STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 05/12/2025, Surveyors conducted 3 complaint investigations at Eagles Rest At Pepin. Data was collected through 05/20/2025. Three of 3 complaints were substantiated. Four deficiencies were identified. Three of the 4 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023, and SOD ZTUE12, dated 11/09/2023. Census: 24	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 immediately notify Resident 2 and Resident 3's physician when they had a change in condition. Findings include: On 04/25/2025, the Department received 2	N 169		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 169	Continued From page 1	N 169		

complaints with multiple allegations that included the provider failed to seek medical care when residents had a change in condition.

RESIDENT 2

On 05/15/2025, Surveyor reviewed Resident 2's record.

Resident 2 had multiple diagnoses, including hypertension, asthma, history of stroke, and dementia. S/he had a legal representative.

Staff documented the following changes in observation notes for Resident 2:

02/21/2025 - "Resident has a sore on the nape of [his/her] neck near [his/her] hairline, possibly a pimple that [s/he] scratched at. It is red and irritating [sic] looking."

02/23/2025 - "Resident still has red sores on nape of neck, [s/he] seems to be scratching at them."

03/01/2025 - "[S/he] has been having a low grade fever all day and [s/he] has been eating meals in [his/her] room."

03/06/2025 - "[S/he] was confuse [sic] at supper [sic] [s/he] went to the front door thinking [his/her] [daughter/son] was here to takr [sic] [him/her] to appointment."

03/25/2025 - "yesterday I found a pink rash on [Resident 2's] legs [sic] the [sic] was 10 or more spots quarter size."

Surveyor did not locate documentation that indicated Resident 2's physician or legal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 169	Continued From page 2	N 169		

representative was notified of the changes staff documented.

On 05/15/2025, Surveyor emailed Administrator A, Licensee B, and Registered Nurse (RN) D. Surveyor asked who was notified of Resident 2's changes and if there was any follow up.

On 05/19/2025 at 1:08 p.m., Administrator A replied via email, in part, "The skin assessments that were performed with the shower state no skin concerns, so I am confused on this one."

On 05/19/2025 at 4:06 p.m., Administrator A replied, via email, in part:
"Our nursing team did further investigation into the dates of skin changes that you mentioned. It does look like the staff noted some skin changes on his/her neck and legs.
I am not sure what the process was before the arrival of the new nursing and administration team. If this were to occur, our staff will notify the nurse to evaluate. Since our nurse is here on site 2 days a week, the administrator might be the first notified of any skin changes ..."
On 05/12/2025 at 9:30 a.m., Surveyor interviewed Administrator A. Administrator A told Surveyor s/he has been in his/her role since the end of February 2025.

RESIDENT 3

On 05/20/2025, Surveyor reviewed Resident 3's record.

Resident 3 had multiple diagnoses, including severe morbid obesity, depression, chronic venous hypertension, and lymphedema.

Staff documented the following changes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 169	Continued From page 3	N 169		

observation notes for Resident 3:

04/09/2025 - "Right lower leg is weeping and [sic] cleaned the area and bandage."

04/11/2025 - "Resident yelled at staff and was visibly upset when [s/he] was requesting narcotic pain management [sic] and staff told resident [s/he] needs to try tylenol [sic] first and if it is not effective [s/he] can go up from there ... [S/he] took tylenol [sic] and did fine for a couple hours but when waking up [s/he] said [s/he] was in severe pain ... [s/he] could not point out what was hurting [sic] staff also noted [his/her] right leg was oozing again and red ..."

04/13/2025, Administrator A documented: "monthly vitals were taken, her O2 (oxygen) was 85 and [his/her] facial skin looked gray, [s/he] was advised to take a neb (nebulizer treatment) and recheck [his/her] O2 sat (saturation) was at 92. [s/he] refuses to be seen. Will recommend staff give [him/her] prn (as needed) nebulizer treatments and recheck [his/her] O2 as needed. The nurse was advised."

04/14/2025, RN D documented: "Resident has weeping calf on right calf and left calf has another weeping area. Writer cleansed area and covered with a foam bordered dressing ..."

04/15/2025 - "Resident seemed super tired and out of it [sic] throughout the night staff had to wake [him/her] up and remind [him/her] about changed [sic] which is unusual for [him/her] ..."

