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 09/09/2025

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 08/27/2025, Surveyors conducted a verification visit and complaint investigation for Eagle Ridge Senior Living. Data was collected through 09/09/2025. Two of 6 complaints were substantiated. Three new violations were identified. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 28.	{N 000}		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount.	N 406		

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

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This Rule is not met as evidenced by:
Based on observation, record review, and interview, the provider did dispose of medications when residents were discharged, or if a resident's medication had been changed or discontinued. The CBRF (community based residential facility) may retain a resident's medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication.

The provider is licensed to care for 35 residents in the client groups terminally ill, irreversible dementia/Alzheimer's disease, traumatic brain injury, physically disabled, and advanced aged.

Findings include:

On 08/22/2025, the Department received 2 complaints regarding medications.

On 08/27/2025 at approximately 10:40 AM, Surveyor interviewed Health Service Lead (HSL) B who stated the last medication destruction occurred on 08/15/2025. HSL B stated s/he knew they had 6 months of morphine that needed to be destroyed.

On 09/02/2025 at 6:46 AM, Surveyors received an email communication that included a document titled Medication Destruction and Return Log History. The last entry indicated medication was destroyed on 07/14/2025.

At approximately 10:45 AM, Surveyor observed there were multiple bubble packs of medications sitting on the counter in HSL B's office. HSL B

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N 406	Continued From page 2 stated these medications needed to be destroyed. HSL B showed Surveyor a drawer full of medications that needed to be destroyed. The following is a list of some of the mediations: Resident 1: Morphine 0.25ML dated 05/06/2024: 29 full syringes Resident 2: -Oxycodone 0.5ML dated 06/16/2025: approximately 30 full syringes -Morphine Sulf 0.5ML dated 06/13/2025: approximately 30 full syringes -Morphine Sulf 0.25ML dated 06/07/2025: approximately 18 full syringes -Morphine Sulf 0.5ML dated 06/13/2025: approximately 30 full syringes -Oxycodone HCL 0.5ML dated 06/14/2025: approximately 40 full syringes -Lorazepam 0.25ML dated 06/17/2025: approximately 35 full syringes -Haloperidol 0.25ML dated 06/17/2025: approximately 43 full syringes Resident 3: -Morphine Sulf 0.25ML dated 05/02/2025: approximately 15 full syringes -Morphine Suf 0.25ML dated 04/25/2025: approximately 19 full syringes -Haloperidol Lac 1ML dated 04/25/2025: approximately 42 full syringes At approximately 12:25 PM, Surveyor interviewed HSL B who stated s/he had lots on his/her plate and knew the medications should have been destroyed. The provider did not ensure medications were destroyed within 30 days of a change in medication or discharge of a resident for three of three residents reviewed.	N 406		

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N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on interview and record review, the provider did not provide services to meet Resident 4's needs for behavior management. Resident 4 displayed aggressive behaviors that were potentially harmful to him/herself, residents, and staff over 20 times from 05/01/2025 to 07/14/2025. Resident 4 was not administered PRN (as-needed) medication to manage behaviors, and scheduled medications were not administered as prescribed due to Resident 4's behaviors. The provider allowed Caregiver G, whose presence increased Resident 4's behaviors, to continue to care for Resident 4 after administrative staff discussed removing him/her from caring for Resident 4. Findings include: The provider is licensed to care for 35 residents in the client groups advanced age, physically disabled, irreversible dementia/Alzheimer's disease, traumatic brain injury, and terminally ill. Resident 4 had diagnoses of Parkinson's disease	N 433		

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and generalized anxiety disorder and was discharged on 07/14/2025.

According to the National Library of Medicine, omittance of medication used to treat Parkinson's disease can result in a drop in brain dopamine levels, which can result in consequences such as " ...a deterioration in disease control, with distressing symptoms such as tremor, pain, rigidity, dysphasia and immobility ..." and " ...an increased risk of developing the life-threatening complication of neuroleptic malignant-like syndrome ..." (Source: "What to do when people with Parkinson's disease cannot take their usual oral medications," Alty et. al., Pract Neurol. April 2016, 16(2):122-128. doi:10.1136/practneurol-2015-001267 (retrieval date - September 23, 2025).).

