STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0013779	A. BUILDING: _____ B. WING _____	C 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRADWOOD HOUSE	2252 BRADWOOD AVE ALTOONA, WI 54720

(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
M 000	INITIAL COMMENTS On 07/21/2025, Surveyor conducted a complaint investigation at Bradwood House. The complaint was substantiated. One deficiency was identified and was a repeat deficiency. See Statement of Deficiency (SOD) XOL411, dated 09/15/2023. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not notify the department within 24 hours when Resident 1 and Resident 2 eloped from the facility and their whereabouts were unknown. This is a repeat deficiency. See Statement of Deficiency (SOD) XOL411, dated 09/15/2023. Findings include:	M 134		

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

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M 134	Continued From page 1 On 04/07/2025, the Department received a complaint regarding multiple elopements requiring police intervention. On 07/21/2025 at approximately 9:00 AM, Surveyor interviewed Team Lead (TL) A and asked about elopement incidents and incidents requiring police intervention. TL A informed Surveyor Resident 1 was no longer residing in the facility and was discharged because s/he "had several elopements." TL A stated Resident 1 was approved for alone time in the community per his/her guardian but would often not return at the agreed upon time. TL A reported they were instructed to call the non-emergency police department to assist in locating Resident 1 when s/he did not return. TL A further stated, "We had to put alarms on the doors; we gave [him/her] a curfew, provided a special phone with tracking, and at one point the guardian did not allow [him/her] out in the community alone, but would then allow [him/her] to go back out. TL A stated Resident 1's whereabouts were unknown approximately 20 times in the last 4 months, with several incidents requiring assistance from the police, and several incidents where facility staff had to transport Resident 1 back to the facility. TL A informed Surveyor Resident 1 had approved outings from his/her guardian, and rarely returned at the agreed upon time. Surveyor then asked TL A if any other residents had eloped from the home. TL A stated Resident 2 had eloped "a few times," but it had not happened since they moved Resident 2 to an upstairs bedroom. TL A informed Surveyor Resident 2's bedroom was previously downstairs in the basement, and s/he would exit out the egress window. TL A stated Resident 2 ended up at the neighbor's house. The neighbor	M 134		

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M 134	Continued From page 2	M 134		

complained, which prompted local law enforcement to get involved. TL A stated there have not been any incidents since.

On 07/21/2025, Surveyor requested incident reports for Resident 1 and Resident 2 from Operations Director (OD) B.

Resident 1 had an admission date of 11/20/2023. The following incidents for Resident 1 were provided by OD B:

-02/08/2025: On 02/06/2025, Resident 1 went on an approved, independent walk in the community at 8:00 AM and said s/he would return by 12:00 AM on 02/07/2025. This time frame [sic] was approved by guardian and managed care organization (MCO). Resident 1 did not return by midnight, so police were contacted to file a missing person report. At 6:45 AM, facility was notified by police Resident 1 was located at a coffee shop. Facility staff arrived at the coffee shop, but Resident 1 was no longer there. Resident 1 was not located until 4:00 AM the following day (02/08/2025) at Kwik Trip on Water Street in Eau Claire.

-04/01/2025: Resident 1 went on an approved walk in the community at 9:00 AM the previous day and said s/he would return by 9:00 PM. Resident 1 did not return. Staff did not notify police or facility management staff immediately. Police were called at 7:00 AM the next morning (04/01/2025) when TL A and OD B were notified to file a missing persons report. Resident 1 contacted facility staff around 12:00 PM on 04/01/2025 as s/he was downtown in Eau Claire. Resident 1 returned to the facility at 12:30 PM.

-04/05/2025: Resident 1 eloped around noon

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(12:00 PM). Police notified immediately. Resident 1 was located around 1:00 AM after calling 911 requesting a ride home. Resident 1 was picked up and returned to the house around 1:30 AM.

-05/04/2025: Resident 1 went on an approved walk per guardian and stated s/he would return at 3:00 PM. Resident 1 did not return. Police contacted. Resident 1 was located in Augusta, WI. Police transported Resident 1 back to the facility.