04/23/2025 - "[Resident 3] has redness and peeling under left breast fold ..."

04/24/2025 - "Resident was sent to the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 169	Continued From page 4	N 169		

this morning. Resident was having confusion, wounds on lower extremities were getting worse, temp (temperature) 100.5, O2 86% RA (room air) ..."

Documentation from the hospital emergency department, dated 04/24/2025, indicated Resident 3 had diagnoses of: cellulitis of the lower extremities, acute on chronic congestive heart failure, lymphedema, and hypoxia (low oxygen).

"Cellulitis (sel-u-LIE-tis) is a spreading skin infection, most commonly of the lower leg. It's caused by bacteria entering through a break in the skin. The affected skin is swollen, painful and warm to the touch. The infection can cause a fever and become very serious, involving deeper tissues ... It's important to find and treat cellulitis early because the condition can spread rapidly throughout the body." (Retrieved on 05/21/2025 from https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762).

On 05/20/2025, Surveyor emailed Administrator A, Licensee B, and RN D. Surveyor asked if Resident 3's physician was notified of the changes in Resident 3 that were documented in staff notes.

On 05/20/2025, Administrator A replied, via email, in part: "I have enclosed updated information for your review ... As we continue to evolve as a new team, our policies and procedures are changing.

Attached to the email was a fax to Resident 3's physician, dated 04/15/2025. The fax read: "Resident's O2 has consistently been 80% - 85%. After nebs resident states [s/he] feels better, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 169	Continued From page 5 O2 remains about 88%. Drops an hour after neb. Resident's lips cyanotic. Refusing ED (emergency department). Resident has 3 red, non [sic] blanchable, warm to touch areas on abd (abdomen) and upper L (left) thigh. Can we schedule nebs and have an as needed neb." This was the only documentation of notification to Resident 3's physician with his/her changes of condition. This was 2 days after Administrator A documented that Resident 3's oxygen saturation was dropping. The provider failed to immediately notify Resident 2 and Resident 3's physician when they exhibited changes in physical and mental condition.	N 169		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 and Resident 3 received all prescribed medications in the dosage and at intervals prescribed by their practitioner. Resident 1 was seen in a medical office setting on 03/07/2025. Resident 1's medical provider made multiple changes to Resident 1's prescription orders that were not implemented by	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 6	N 352		

the provider. The provider did not become aware of the medication changes until Resident 1 was hospitalized on 03/24/2025.

Resident 3 did not receive his/her prescribed topical medications as ordered. S/he developed a skin infection.

This deficiency is being cited for the third time. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023, and SOD ZTUE12, dated 11/09/2023.

Findings include:

On 04/25/2025 and 05/01/2025, the Department received complaints about medication administration.

RESIDENT 1

On 05/12/2025 at approximately 10:45 AM, Surveyor interviewed Registered Nurse (RN) D. When asked how new medication orders got updated by the provider, RN D stated s/he or Administrator A would update the orders. RN D stated staff would fax the nurse line with any new orders received. RN D stated the provider also had an external nurse who could review orders. RN D stated orders were typically updated in less than 24 hours. When asked about residents with behavioral considerations, RN D stated Resident 1 had depression and suicidal ideation. RN D stated s/he was not aware of any recent issues with Resident 1's medications.