On 08/27/2025, at approximately 9:57 AM, Surveyors interviewed Hospice Nurse (HN) C, who stated staff at the facility did not administer as needed (PRN) medication appropriately. HN C stated s/he had spoken to Health Service Lead (HSL) B and Director D regarding staff not administering PRN medications. HN C stated Resident 4 was prescribed scheduled Carbidopa/Levodopa for his/her Parkinson's disease. HN C stated staff would consistently chart that Resident 4 had refused his/her Carbidopa/Levodopa and that staff would not administer PRN medications. HN C stated Resident 4 had behaviors and that staff would call hospice for assistance and direction. HN C stated s/he had tried to educate staff on administering medications. HN C stated the first time PRN Haloperidol was administered to Resident 4 for behaviors was when hospice was there to shower Resident 4. HN C stated the hospice agency would send more aides to the provider than to

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other facilities because they needed it there.

On 09/03/2025, Surveyor reviewed Resident 4's records.

Resident 4's individual service plan, which was dated the date of the survey (08/27/2025), read, in part:

" - MEDICATION MANAGEMENT - STAFF ADMINISTER (Medication Administration/Medication Management)
Resident's Needs: Resident requires staff to manage/administer medications.
Resident's Desired Outcomes: To receive assistance from staff with managing/administering medications per physician's orders.
- AGGRESSIVE/COMBATIVE (Behavior Patterns/Aggressive/Combative)
Directions: Resident requires staff assistance to manage/redirect aggressive/combative behaviors. [Resident 4] has a history of aggressive outbursts. Approach and redirect slowly and softly. Limit over stimulating [sic] environments. [S/he] responds well to vanilla ice cream and conversations about politics for redirection.
Resident's Needs: Resident requires staff assistance to manage/redirect aggressive/combative behaviors.
Resident's Desired Outcomes: To have interventions in place that help alleviate behaviors.
- INTERACTION - STAFF ASSISTANCE (Mental Health/Interaction)
Directions: Resident requires staff assistance/intervention to maintain positive interactions with others. Resident has a history of aggressive outbursts and intense frustration.

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When redirecting the behavior, speak slow and soft and avoid over stimulating [sic] environments.

Resident's Needs: Resident requires staff assistance/intervention to maintain positive interactions with others.

Resident's Desire Outcomes: To have pleasant and positive interactions with others."

Resident 4's progress notes contained the following:

- An entry by a caregiver, dated 05/28/2025, which read, "[Resident 4] had violent behavior. Broke [his/her] closet. Handed [sic] piece of wood and threatened employees with. Got prn [as-needed] and calmed down ..."
- An entry by a caregiver, dated 05/08/2025, which read, "Very aggressive tonight. Bad behaviors."
- An entry by Caregiver G dated 05/12/2025, which read, "Resident was changed and washed up [sic] had some behaviors [sic] was given prn [as-needed] for behavior [sic] was hitting [sic] punching staff ...prn [as-needed] was effective ..."
- An entry by Caregiver G, dated 05/21/2025, which read, "Resident attacked ras [resident assistants] stiked [sic] ra [resident assistant] with close [sic] fist in face ...Resident then struck another ra [resident assistant] in back of upper side [sic] shoulder blade ..."
- An entry by a caregiver, dated 05/21/2025, which read, "Resident shoved [his/her] dresser over, [sic] and broke it,tried [sic] to throw drawers at staff ..."
- An entry by a caregiver, dated 05/23/2025, which read, " ...very aggressive when trying to put to bed"
- An entry by Caregiver G, dated 05/24/2025, which read, "Resident came out very crabby hot

