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 _____	R-C 09/30/2026

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 000}	Initial Comments On 09/28/2026, Surveyor began a complaint investigation and a verification visit at Birch Haven Senior Living Eagles Ridge. Data was collected through 09/30/2026. The complaint was substantiated. Two violations were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 7	{N 000}		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not give a written 30-day involuntary discharge notice to Resident 2 when they discharged him/her from the facility to the hospital. The provider did not provide assistance	N 326		

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

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N 326	Continued From page 1 in ensuring a living arrangement suitable to meet Resident 2's needs was available before discharging him/her. Findings include: On 09/14/2026, the Department received a complaint regarding the involuntary discharge of a resident. On 09/23/2026, Surveyor reviewed hospital and county department of health services (DHS) documentation relating to the complaint. The documentation included: - A county DHS note, dated 08/20/2026. The note read, in part, "[Resident 2] arrived in urgent care yesterday from [facility name] for the stated purpose of re-curring [sic] UTI [urinary tract infection] and weakness. [Facility name] staff were unable to complete a UA [urinary analysis] collection. [Resident 2] has been medically cleared "no medical need to be there", [sic] but [facility name] is unwilling to take [him/her] back. Hospital will...begin looking for placement..." - A county DHS note, dated 09/15/2026. The note read, in part, "...the hospital staff are still actively looking for SNF [skilled nursing facility] placement." - A hospitalist admission note, dated 08/19/2026. The note read, in part, "...provider reached back out to the assisted living facility to discuss a discharge plan and they stated they could no longer meet [his/her] needs there, so decision was made for admission for treatment of UTI and placement..." The same document later read, in part, "social services to assess given concerns about placement issues and ability to meet [his/her] needs at current facility..." - A document titled, "Hospital Issued Notice of Noncovered Continued Stay," read, in part, "The	N 326		

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N 326	Continued From page 2	N 326		

purpose of this notice is to inform you that we believe your continued hospital stay will not be paid for by [federal health insurance program] because: Patient brought in due to [facility name] stating that [his/her] needs exceeded what they could do. Patient is medically stable and no acute illness at this time. Patient is awaiting placement to a nursing home at this time...we believe that beginning on 08/25/2026, you will be responsible for payment of your continued stay...We estimate the cost of your continued stay to be: Estimated daily cost - $1450.63..."

On 09/28/2026, at approximately 1:00 PM, Surveyor interviewed Caregiver C. Caregiver C stated Resident 2 had been discharged from the facility due to becoming a 2- or 3-person assist. Caregiver C stated Resident 2 had been admitted to the hospital.

At approximately 1:46 PM, Surveyor interviewed Administrator B. Administrator B stated Resident 2 had been declining after a UTI. Administrator B stated Resident 2 had gone to the hospital per his/her primary care provider (PCP).

At approximately 2:28 PM, Surveyor interviewed Caregiver A. Caregiver A stated Resident 2 had been discharged because s/he had become a 2-person assist and the facility only had 1 staff on duty at a time. Caregiver A stated Resident 2 had been sent to the hospital, and hospital staff said s/he needed to be in a nursing home.

At approximately 3:30 PM, Surveyor interviewed Administrator B again. Administrator B stated a 30-day notice of involuntary discharge had not been issued to Resident 2. Administrator B stated the provider did not try to find other living arrangements for Resident 2, because Resident

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N 326	Continued From page 3 2 had been admitted to the hospital. From 09/28/2026 to 09/30/2026, Surveyor reviewed records for Resident 2, as well as records for the facility. The records included the following: - An email from Administrator B to a member of Resident 2's managed care team, dated 08/14/2026. The email read, in part, "[Resident 2] has been increasingly difficult to engage in transfers and can become very combative, particularly since [his/her] fall a couple of weeks ago...Given [his/her] current COC [change in condition], it may be in [Resident 2's] best interest to begin exploring SNF placement to ensure [s/he] can receive the level of care and support [s/he] now requires..." - An email from Care Coach (CC) F to Administrator B and other facility staff, dated 08/19/2026. The email read, in part, "...the hospital just told [Resident 2's guardian] that you guys are refusing to take [Resident 2] back? Not sure if there is a miss communication [sic] going on?..." - An email response from Administrator B to Resident 2's care team, dated 08/19/2026. The email read, in part, "...increased needs are becoming more difficult to safely manage for both [Resident 2] and staff. Our buildings are not equipped or staffed to provide two-person transfers...We are unable to do this...Based on [his/her] current level of care and the increased assistance [s/he] requires, we are no longer able to safely meet [Resident 2's] needs..." - An email response from Managed Care Worker (MCW) E to Administrator B and other facility staff, dated 08/19/2026. The email read, in part, "...It is not appropriate for the facility to discharge [Resident 2] to the hospital due to a potential infection, which has caused a change in	N 326		

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condition. We can work with [Resident 2] to identify alternate placement if this is what [s/he] needs, but [s/he] needs to return to [facility name] from the hospital and you would issue a 30 day discharge notice if you can no longer meet [his/her] needs. The ER [emergency room] is not a crisis bed or appropriate placement..."

- An email from Hospital Social Worker (HSW) D to Administrator B, dated 08/20/2026. The email read, in part, "From what I gather from notes and discussion...[Resident 2] is a "social admission" as [s/he] has no medical need to be in a hospital setting. ER [emergency room] staff was updated by [provider name] staff that [provider name] could no longer meet the patient's needs and [s/he] would need to be admitted for placement..."
- An email from Administrator B to other facility management staff, dated 08/26/2026. The email read, in part, "Family has emptied [Resident 2's] Room [sic]...I will be discharging [him/her]..."
- The facility program statement, dated.... The program statement read, in part, "...Before [provider name] involuntarily discharges a resident, [provider name] will give the resident or legal representative a 30-day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. The [provider name] will provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident..."