At approximately 12:45 PM, Surveyor interviewed Administrator A. When asked about residents with behavioral considerations, Administrator A stated Resident 1 had been sent to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 7 emergency room (ER) in the past for suicidal ideation. Resident 1 returned to the provider the same day as that ER visit. When asked why Resident 1 was hospitalized in March 2025, Administrator A stated it was because Resident 1 could not get up. Resident 1 was lying in bed for 24 hours a day and did not want to leave his/her room. Administrator A stated the provider did not get the medication changes ordered by Resident 1's doctor at an appointment that took place in early March 2025. Administrator A stated Resident 1 was super dehydrated and was hospitalized for a couple of weeks to build his/her strength back up. When asked why Resident 1 became dehydrated, Administrator A stated it was because the provider did not receive the medication changes. Administrator A stated the provider did not receive any medication changes from the pharmacy and did not learn of the medication changes until Resident 1's hospitalization. When asked why the provider did not know of the medication changes, Administrator A stated residents were typically given a document to get signed by their medical providers during medical appointments. Administrator A stated residents would usually return that document to staff upon return to the facility. Administrator A stated s/he did not recall seeing any notes from Resident 1's visit. Surveyor requested Resident 1's records from Administrator A. Resident 1's records included the following: Resident 1 was admitted on 12/17/2024 with multiple diagnoses, including vascular dementia, moderate, with mood disturbance, major depression disorder, chronic kidney disease, stage 3b, and Type 2 diabetes. Resident 1 was his/her own legal decision maker.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 8 Staff observation notes, dated between 01/01/2025 and 05/12/2025, included: 02/18/2025: "Resident had told staff that [s/he] is very depressed and just does not want to get up or wake up anymore [sic] staff [sic] asked why and [s/he] would not tell staff ..." 02/20/2025: "Patient expressed feelings of depression and SI (Suicidal Ideation) with a plan while we were in a meeting with [his/her] [Managed Care Organization] team. [S/he] refused to tell any of us what [his/her] plan would be. We will continue to monitor and [his/her] MD (medical doctor) will be updated at [his/her] appointment." 04/14/2025: "Spoke with [Staff] at [Medical Provider] to confirm medication changes for appointment from 3/7/25 with [Physician F] ...I spoke with [Staff] at [Pharmacy] and [s/he] has these changes noted as well which match with the medications sent to the facility for patient to be given. current [sic] medications updated again on 4/10 after hospital stay and all medications in system match with script order at [Pharmacy] ..." Resident 1's March 2025 Medication Administration Record (MAR) included the following orders: Spironolactone 50 MG 1 tablet daily at 8:00 AM. Start date 12/17/2024; End date 04/10/2025. It was signed as administered 03/01/2025-03/23/2025. Trulicity Inject .5ml (4.5mg) under the skin every 7 days in the morning on Friday at 8:00 AM. Start date 12/17/2024; End date 04/10/2025. It was signed as administered on 03/07/2025, 03/14/2025 and 03/21/2025. Furosemide 20 MG Take 1.5 tablets (30mg) by mouth every morning at 8:00 AM. Start date 01/14/2025; End date 04/10/2025. It was signed	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 9	N 352		

as administer on 03/01/2025-03/23/2025. Duloxetine 30 MG Take 1 capsule (30mg) by mouth daily. 8:00 AM. Start date 12/17/2025; End date 04/10/2025. It was signed as administered on 03/01/2025-03/23/2025.

Resident 1's April 2025 MAR included the following orders:
Trulicity 1.5MG Inject 1.5mg under skin every 7 days for 28 days. Start date 04/10/2025, No end date.
Duloxetine ER 30 MG Take 1 capsule (30mg) by mouth daily. Start date 04/10/2025, No end date.
Spironolactone and Furosemide were discontinued.

A hospital discharge summary indicating Resident 1 was admitted to the hospital on 03/24/2025 and discharged on 04/10/2025. The principal diagnosis was Debility. The resolved hospital problems were identified as dehydration and AKI (acute kidney injury). Under the summary of admission and chief complaint section, it read, in part, "Pt (patient) treated for dehydration due to not eating and drinking for 9 days and meds (medications) not properly reconciled by [Provider] from pt appt (appointment) w (with) PCP (Primary Care Provider) on 3/7. Spironolactone dose was decreased, and Furosemide was dc'd (discontinued) at that appointment, (along w increase in Duloxetine and decrease in Trulicity) but these med changes were not initiated by ALF (Assisted Living Facility) despite new Rx (Prescription) and orders give [sic] to ALF by PCP."