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N 433	Continued From page 7 headed [sic] was able to give prn [as-needed] was aggressive towards staff ...was changed after prn [as-needed] not effective [sic] was racing in [sic] hall raming [sic] wheel chair [sic] into mc [memory care] doors ..." - An entry by a caregiver, dated 05/29/2025, which read, "Became violent. Punching employees." - An entry by a caregiver, dated 05/31/2025, which read, " ...was combative and aggressive towards RAs [resident assistants] and other residents" - An entry by a caregiver, dated 06/03/2025, which read, "Resident was very aggressive and combative with staff, hitting and biting ect [sic]" - An entry by a caregiver, dated 06/04/2025, which read, "Resident was very combative and aggressive with staff throughout [sic] evening, threw staff on [sic] floor multiple times. Also got aggressive with other residents" - An entry by a caregiver, dated 06/08/2025, which read, " ...got combative a few times" - An entry by a caregiver, dated 06/10/2025, which read, "Very aggressive towards the end of the shift" - An entry by a caregiver, dated 06/10/2025, which read, "Was very combative at the beginning of the day ..." - An entry by a caregiver, dated 06/11/2025, which read, " ...became combative at night ..." - An entry by a caregiver, dated 06/12/2025, which read, "[Resident 4] did not take any of [his/her] meds today. [sic] Except for the control ones ..." - An entry by a caregiver, dated 06/15/2025, which read, "Punched RA [resident assistant] in the face ..." - An entry by a caregiver, dated 06/16/2025, which read, "Extremely aggressive and loud at the beginning of the shift ..."	N 433		

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N 433	Continued From page 8 - An entry by Caregiver G, dated 06/18/2025, which read, " ...[Resident 4] became agitated with staff ...resident became impatient [sic] started swinging at staff several times ...struck another staff member in lip [sic] gave [him/her] [sic] bloody lip ...tried to redirect [sic] unable too [sic]" - An entry by a caregiver, dated 06/18/2025, which read, "Resident was very stubborn and aggressive with RAs [resident assistants]" - An entry by Assistant Director (AD) E, dated 06/26/2025, which read, "We CANNOT be refusing [Resident 4's] Carbidopa. This is a very important medication for [his/her] Parkinson's disease. If [s/he] is sleeping [s/he] needs to be woken up. If [s/he] is refusing, it needs to be attempted multiple times." - An entry by a caregiver, dated 07/04/2025, which read, "Doesn't want to cooperate to get changed. Still want [sic] to fight." - An entry by a caregiver, dated 07/08/2025, which read, "Was combative when changing ..." - An entry by HSL B, dated 07/09/2025, which read, "[Resident 4] now has prn [as-needed] liquid Haloperidol; it is in the med [medication] cart with the morphine." - An entry by a caregiver, dated 07/13/2025, which read, "...would not wake up for [his/her] 12 pm meds [medications]." Resident 4's hospice records contained the following: - A narrative by hospice staff, dated 05/08/2025, which read, "...[Resident 4] was...yelling at staff and throwing self on [sic] floor...No recorded PRN [as-needed] use of RX [prescription] for agitation was used and last PRN [as-needed] dose of Diazepam was 5/06/25. [S/he] has scheduled [quetiapine]...and 25 mg [milligrams] 3x/day PRN [as-needed] for agitation...Discussed need to use	N 433		

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PRN [as-needed] [quetiapine] for agitation more freely..."
-A narrative by HN C, dated 05/22/2025, which read that HSL B reported " ...[Resident 4] punched 2 staff members yesterday while in the restroom and getting into the shower. Report that 3 staff members came into restroom, as [s/he] was sitting naked and were instructing [him/her] to get into shower. [HSL B] reports [s/he] feels [his/her] behavior for this incident was related to how staff approached [Resident 4] in a small [sic] confined space and [s/he] felt threatened. [HSL B] and [Director D] (facility administrators) are having a mandatory meeting with staff about approaching residents and de escalation [sic]. [HSL B] reports [s/he] feels [Resident 4] lashes out with these behaviors with one specific staff member and [s/he] will be requesting this staff member does not care for [Resident 4] anymore. Spoke to [Resident 4] about incident and [s/he] stated, "I told them to leave me alone and they wouldn't, they just keep on and won't leave me alone" ..."
- A narrative by HN C, dated 05/29/2025, which read, "...Staff report [Resident 4] broke another dresser last evening (has broken a total of 2 dressers). Facility will no longer allow [him/her] to have [sic] dresser in [his/her] room due to [him/her] breaking them. [S/he] also broke the corner of [his/her] counter top [sic] in [sic] room. Staff do not appear to be utilizing PRN [as-needed] Diazepam before behaviors escalate. Staff has not utilized PRN [as-needed] [quetiapine] since May 1...Facility administration have removed one staff member [Caregiver G] from caring for [Resident 4], they feel [his/her] behaviors are better when [s/he] is not in the memory care unit working with [him/her] ..."
- A narrative by HN C, dated 06/05/2025, which read, " ...Staff report [Resident 4] was aggressive