In summary, Resident 2 went to the hospital emergency department on 08/19/2026 due to a change in condition relating to a fall and a UTI. The provider had recognized Resident 2's change in condition which also involved the need for a 2-person transfer. The provider stated they were unable to meet Resident 2's needs. When the

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N 326	Continued From page 5 hospital reached out to discharge Resident 2 back to the facility, the provider would not take him/her back. This resulted in Resident 2 being admitted to the hospital and incurring charges of $1450.63 a day as of 08/25/2026. The provider did not issue a 30-day written discharge notice or assist with finding another living arrangement for Resident 2.	N 326		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure to update the individual service plan (ISP) for Resident 1 when s/he had a change in his/her needs. Resident 1 had physician orders for 2 ounces of alcohol per night. Staff would routinely supervise Resident 1 while s/he drank, despite him/her expressing a desire to be left alone. Resident 1's ISP did not address staff monitoring and interventions of Resident 1's alcohol consumption.	N 389		

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N 389	Continued From page 6 Findings include: On 09/28/2026, at approximately 1:10 PM, Surveyor interviewed Resident 1. Resident 1 stated a caregiver had supervised him/her while s/he had consumed his/her alcoholic beverage a few weeks prior. Resident 1 stated s/he would like to drink his/her alcoholic beverage alone in his/her room. At approximately 2:28 PM, Surveyor interviewed Caregiver A. Caregiver A stated Resident 1 would get his/her allotted amount of alcohol every night at around 8:00 PM or 9:00 PM. Caregiver A stated s/he typically worked the PM shift and would sit with Resident 1 while s/he consumed his/her alcoholic beverage. Caregiver A stated Resident 1 would express that s/he wanted to drink his/her alcohol alone while sitting and watching a movie. Caregiver A indicated s/he would sit with Resident 1 anyway, and s/he thought that every staff member would also watch Resident 1 while s/he drank his/her alcoholic beverage. Caregiver A stated s/he had been trained to sit with Resident 1 while s/he consumed his/her alcoholic beverage. Caregiver A stated Resident 1 used to spill liquid in his/her room and then ask for more alcohol. Caregiver A stated it was just easier to sit with Resident 1 while s/he had his/her alcohol. At approximately 3:00 PM, Surveyor interviewed Administrator B. Administrator B stated staff were to supervise Resident 1 while giving him/her nightly alcohol. Surveyor reviewed Resident 1's records, which included the following: - Resident 1's task administration record (TAR)	N 389		

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for July 2026. The TAR indicated Resident 1 had a physician order to receive 2 ounces of alcohol at 8:00 PM daily. The TAR read, in part, "ORDERS FOR 2OZ [ounces] OF ALCOHOL AT BEDTIME [Resident 1] is to have 2oz [ounces] of whiskey at bedtime. The bottle will stay in the med [medication] cart and be documented on the bottle for amount consumed...ALCOHOL CONSUMPTION Resident has a physician order to receive 2oz [ounces] of alcohol prior to bedtime. Resident is not able to manage alcohol consumption on [his/her] own and all alcohol will be kept in [his/her] med [medication] cart. [His/her] guardian will bring in alcohol and give to staff. Guardian and Care team are aware..."
- A negotiated risk agreement, dated 02/25/2026. The risk agreement read, in part, "Resident has a history of alcoholism and wishes to purchase and drink alcohol in the facility...Resident wishes to remain independent and enjoy alcoholic beverages daily...The company will monitor the safe use of alcohol consumption...Resident can grant permission to staff to maintain alcoholic beverages in the facility main pantry, refrigerator or medication cart. When resident wishes to have the beverage, staff will give it to [him/her] within the prescribed order limits..."
- Resident 1's ISP, dated 06/18/2026. Resident 1's ISP read, in part, "ALCOHOL CONSUMPTION (Fall Management/Ambulation/Adaptive devices/Fall risk) Directions: Resident has a physician order to receive 2oz [ounces] of alcohol prior to bedtime. Resident is not able to manage alcohol consumption on [his/her] own and all alcohol will be kept in [his/her] med cart. [His/her] guardian will bring in alcohol and give to staff. Guardian and Care team are aware..."
- Follow-up paperwork from an appointment with Resident 1's advanced practice nurse practitioner

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N 389	Continued From page 8 (APNP), dated 05/18/2026. The follow-up read, in part, "Substance Use: [Resident 1] has an order for 2 ounces of whiskey at bedtime, dispensed by staff, due to a history of overindulging and obtaining alcohol from outside sources. There is concern that a friend may have brought [him/her] additional alcohol, but there was no evidence of intoxication at this visit...Continue to dispense 2 ounces of whiskey at bedtime from the medication cart to manage alcohol use. Monitor for signs of intoxication or evidence of obtaining alcohol from outside sources..." On 09/29/2026, at approximately 8:24 AM, Surveyor received an email from Administrator B. The email read, in part, "In following up with PCP [primary care provider] on [Resident 1] alcohol consumption- Provider doesn't want [him/her] consuming alcohol at all due to [his/her] history and ER [emergency room] visit after becoming intoxicated. However, [sic] PCP has added: "May have 2ox [sic] of liquor or 1 12oz beer...must be supervised by staff" -This has been updated in our system..." The provider did not ensure to update Resident 1's ISP with interventions and approaches to his/her alcohol consumption.	N 389		