On 05/13/2025, Surveyor emailed Physician F regarding Resident 1's health status. Physician F responded via email and stated, in part, "[Provider] did not make medication changes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 10 clearly stated in my office visit note and in a follow up faxed report to the assisted living facility, including discontinuation of diuretic furosemide; decreasin [sic] in dosage of diuretic spironolactone, decrease in diabetes medication trulicity, and increase in antidepressant duloxetine. These medications occurred a [sic] due to my concern for alleviating urinary frequency problems but also concerns for kidney function as well as weight loss resulting in potential dehydration. I also noted that [s/he] had had depression with suicidality recently, prompting me to increase antidepressant medication duloxetine. I recommended with daily weights with close notification if [s/he] changed substantially within 24 hours, something we never heard from them in time going forward. [S/he] had poor appetite and that is why I lowered [his/her] Trulicity dosage, which is a diabetes and obesity medication that can suppress appetite especially in older people ...We had issues with staff not reliably answering the phone, both with myself and with the pharmacist as I above noted, and incorrect phone numbers." On 05/20/2025, at 2:00 PM, Surveyors interviewed Licensee B, Consultant C, RN D, and RN H via phone. Surveyors shared concerns related to the provider's lack of implementation of Resident 1's medication changes made during his/her clinic visit. When asked about the provider's practice of sending a document along with residents to clinic appointments, RN H stated they were working on changing that. RN H stated they would implement brightly colored folders instead of keeping track of papers. RN H stated the folder should be brought back with the resident, brought to the staff desk, and copies should be made. The nurse would follow up on any medication changes and recommendations.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 11	N 352		

Licensee B stated RN D would work on a process to ensure the appropriate follow up was conducted after resident appointments. Licensee B stated staff should be looking at the resident's "After Visit Summaries" on the same day as the medical visit to review for changes. Licensee B stated if an after visit summary was not obtained, staff should be making efforts to contact the resident's medical provider to obtain one.

RESIDENT 3

On 05/20/2025, Surveyor reviewed Resident 3's record.

Resident 3 had multiple diagnoses, including severe morbid obesity and lymphedema.

Resident 3 had an order for nystatin powder (topical antifungal powder) to be applied to affected area twice daily until resolved and may resume applying twice daily as needed for recurrence. This order had an active date of 10/24/2023.

Resident 3's MAR for January, February, March, and April 2025, did not indicate staff administered nystatin powder.

Resident 3 was hospitalized from 02/06/2025 - 02/24/2025. Documentation from the hospital included the following physician's assessment and plan:
1. Diffuse superficially desquamating rash (outer layer of skin peeling off) likely due to acute generalized exanthematous pustulosis (adverse skin reaction to a medication) due to cephalosporin (antibiotic) allergy.
2. Superimposed bacterial cellulitis (a new skin infection develops on top of an existing skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 12 problem). 3. Possible Candida intertrigo (a fungal infection caused by yeast in the skin folds). "WOUND CARE: The following wound care was recommended for the areas on the right and left behind thighs, left calf, and buttocks, as well as anywhere else on the body that rash is noted ... Two [sic] areas of active inflammation (red or pustular), a topical steroid such as triamcinolone 0.1% cream applied to the trunk and extremities and hydrocortisone 2.5% cream applied to the body folds will be used up to twice a day to help diminish the inflammation. In addition, continue topical antifungal treatment to the skin folds, as well as keeping the area dry ..." On 02/24/2025, Resident 3 was discharged from the hospital and returned to the assisted living facility. S/he was discharged with the following prescriptions: Triamcinolone 0.1% cream - "Apply 1 Application topically 2 times a day as needed for rash (rash on trunk and extremities if frankly erythematous, do not apply to skin folds or if skin is sloughing and only mildly erythematous). Apply twice daily to rash on trunk and extremities if erythematous." Hydrocortisone 2.5% Ointment - "Apply 1 Application topically 2 times a day as needed for rash (apply to skin folds if any significant erythema, do not apply if appears more like intertrigo with only mild erythema as steroid can worsen fungal infection). Apply 2 times daily to skin folds if any significant erythema." Resident 3's MAR for February, March, and April 2025, did not indicate staff administered triamcinolone cream or hydrocortisone ointment.	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 13 Staff documented skin changes on the following dates: 2/26/2025 - "numerous skin concerns, black and blue left breast, wound on tailbone, wound on right hip area, tubi grips on both ankles. Skin is peeling." 03/17/2025 - "Interim wound nurse arrived while resident was at an appointment. Writer updated Interim on the new wound on resident's left leg inside the skin fold. Interim nurse stated [s/he] will look at it Wednesday and/or Friday." 04/09/2025 - "Right lower leg is weeping and [sic] cleaned the area and bandage." 04/11/2025 - " ... [S/he] took tylenol [sic] and did fine for a couple hours but when waking up [s/he] said [s/he] was in severe pain ... [s/he] could not point out what was hurting [sic] staff also noted [his/her] right leg was oozing again and red ..." 04/14/2025, RN D documented: "Resident has weeping calf on right calf and left calf has another weeping area. Writer cleansed area and covered with a foam bordered dressing ..." 04/23/2025 - "[Resident 3] has redness and peeling under left breast fold ..." 04/24/2025 - "Resident was sent to the hospital this morning. Resident was having confusion, wounds on lower extremities were getting worse, temp (temperature) 100.5, O2 86% RA (room air) ..." Documentation from the hospital emergency department, dated 04/24/2025, indicated Resident 3 had diagnoses of cellulitis of the lower	N 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 352	Continued From page 14 extremities, acute on chronic congestive heart failure, lymphedema, and hypoxia (low oxygen). On 05/20/2025, from approximately 2:00 p.m. - 2:45 p.m., Surveyor interviewed RN D, RN H, Licensee B, and Consultant C on the phone. Surveyor asked why staff did not administer the nystatin powder, triamcinolone cream, and hydrocortisone ointment as ordered. RN D said staff did use the powder but thought it was like "baby powder." RN D said s/he educated staff on the importance of following orders and documenting topical medications on the MAR.	N 352		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure staff implemented Resident 3's individual service plan (ISP) as written. This is a repeat deficiency. See Statement of deficiency (SOD) ZTUE12, dated 11/09/2023. Findings include: On 04/25/2025, the Department received a complaint that alleged residents did not receive baths/showers. On 05/12/2025 at approximately 10:20 a.m., Surveyor interviewed Caregiver I. Caregiver I told Surveyor s/he was the shower aide since November 2024. Caregiver I told Surveyor s/he	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 388	Continued From page 15	N 388		