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last night with NOC [night shift] staff, possibly hitting/biting staff members and attempting to choke them. Documented in pt [patient] chart states pt [patient] was aggressive to staff and other residents ...Today staff report they were unable to get [Resident 4] to take all of [his/her] morning medications...Reinforced to staff they need to get [him/her] to take [his/her] medications to be effective and prevent behavioral issues ..."
- A narrative by HN C, dated 06/19/2025, which read, " ...Staff have not utilized PRN [as-needed] Haldol for behaviors yet ...Staff report [sic] [Resident 4] punched staff member in the face yesterday. [Caregiver H] reports [s/he] and [Caregiver G] (facility staff [Resident 4] does not get along with) were assisting [him/her] to the restroom. [Caregiver H] reports [Caregiver G] was quick in [his/her] cares with [Resident 4] and [s/he] punched [Caregiver H] in [sic] face as [s/he] was at [his/her] face level while assisting [him/her]. [Caregiver H] reports [Resident 4] does not do well with quick movements or being rushed through cares ..."
- A narrative by HN C, dated 06/23/2025, which read, " ...Staff continue to report aggressive behaviors from [Resident 4]...however they have not given PRN [as-needed] doses of Haloperidol. Encouraged staff to utilize medication PRN [as-needed]. Over past week, staff have not been giving [him/her] [his/her] Carbidopa-Levodopa on a regular basis, on average [Resident 4] only getting 2x doses each day, [s/he] [sic] scheduled to have 4x doses per day...Educated this is most likely what caused mobility issues this past weekend and contributed to [Resident 4] having falls recently. Stressed importance of [Resident 4] getting these medications and getting them on schedule in order for [him/her] to maintain mobility ..."
- A narrative by HN C, dated 06/26/2025, which

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read, " ...Requested staff to administer PRN [as-needed] Haloperidol before personal cares today which was administered by writer...Otherwise no PRN's [as-needed] [sic] have been administered despite staff reporting [Resident 4] has been agitated past few days. RN [Registered Nurse] continues to educate facility staff to give PRNs [as-needed] when needed...Staff continue to not give [Resident 4] [his/her] [Carbidopa/Levodopa], [s/he] continues to only get 2 out of 4 times per day, staff charting pt [patient] "refuses" ...[AD E] placed alert on [Resident 4's] MAR [medication administration regimen] to staff stating [s/he] cannot refuse this medication, however this alert was placed on [his/her] chart this morning, despite [him/her] being made aware of the issue on Monday 6/23 ..."

Resident 4's medication administration record (MAR) from May, June, and July 2025 indicated s/he was prescribed Carbidopa/Levodopa, scheduled 4 times a day. The May MAR indicated Resident 4's scheduled Carbidopa/Levodopa had not been administered 6 times. The June MAR indicated Resident 4's scheduled Carbidopa/Levodopa had not been administered 20 times. The July MAR (dated 07/01/2025-07/14/2025) indicated Resident 4's scheduled Carbidopa/Levodopa had not been administered 6 times. The July MAR indicated Resident 4 had been prescribed PRN Haloperidol for behaviors and agitation. The July MAR indicated Haloperidol had been administered 4 times to Resident 4 between 07/01/2025 and 07/14/2025.