-05/08/2025: Resident 1 went for a walk at 9:00 AM in the community with the understanding s/he would return at 11:00 AM. Resident 1 did not return, police were notified. Resident 1 was located downtown at 12:00 PM.

-05/25/2025: Resident 1 noted missing around 7:45 AM. Guardian did not approve him/her to walk. Police notified and located Resident 1 at 9:55 AM at Hardee's. Facility staff transported Resident 1 back to the facility at 10:15 AM.

-05/26/2025: Resident 1 eloped around 8:00 AM. Wouldn't respond to staff requesting him/her to return to the house. Returned within 30 minutes independently. Resident 1 informed staff s/he went for a walk, but staff reminded him/her s/he did not have approval to walk.

-06/09/2025: Resident 1 went on an unapproved walk at 4:45 (time of day not indicated). Police notified immediately. Resident 1 was found at 11:00 (time of day not indicated) in Eleva, WI by police. Resident 1 was transported back to the house by facility staff.

-06/14/2025: Resident 1 went on an unapproved walk at 11:00 AM. Police were notified

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immediately. Resident 1 was located by police in Eau Claire at 2:10 PM. Police transported Resident 1 back to facility at 2:30 PM.

The provider sent the Department 3 self-reports for Resident 1's elopements on 02/08/2025, 04/01/2025 and 04/05/2025. The 04/05/2025 notification was sent with the same incident report for 02/08/2025.

Surveyor reviewed a list of contact dates for Resident 1's elopements between 03/13/2024 and 04/05/2025, provided by the police department, which documented Resident 1 was reported missing 12 times. Additionally, the police department received missing person reports for Resident 1 on 05/04/2025, 05/08/2025, 05/20/2025, 05/26/2025, 06/09/2025 and 06/14/2025.

The police department's list of contact dates with Resident 1 also included the following information:

-6/26/2024: Resident 1 reported missing. Contacted by police in Eau Claire after a panhandling complaint.

-07/18/2024: Resident 1 contacted by police after asking for food and money at Starbucks, not reported missing at the time.

-09/04/2024: Resident 1 reported missing and was found in Fairchild, WI asking for rides to Michigan at a gas station.

-11/13/2024: Resident reported missing for approximately 1.5 days. Resident 1 called police stating s/he ran away from the group home and needed a ride back.

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M 134	Continued From page 5 -11/16/2024: Less than 12 hours after being returned, Resident 1 left the residence and was reported missing. Staff reported Resident 1 should not be walking without a manager. -12/10/2024, 12/22/2024 and 12/25/2024: Resident 1 contacted by police following panhandling complaint and banned from the store at a business not near the facility. Resident 1 was not reported missing at the time. -12/26/2024: Resident contacted by police after stealing a sandwich and refusing to pay for it. Resident 1 was banned from the gas station. Resident 1 was not reported missing at the time. -02/10/2025: Resident 1 stole items from a shop in downtown Eau Claire. Resident 1 was arrested for retail theft. The Department did not receive notification of all Resident 1's elopements or incidents where whereabouts were unknown. Local law enforcement was contacted approximately 18 times from 03/13/2024 to 06/14/2025, when Resident 1 was reported missing. Resident 2 had an admission date of 01/28/2021. The following incidents for Resident 2 were provided by OD B: -05/16/2025: Resident 2 left on an unapproved walk in the community in the evening around 6:30 PM and returned at 7:00 PM on his/her own. -05/17/2025: Resident 2 left on an unapproved walk in the community in the evening around 10:00 PM. Resident 2 returned on his/her own. Guardian and law enforcement notified. Law	M 134		

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M 134	Continued From page 6 enforcement arrived at the facility the next day and spoke with Resident 2 as Resident 2 was reported to be at a neighbor's house trying to open their back door. Resident 2 was given a warning for trespassing. On 07/21/2025 at approximately 1:00 PM, OD B informed Surveyor via email that Resident 2's spike in elopements was "not typical." OD B further stated, " ...we moved [Resident 2] from the basement to [his/her] original room upstairs and this has corrected the behavior." On 07/21/2025 at approximately 3:15 PM, OD B confirmed via email the Department was not notified of Resident 2's elopements when his/her whereabouts were unknown.	M 134		