different arrangement has been agreed upon" section, it read, "Facility leadership educated staff on the importance of ensuring Member returns from the ER/hospital to a clean room. Facility also updated	N 481		

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N 481	Continued From page 8 Member's care plan to include more frequent checks from staff." Under a "Summary of Findings" it read, in part, "Substantiated health/safety concern and dissatisfaction related to the unmet housekeeping/laundry needs...Member's laundry was not cleaned, and trashcan was not emptied while member was hospitalized. Tests indicated that member was anemic. Member had a transfusion and the impacted area in the member's nose was cauterized to stop the bleeding..." On 12/18/2025, at approximately 2:00 PM, Surveyor interviewed Administrator A. When asked about the findings related to Resident 2's room being maintained during his/her ER visit, Administrator A stated it was their standard to ensure a resident's room was in tip top shape after an ER visit. Administrator A stated that standard was not met after Resident 2's ER visit and staff did not complete their responsibilities as required. Administrator A stated they pulled everyone in and reviewed expectations moving forward.	N 481		