STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017895	A. BUILDING: _____ B. WING _____	R-C 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE RIDGE SENIOR LIVING	101 RIDGE RD OSCEOLA, WI 54020

(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 04/07/2025, Surveyor conducted a verification visit and complaint investigation at Eagle Ridge Senior Living. Data was collected through 04/09/2025. Four violations were corrected. One new violation was identified. One of 2 complaints was substantiated. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 30.	{N 000}		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment when his/her surgical staples were left in place for approximately 6 weeks. Findings include: The provider is licensed to care for 35 residents in the client groups traumatic brain injury, terminally ill, irreversible dementia/Alzheimer's disease, physically disabled, and advanced aged.	N 353		

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

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N 353	Continued From page 1 On 03/07/2025, the Department received a complaint about resident care. On 04/07/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 11/12/2024 and diagnosed with hyperlipidemia, unspecified dementia, depression, generalized anxiety disorder, restless leg syndrome, and Parkinson's Disease. Resident 1 has an activated power of attorney for health care (POAHC). On 04/07/2025 at approximately 12:36 PM, Surveyor interviewed Administrator A, who stated Resident 1 had a fall on 12/29/2024 resulting in a broken hip/femur. Resident 1 had surgery and returned to the provider within a week. Administrator A stated that when Resident 1 returned, s/he did not want to get out of bed, was often asleep, and was intermittently combative. Administrator A stated Resident 1 was eventually sent to the emergency room (ER) to have his/her surgical staples removed. On 04/08/2025 from 10:11 AM to 10:54 AM, Surveyor interviewed Administrator A by phone. Administrator A stated Resident 1 had another fall on 01/26/2025 and was taken to the ER for x-rays. Resident 1 had an x-ray on 01/26/2025 that showed no hip fracture. Administrator A stated s/he spoke with an orthopedic clinic regarding Resident 1's surgical post-op (operation) appointment. The orthopedic clinic stated there was no need for the surgical post-op appointment because Resident 1's x-rays completed on 01/26/2025 were negative for fracture. Administrator A stated s/he could not recall the date of this conversation and had no documentation of the conversation but did say	N 353		

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N 353	Continued From page 2 removal of the staples was not discussed. On 04/08/2025, from 2:15 PM to 2:32 PM, Surveyor interviewed Family B who stated that approximately a month ago, s/he received a call from Health Services Lead (HSL) C, who stated they had assumed Resident 1's "stitches" were dissolvable. On 04/09/2025 from 11:26 AM to 11:52 AM, Surveyor interviewed HSL C, who stated s/he shared the responsibility of reviewing discharge paperwork with Administrator A and Assistant Director (AD) E. HSL C stated s/he spoke with Registered Nurse (RN) D on 02/26/2025 about Resident 1's staples and s/he was not comfortable removing them as Resident 1's skin was growing over the staples. HSL C stated Resident 1's discharge hospital record was not read until "way after" s/he returned from the hospital. On 04/08/2025, Surveyor reviewed Resident 1's record. - On 12/30/2024, Resident 1 was admitted to the hospital, had hip surgery on 12/31/2024, and discharged on 01/03/2025. Resident 1's hospital discharge summary read, "There are staples to incision area. Do not remove staples. Staples will be removed at first post-op appointment ...Follow up with [Doctor] in 2 weeks at [Orthopedic Medical Provider] ...you can make an appointment by calling [Phone Number]. ...Patient is discharging back to the assisted living facility ...follow up with PCP (primary care provider)." -The provider's observation notes, dated 02/26/2025, read, "[RN D] was here to assess residents Rt (right) hip and upper femur and to possibly remove staples. The incision looked red and sore where the staples [sic] and [s/he]	N 353		

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N 353	Continued From page 3 advised me to call the family and have [him/her] brought to the er [sic] and have them [sic] the staples. I did talk to [Family B] to give the update and what [RN D] advised to be done ...[Resident 1's] [family] came in at 6:30pm and took [him/her] to the er [sic] ..." -The provider's observation note, dated 02/27/2025, read, "[Resident 1] did come back from the er [sic] last night with a total of 17 staples removed from [his/her] rt (right) hip and upper femur. Watch that this is not getting infected ..." The provider received Resident 1's hospital discharge instructions on 01/03/2025, directing them to make a post-op appointment 2 weeks after discharge. Administrator A stated the orthopedic facility called the provider to set up a post-op appointment and at that time it was decided Resident 1 did not need to be seen. Resident 1 had a fall on 01/26/2025 and was evaluated in the ER but the staple removal was not addressed. Resident 1's staples were removed on 02/26/2025, approximately 6 weeks past the time indicated on the discharge papers. The provider did not ensure Resident 1 received prompt and adequate treatment.	N 353		