gave Resident 3 a full bed bath once a week. S/he said it would take 2 - 3 staff to assist in rolling Resident 3 to get all areas cleaned. Caregiver I said Resident 3 wanted to get up and get into the shower but the shower chair was broken. S/he said they got a new shower chair but it did not work properly for Resident 3. S/he said Resident 3's legs went straight out, and s/he was unable to bend them, making it impossible to get Resident 3 into the shower.

On 05/19/2025, at approximately 12:00 p.m., Surveyor interviewed Resident 3 on the phone. Resident 3 told Surveyor everything was going well until his/her shower chair broke. It took long time to get a new shower chair and when they did, it was the wrong size. Resident 3 said that while waiting for the shower chair, "I was left in bed all the time, they only gave me sponge baths." Resident 3 told Surveyor s/he preferred to get in the shower in the shower room. Resident 3 said s/he was supposed to get showers/bed baths on Tuesdays and Fridays but they changed the hours of the shower aide. The shower aide only worked Monday - Thursday. Resident 3 said they did not change his/her Friday shower day to a different day. Resident 3 said s/he received a sponge bath on Tuesdays. S/he said s/he was told to talk to Administrator A about changing his/her Friday shower to a different day. Resident 3 said that every time s/he was not able to get a hold of Administrator A. Resident 3 said, "I'd love to have a shower every day too but it's not possible."

On 05/20/2025, Surveyor reviewed Resident 3's record.

