

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 09/02/2026, Surveyor conducted an abbreviated survey and complaint investigation at Bridge to Independence Keith House. Data collection continued through 09/10/2026. The complaint was substantiated. Five deficiencies were identified. Census: 4	M 000		
M 286	88.05(3)(e)2 HEATING SYSTEM INSPECTIONS The heating system shall be inspected as follows, with written documentation of the inspections maintained in the home: This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the provider's gas furnace was inspected every 3 years. The gas furnace was last inspected 02/13/2023. Findings include: On 09/02/2026, at approximately 1:15 PM, Surveyor toured the home with House Lead (HL) A. Surveyor observed a gas furnace and asked HL A for the most recent furnace inspection. HL A stated it was usually kept by the furnace, but s/he did not see it. At 2:58 PM, Surveyor emailed Operations Director (OD) B and requested the most recent furnace inspection.	M 286		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 286	Continued From page 1 On 09/03/2026, Surveyor reviewed a furnace inspection provided by OD B. The inspection indicated the furnace was last inspected on 02/13/2023. There was a post it note attached to the inspection that read, in part, "9/2/26 I called [Furnace Agency] for reinspection. They will inspect on Tuesday of next week." The post it note appeared to have the signature of OD B at the bottom of the note. The provider did not ensure that the provider's gas furnace was inspected every 3 years.	M 286		
M 570	88.10(3)(I) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was safeguarded from environmental hazards. The provider did not assess Resident 1's abilities to safely utilize a bed rail after s/he experienced a decline in functioning. On 03/27/2026, Resident 1 fell out of bed and	M 570		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 570	Continued From page 2 had his/her neck caught between the bed railing and bed. Resident 1 was described as having trouble breathing before staff were able to intervene. Findings include: The provider is licensed to care for 4 residents in the client groups of: developmentally disabled, emotionally disturbed/mental illness, physically disabled, and traumatic brain injury. On 06/03/2026, the department received a complaint regarding the provider's use of bed rails. Wis. Admin. Code ch. 88 defines physical restraints as follows: Wis. Admin. Code § DHS 88.02(24) - "Physical restraint" means any manual method or any article, device or garment interfering with the free movement of a resident or the normal functioning of a portion of the resident's body or normal access to a portion of the body, and which the individual is unable to remove easily, or confinement in a locked room. On 09/02/2026, at approximately 12:15 PM, Surveyor interviewed House Lead (HL) A. When asked about Resident 1's physical and cognitive abilities, HL A stated Resident 1 ended up being bedbound and could do nothing on his/her own. HL A stated Resident 1 was a fall risk and always needed to wear a helmet. HL A stated Resident 1 had a traumatic brain injury. HL A stated Resident 1 had a bed rail, and s/he did not complete any assessments related to use of the bed rail. HL A stated Operations Director (OD) B did everything. HL A stated Resident 1 also had a railing on the	M 570		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 570	Continued From page 3 wall but could not use it independently. HL A stated Resident 1 could not reposition him/herself in bed as s/he did not have the strength to do so. When asked about Resident 1's falls, HL A stated Resident 1 was reaching for a remote during an incident and fell out of bed. HL A stated his/her bed alarm sounded, and Resident 1 was observed limp and caught between the railing gasping for air. Surveyor requested Resident 1's closed record from HL A. HL A stated OD B would need to provide that documentation. At 2:58 PM, Surveyor emailed OD B and requested Resident 1's closed record. On 09/03/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 06/12/2023 and had a guardian of person and estate. Resident 1 was discharged on 06/08/2026. Resident 1 had multiple diagnoses including history of falling, foot drop of right foot, major depressive disorder, symptomatic epilepsy and epileptic syndromes with complex partial seizures, personal history of traumatic brain injury, spastic hemiplegia affecting right dominant side, and unspecified intellectual disabilities. Resident 1 was prescribed multiple medications to treat partial onset seizures and epilepsy. A staff observation note, dated 03/27/2026 at 3:10 PM, read, "Staff had just checked on [Resident 1] at 2:30 PM [sic] [s/he] was sleep [sic]. Around 3ish [sic] [Resident 1's] bed alarm went off. Staff went to check on [him/her]. [Resident 1] was on [his/her] knee with neck between bed railing and bed having trouble to breathe [sic] ..." Staff was able to remove Resident 1 from the railing and did not identify	M 570		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 570	Continued From page 4 any injuries. Resident 1's individual service plan (ISP), dated 07/09/2025, indicated Resident 1 utilized a helmet to minimize injury occurring in the event of a seizure. It stated Resident 1 had physical limitations due to his/her foot drop, right foot, personal history of traumatic brain injury and history of falling. The ISP did not contain evidence of use of a bed rail or bed alarm. On 09/10/2026, at 10:30 AM, Surveyor interviewed Care Coach (CC) C, CC D, Care Coach Manager (CCM) E and Provider Quality (PQ) F via virtual meeting. When asked about Resident 1's bed railing, CC C stated Resident 1 was transferring him/herself when it was authorized. It was a small U shaped rail. Resident 1 was able to get up independently initially. CC C stated Resident 1 experienced a rapid decline, lost weight, lost mobility and was not able to do transfers anymore. CC C stated the provider thought there was less risk to keep the rail than to remove it. CC C stated they talked about the risk with the decline and they had noticed Resident 1's weakness. CC C stated "If [s/he] does get in there, we know [s/he] can't get out." CC C stated they would have liked to see the bed rail removed. At 2:00 PM, Surveyor interviewed OD B via phone. OD B stated there was a lack of documentation related to assessments associated with Resident 1's bed rail. OD B stated s/he had communications with Resident 1's care team and Resident 1's care team approved and authorized the bed rail. OD B stated s/he felt confident it was appropriate based on that approval.	M 570		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 582	Continued From page 5	M 582			