Resident 4's MARs from May, June, and July indicated that after 05/29/2025, Caregiver G administered or attempted to administer

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(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 433	Continued From page 12	N 433		

medications to Resident 4 on 1 day in May, 10 days in June, and 3 days in July.

An incident report written by HSL B for Resident 4, dated 02/28/2025, read, in part:

"The following were left in the cards [bubble-packed medications] at the end of the month cycle for the month of February and were never given and were destroyed by Kitty Litter: Pramipexole 0.5mg tablets (3 were destroyed), Tramadol HCL 50mg (3 were destroyed), Diazepam 5mg (2 destroyed), Tamsulosin 0.5mg (1 destroyed), Acetaminophen 500mg (2 destroyed), Quetiapine Fumarate 25mg (4 destroyed), Quetiapine Fumarate 50 mg (2 destroyed), Carbidopa-Levo 25-100mg (7.5 Destroyed), Memantine HCL 10mg (1 destroyed), Mexiletine 200mg (2 destroyed), Eliquis 5mg (2 destroyed)."

An incident report written by HSL B for Resident 4, dated 07/05/2025, read, in part:

"Resident didn't receive [his/her] 12pm Carbidopa and [his/her] 2pm meds [medications] Acetaminophen 500mg, Diazepam 5mg, Pramipexole 0.5mg and Tramadol 5mg. I did reach out to [resident assistant] and [s/he] asked another ra [resident assistant] to give the 12pm carbidopa [sic], I did call [Caregiver G] and [s/he] said the carbidopa [sic] was not given. I asked [Caregiver G] about 2pm meds [medications] and they were not given."

On 09/04/2025, at approximately 1:13 PM, Surveyor interviewed AD E. AD E stated staff were talked to regarding not giving routine and/or PRN medications. AD E stated hospice taught a class on medications and recognizing signs for

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 09/09/2025

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EAGLE RIDGE SENIOR LIVING	101 RIDGE RD OSCEOLA, WI 54020

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N 433	Continued From page 13 when medications were needed, and that this had been discussed in staff meetings. AD E stated Carbidopa must be administered at the exact, correct time. The provider did not implement services to manage Resident 4's behaviors that may have been harmful to his/herself or others.	N 433		
N 492	83.45(1)(a) Exterior areas. Exterior areas. The CBRF shall maintain the yard, any fences, sidewalks, driveways and parking areas of the CBRF in good repair and free of hazards. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not maintain the yard and sidewalk area of the community based residential facility (CBRF) in good repair and free of hazards. On 08/22/2025, the Department received a complaint regarding the exterior area of the facility. Findings include: The provider is licensed to care for 35 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, advanced aged, terminally ill, and traumatic brain injury. On 08/27/2025, at approximately 10:22 AM, Surveyor interviewed Maintenance A. Maintenance A stated the back patio had uneven slabs of concrete due to rainwater from the gutter	N 492		

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 09/09/2025

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N 492	Continued From page 14 washing out underneath the patio. Maintenance A stated s/he had been in communication with the owner regarding a solution. At approximately 11:29 AM, Surveyor observed the patio located at the back exit of the building had uneven slabs, which had caused a lip to form, approximately a half inch to an inch deep. At approximately 12:00 PM, Maintenance A provided Surveyors with a document titled, "Total Monthly/Annual Savings." The document read, in part: "Concrete Jacking/Raising (Back Patio) This issue has happened due to the building having no or improper drainage...There is a down spout on the back side of the building...which has been washing out the sand and base under the back concrete patio area which has made one large section of the concrete to sing [sic] and creating a lip trip hazard. (I was told one person has already tripped on this hazard area)." Maintenance A indicated the document was sent to the owner on 07/15/2025, and that s/he had communicated with the owner regarding the issue again on 08/01/2025. Maintenance A stated s/he had begun employment with the provider a few months prior, and that the patio had been in that condition when s/he had started. The provider did not ensure that the yard and sidewalks of the CBRF was in good repair and free of hazards.	N 492		