Resident 3 had multiple diagnoses, including severe morbid obesity and lymphedema.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 388	Continued From page 16 Resident 3's ISP, dated 03/21/2025, read, in part: "Resident requires a mechanical lift for transfers. Has [sic] special bariatric hoyer [sic] lift that requires 3-4 staff when operating ... Resident requires staff assistance with all positioning needs. 2-3 assist with all positioning ... allow staff to reposition q (every) 2 hours and utilize wheelchair 3 times weekly ... Resident requires full assistance from staff to complete bathing tasks .... Resident receives a bed bath at this time." The ISP indicated Resident 3's bed bath was to be done on Tuesdays and Fridays. Staff documentation indicted Resident 3 received a bed bath once a week on the following dates: 03/02/2025, 03/11/2025, 03/17/2025, 03/25/2025, 04/01/2025, 04/08/2025, and 04/15/2025. On 04/03/2025, staff documented: "[S/he] got a shower tonight and hair washed. It was determined that the chair was not safe to continue using ..." On 04/24/2025, Resident 3 was sent to the hospital with a fever, confusion and worsening wounds to his/her lower extremities. Documentation from the hospital indicated Resident 3 had cellulitis of the lower extremities. Surveyor reviewed the employee schedule for March and April 2025. Caregiver I was identified on the schedule as the bath aide, and s/he worked Monday - Thursday. The schedule indicated 2 caregivers worked each shift. On 05/20/2025, from approximately 2:00 p.m. - 2:45 p.m., Surveyor interviewed Registered Nurse (RN) D, RN H, Licensee B, and Consultant C on the phone. Surveyor confirmed the schedule that	N 388		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 388	Continued From page 17 Caregiver I did not work on Fridays when Resident 3's other bath day was scheduled. Surveyor asked how staff were to reposition Resident 3 and assist him/her with transfers when they only scheduled 2 caregivers per shift and Resident 3's ISP indicated s/he required 3 - 4 staff for transfers and 2 - 3 staff for positioning. Licensee B confirmed there were only 2 caregivers scheduled. S/he said that during the day, other staff, such as administration staff, and cooks that were trained, would be able to assist with repositioning and transfers, but in the evenings and overnights there were only 2 staff working. Licensee B said they could call staff that lived nearby if they needed assistance. The provider failed to implement Resident 3's ISP as written. Resident 3 did not receive 2 showers/baths per week. The provider did not ensure adequate staff worked to reposition and transfer Resident 3 per his/her ISP. Resident 3's wounds worsened, and s/he was hospitalized.	N 388		
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	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 18 8.02(1), unless seen by a physician or an 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 monitor the health and make arrangements for health services for Resident 2 and Resident 3. This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. Findings include: On 04/25/2025, the Department received complaints that alleged the provider did not arrange for medical follow ups and did not monitor the health of residents. On 05/12/2025 at approximately 11:00 a.m., Surveyor interviewed Registered Nurse (RN) D. RN D said residents are weighed monthly unless ordered more frequently. S/he said s/he reviewed the weights and vital signs monthly for any changes and was working with physicians for parameters on when they needed to be notified. RN D said Administrator A scheduled appointments and they had a wheelchair	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 19	N 431		

accessible van for transportation. Surveyor asked about Resident 3. RN D told Surveyor Resident 3 was in the hospital and was a pending discharge from the assisted living facility as they could no longer meet Resident 3's needs. RN D said Resident 3 was filling with fluids, had wet lung sounds, had decreased oxygen saturation, and a worsening skin condition. S/he said the mechanical lift they used for Resident 3 was for bariatric residents but it broke. RN D confirmed Resident 3 missed an appointment since the lift was broken. Surveyor asked if they monitored Resident 3's weights for changes in fluid retention. RN D said they did not monitor his/her weights.

On 05/12/2025 at approximately 12:00 p.m., Surveyor interviewed Adult Protective Service (APS) E on the phone. APS E told Surveyor Resident 3 was in the hospital for fluid overload. APS E said the provider's shower chair was broken, their bariatric mechanical lift was broken, and Resident 3 missed appointments. APS E said, "If [Resident 3] made [his/her] appointments, maybe [s/he] would not have been hospitalized." APS E said they (Eagles Rest at Pepin) cannot meet the needs of the residents they are admitting. S/he said s/he received 2 -3 reports per week on concerns related to the vulnerable residents that reside in the facility. APS E told Surveyor Resident 2 was sent to the emergency department and was septic. S/he said Resident 2 had a high temperature, which caused seizures. S/he had a stroke secondary to sepsis and died. APS E said the provider failed to seek medical care for Resident 2.

On 05/15/2025, Surveyor reviewed Resident 2's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 20	N 431		

Resident 2 had multiple diagnoses, including hypertension, asthma, history of stroke, and dementia. S/he had a legal representative.

The provider's Physician Visit Form indicated Resident 2 had a doctor's appointment on 05/23/2024 to recheck hypertension, mild dementia and asthma. The physician signed and dated the form on 05/23/2024, with orders to return for next appointment in 3 months.