M 582	88.10(3)(q) Medications Medications. To receive all prescribed medications in the dosage and at the intervals prescribed by the resident's physician, and to refuse medications unless there has been a court order under s. 51.61(1)(g), Stats., with a court finding of incompetency. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1 received prescribed medications in the dosage and at the intervals prescribed by the resident's physician. Resident 1 did not receive her/his prescribed medications between 04/01/2026 and 04/23/2026. Findings include: On 06/03/2026, the department received a complaint alleging residents were not receiving medications as prescribed. On 09/02/2026, at approximately 12:35 PM, Surveyor interviewed House Lead (HL) A. HL A stated the provider had multiple medication errors in the past and staff had signed off medications as given when they were not. At 2:58 PM, Surveyor emailed OD B and	M 582			

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 582	Continued From page 6 requested Resident 1's closed record. On 09/03/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 06/12/2023 and had a guardian of person and estate. Resident 1 was discharged on 06/08/2026. Resident 1 had multiple diagnoses including symptomatic epilepsy and epileptic syndromes with complex partial seizures. Resident 1's medication administration record (MAR) for April 2026 indicated s/he was prescribed Briviact 50 MG tablet. It read, "Reorder when down to a 7 day supply. Take one tablet by mouth two times a day at 8am and 8pm ..." Briviact (brivaracetam) was an anti-epileptic medication used to treat partial-onset seizures. The back of the MAR included 18 hand written entries next to the medication that read, "Not in home." There were 31 circles around the spaces for staff to sign when the medication was administered. The 31 spaces were not signed. There were 10 spaces that had a signature in the spaces to indicate the medication was administered. On 09/10/2026, at 2:00 PM, Surveyor interviewed OD B via phone. OD B stated staff requested a refill of Resident 1's Briviact medication and there was a discrepancy between the pharmacy and Resident 1's prescriber. OD B stated s/he called the prescriber directly to identify what the issue was. OD B stated there were a few days Resident 1 went without his/her medication due to the prescriber's claim that they did not get the refill fax request. When asked about the intermittent staff signatures on the MAR, OD B stated s/he did have a staff that absent mindedly signed it	M 582		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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 582	Continued From page 7 when it was not administered. OD B stated the staff probably went too fast and did not go through the medication protocol.	M 582		
Z 022	50.065(3)(b) COMPLETE BACKGROUND CHECK PROCESS Every 4 years or at any other time within that period that an entity considers appropriate, the entity shall request the information specified in sub. (2) (b) 1. to 5. for all caregivers of the entity. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a complete caregiver background check (CBC) was conducted every 4 years for 1 of 1 caregiver employed more than 4 years. Findings include: A complete CBC consists of the following: - A completed Background Information Disclosure (BID) form. - A report of findings from the Department of Justice (DOJ). - Government Findings Report (GFR) from the Department of Health Services (DHS).	Z 022		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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
Z 022	Continued From page 8 On 09/02/2026, Surveyor requested a staff roster with dates of hire. House Lead (HL) A had a hire date of 05/31/2022. The record contained a background check at the time of hire in 2022. On 09/08/2026, at 10:59 AM, Surveyor emailed Operations Director (OD) B and asked if HL A had completed a background check since 2022. At 9:45 PM, Surveyor received an email from OD B that read, in part, "Attached are [HL A's] DOJ caregiver background check and federal background check. I can send you the completed results of [his/her] federal background check once it is completed..." The documents attached were dated 09/08/2026. The provider did not ensure a complete CBC was conducted every 4 years for HL A.	Z 022		
Z 023	50.065(4m) (b) intro CAREGIVER HIRING AND CONTRACTING PROCESS Notwithstanding s.111.335, and except as provided in sub. (5), an entity may not hire or contract with a caregiver or permit to reside at the entity a nonclient resident if the entity knows or should have known any of the following: 1. That the person was convicted of a serious crime. 3. That a unit of government or a state agency, as defined in s. 16.61 (2) (d), has made a finding that the person has abused or neglected any	Z 023		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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
Z 023	Continued From page 9 client or misappropriated the property of any client. 4. That a determination has been made under s. 48.981 (3) (c) 4. that the person has abused or neglected a child. 5. That, in the case of a position for which the person must be credentialed by the Department of Safety and Professional Services, the person's credential is not current, or is limited so as to restrict the person from providing adequate care to the client. This Rule is not met as evidenced by: Based on record review and interview, the provider permitted Caregiver B to work in the home when Caregiver G had a barred offense. Caregiver G was charged with substantial battery 940.19(2). Findings include: On 09/02/2026, Surveyor requested the employee file for Caregiver G from Operations Director (OD) B. Caregiver G's record identified the following: -Caregiver G had a hire date of 12/11/2023. -Caregiver G's Department of Justice, noted Caregiver G was charged with substantial battery 940.19(2), on 10/26/2022 (the county case document showed Caregiver G was guilty due to no contest plea of Felony I 940.19(2)). No documentation of an approved rehabilitation review was found.	Z 023		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0014924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/10/2026
NAME OF PROVIDER OR SUPPLIER BRIDGE TO INDEPENDENCE KEITH HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1010 KEITH STREET EAU CLAIRE, WI 54703		
(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	
Z 023	Continued From page 10 On 09/10/2026, at 2:00 PM, Surveyor interviewed OD B via phone. OD B stated s/he was not aware Caregiver G had a barrable offense that required a rehabilitation review. OD B stated s/he would ensure that process was initiated immediately. The provider permitted Caregiver G to work in the home when Caregiver G had a barred offense.	Z 023			