Surveyor did not locate any other documentation in Resident 2's record to indicate s/he had a 3 month follow-up with his/her doctor.

On 05/15/2025, Surveyor reviewed Resident 2's medical record from his/her physician. The last encounter on 03/27/2025 was a medication refill request. Documentation indicated Resident 2's last doctor's visit was 05/23/2024. Resident 2 did not have a 3 month follow-up of his/her appointment on 05/23/2024.

Resident 2's weights history from 01/01/2025 - 05/12/2025 indicated s/he was weighed In January and February. His/her last weight was 223 pounds on 02/04/2025.

On 02/21/2025 and 02/23/2025, staff documented Resident 2 exhibited a rash near his/her neck.

On 03/01/2025, staff documented Resident 2 had a low grade fever.

On 03/06/2025, staff documented Resident 2 was confused.

On 03/25/2025, staff documented a quarter-sized rash on Resident 2's legs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 21 There was no documentation of notification to Resident 2's physician. On 04/17/2025 staff documented: "around 4:15 pm i [sic] went down to get [Resident 2] up for supper [sic] when i [sic] walked in i [sic] thought [s/he] was snoring so i [sic] said hey [Resident 2] [sic] lets [sic] get up for supper and [s/he] didn't respond, so i [sic] flipped the light on and and [sic] walked over and said [his/her] name again and that [sic] when i [sic] noticed that [s/he] was shaking and foaming at the mouth, i [sic] then yelled for the other staff member and had [him/her] come in there while [sic] ran down to call 911 ..." Pre-hospital Care Report, dated 04/17/2025, indicated the ambulance was dispatched at 4:24 p.m. and arrived on scene at 4:50 p.m. The narrative read, in part: "Upon arrival, the patient was laying [sic] supine in [his/her] reclining chair having visible convulsions. At the time, the patient was unresponsive to verbal stimuli ... The patient was visibly cyanotic with snoring respirations but was breathing on [his/her] own ... the patient was unresponsive to sternum rubs ..." Documentation from the emergency department, dated 04/17/2025, indicated Resident 2's diagnoses were sepsis due to unspecified organism, unresponsive, and acute respiratory failure. Resident 2 was noted to have a fever of 104 degrees Fahrenheit, hypoxic (low oxygen saturation) with saturation around 80% and tachycardic (high heart rate). Resident 2 had "copious amounts of brown drainage from the nose." Resident 2 was intubated and was given fluids and antibiotics per sepsis protocol. On 04/30/2025, Administrator A documented	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 22 Resident 2 was discharged from the facility due to being deceased. The provider did not ensure Resident 2 was seen by his/her medical provider for regularly scheduled appointments. They did not monitor his/her weights monthly and did not notify his/her physician when s/he exhibited a changes in condition. Resident 2 became septic and died. RESIDENT 3 On 05/20/2025, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 09/05/2023. S/he had multiple diagnoses including: severe morbid obesity, depression, chronic venous hypertension, and lymphedema. Prior to his/her admission, documentation from a skilled nursing facility indicated Resident 3 had an order for daily weights for 3 days, then weekly weights for 3 weeks, then monthly weights following. The order indicated to re-weigh if there was a change of 5 pounds since the previous weight. Surveyor reviewed Resident 3's vital signs and weight history from 01/01/2025 - 05/12/2025. There was one weight documented on 02/20/2025, which indicated s/he weighed 539 pounds. Vital signs were recorded on 01/31/2025 and 04/23/2025. There were no vital signs recorded in February and March on this record. On 02/06/2025, an internal medical physician documented the following "history of present illness" note: "[Resident 3] is a [age] [fe/male] [sic] was recently hospitalized at [hospital] with pneumonia, volume overload, acute hypoxic	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 23	N 431		

respiratory failure, urinary retention requiring Foley catheter, and encephalopathy ... [S/he] presents to the [hospital] ED (emergency department) today with complaints of worsening rash associated with discomfort. The assisted living facility is unable to provide the extent of care that [s/he] needs for [his/her] rash at this time. Patient states that [his/her] rash developed after initiation of IV (intravenous) antibiotics in the hospital. However [sic] this has documentation from outside records that patient did have erythematous skin lesions over [his/her] right thigh on 01/31/2025 while in the hospital."

Resident 3 was admitted and treated at the hospital from 02/06/2025 - 02/24/2025. S/he then returned to the assisted living facility.

On 03/24/2025, Resident was seen by his/her nurse practitioner for cellulitis in his/her breast and was prescribed an oral antibiotic. S/he was scheduled to have a follow-up appointment with his/her physician on 04/18/2025.

On 04/09/2025, 04/11/2025 and 04/14/2025, staff documented Resident 3's skin was starting to weep and ooze, and was red and warm to the touch.

04/13/2025, Administrator A documented: "monthly vitals were taken, her O2 (oxygen) was 85 and [his/her] facial skin looked gray, [sic][s/he] was advised to take a neb (nebulizer treatment) and recheck [his/her] O2 sat (saturation) was at 92. [s/he] refuses to be seen. Will recommend staff give [him/her] prn (as needed) nebulizer treatments and recheck [his/her] O2 as needed. The nurse was advised."

A fax to Resident 3's physician, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 24	N 431		

04/15/2025, read: "Resident's O2 has consistently been 80% - 85%. After nebs (nebulizer treatments) resident states [s/he] feels better, but O2 remains about 88%. Drops an hour after neb. Resident's lips cyanotic. Refusing ED (emergency department). Resident has 3 red, non [sic] blanchable, warm to touch areas on abd (abdomen) and upper L (left) thigh. Can we schedule nebs and have an as needed neb. [sic]"

Resident 3's physician returned a fax on 04/16/2025, with an order for ipratropium 0.5 milligrams (mg)/albuterol 3 mg, inhale 1 vial 4 times daily as needed for wheezing or shortness of breath. Prior to this order, Surveyor did not locate an order in Resident 3's record for nebulizer treatments. Surveyor did not locate documentation of staff monitoring Resident 3's oxygen saturation after 04/15/2025.

On 04/18/2025, Resident 3 did not attend his/her medical appointment as the bariatric mechanical lift was broken.

There was no documentation in Resident 3's record from 04/15/2025 - 04/22/2025 to indicate if staff were monitoring Resident 3's oxygen and skin.

On 04/22/2025, RN D documented a wound chart note that indicated Resident 3's wounds to his/her right and left calf had serous drainage, were red, and had an odor. S/he documented a wound to resident 3's left breast was red. No vital signs were documented.

04/24/2025 - "Resident was sent to the hospital this morning. Resident was having confusion, wounds on lower extremities were getting worse, temp (temperature) 100.5, O2 86% RA (room air)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 25 ..." Documentation from the hospital emergency department, dated 04/24/2025, indicated Resident 3 had diagnoses of: cellulitis of the lower extremities, acute on chronic congestive heart failure, lymphedema, and hypoxia (low oxygen). On 05/19/2025 at approximately 12:00 p.m., Surveyor interviewed Resident 3 on the phone. Resident 3 was still in the hospital. S/he told Surveyor s/he missed his/her recheck from his/her previous hospital stay due to the mechanical lift being broken. On 05/20/2025, from approximately 2:00 p.m. - 2:45 p.m., Surveyor interviewed RN D, RN H, Licensee B, and Consultant C on the phone. Surveyor asked why they could not have Resident 3 transferred for his/her appointment using the local fire department and/or ambulance. Licensee B told Surveyor they had only 1 local ambulance and they did not do non-emergent transfers. S/he said the county has 2 ambulances and the county has gotten upset in the past when they have requested an ambulance for non-emergent transport. Surveyor asked if they ever weighed Resident 3 while s/he resided at the facility. Licensee B told Surveyor they did not. S/he said they did have a wheelchair scale but they could not get Resident 3's wheelchair on the scale. Licensee B said they will consider these things before they admit residents in the future. The provider failed to monitor Resident 2 and Resident 3's vital signs and weights. The provider failed to arrange for Resident 2 and Resident 3 to be seen by their medical providers. Resident 2 became septic and died. Resident 3 was	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019052	A. BUILDING: _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLES REST AT PEPIN	1110 2ND ST PEPIN, WI 54759

(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 431	Continued From page 26 hospitalized with cellulitis of the lower extremities, acute on chronic congestive heart failure, lymphedema, and hypoxia.	N 431		