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 _____	R-C 10/18/2024

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 10/10/2024, Surveyor conducted a complaint investigation and verification visit at Eagles Rest at Pepin. Data collection continued through 10/18/2024. The complaint was substantiated. Three deficiencies were identified. Two of 3 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) XK2K11, dated 06/11/2024, SOD ZTUE12, dated 11/09/2023, and SOD ZTUE11, dated 08/10/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 27	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the	N 164		

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 _____	R-C 10/18/2024

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 164	Continued From page 1 provider did not ensure a written report was sent to the department when law enforcement was called to the CBRF (community based residential facility) in response to an incident that jeopardized the health, safety, or welfare of residents on 06/09/2024. Findings include: This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. On 07/09/2024, the Department received a complaint regarding resident care. On 10/10/2024 at approximately 11:30 AM, Surveyor interviewed Administrator A and asked if any resident altercations had occurred from June 2024 to current. Administrator A stated there was an altercation between Resident 4 and Resident 5 when they were outside smoking. Administrator A further stated the residents argued and the police were called by Resident 4 when s/he was physically struck by Resident 5. Administrator A further stated, "It wasn't a formal thing. The police came out, talked to them and they were separated. There was no formal report made." On 10/10/2024, Surveyor reviewed staff charting documentation for Resident 4 and Resident 5. On 06/09/2024 at 3:15 PM, staff charted Resident 4 was hit by another resident with their cane and sustained scratches on his/her arm and wrist. Resident 4 stated Resident 5 knocked his/her glasses off his/her face and stole his/her cigarettes.	N 164		

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 _____	R-C 10/18/2024

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 164	Continued From page 2 The incident report documented another resident (Resident 6) was involved (present) for the incident. On 10/10/2024 at approximately 1:20 PM, Surveyor interviewed Caregiver C. Caregiver C stated Resident 5 had a history of altercations and tended to stay in his/her room. Caregiver C stated s/he recalled the incident between Resident 4 and Resident 5 and stated the police were called by Resident 4, who had his/her own cell phone. On 10/10/2024, Surveyor reviewed the facility's electronic record, maintained by the Department. The provider did not submit a self-report for the above incident.	N 164		
{N 387}	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.	{N 387}		

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 _____	R-C 10/18/2024

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 387}	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents were involved in developing the individual service plan (ISP), when the ISP was not signed by the resident and the resident's legal representative, as appropriate, acknowledging their involvement in, understanding of, and agreement with, the plan. Findings include: This is a repeat deficiency. See Statement of Deficiency (SOD) XK2K11, dated 06/11/2024, SOD ZTUE12, dated 11/09/2023, and SOD ZTUE11, dated 08/10/2023. On 10/10/2024 at 1:30 PM, Surveyor reviewed the following ISPs with Administrator A: Resident 1 had an admission date of 08/26/2024. The ISP, dated 09/25/2024, was not signed by the resident or the resident's legal representative. Administrator A stated the ISP was reviewed over the phone with Resident 1's guardian. Resident 2 had an admission date of 08/07/2024. The ISP, dated 09/19/2024, was not signed by the resident. Administrator A stated Resident 2 was his/her own decision-maker and informed Surveyor s/he had not reviewed the ISP with the resident. Resident 3 had an admission date of 08/21/2024. The ISP, dated 09/19/2024, was not signed by the resident. Administrator A stated Resident 3 was his/her own decision-maker and informed	{N 387}		

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 _____	R-C 10/18/2024

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 387}	Continued From page 4 Surveyor s/he had not reviewed the ISP with the resident.	{N 387}		
N 503	83.46(1)(b) Portable space heaters prohibited. The use of portable space heaters is prohibited except for Underwriters Laboratories listed electric heating equipment that is listed for permanent attachment to the wall. Portable space heaters shall have an automatic thermostatic control and shall be physically attached to a wall. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure an approved portable space heater was used in a resident bedroom when it was not physically attached to a wall. Findings include: On 07/09/2024, the Department received a complaint regarding temperatures in the building. On 10/10/2024 at approximately 12:00 PM, Surveyor observed a portable heating and cooling device in Resident 6's room. The device was in use, on wheels, and vented out the window. The device was not physically attached to the wall. On 10/10/2024 at 12:05 PM, Surveyor interviewed Licensee B about the heating and cooling device used in Resident 6's room. Licensee B stated s/he had purchased that for Resident 6 to use because s/he was frequently adjusting the facility temperatures without approval. Licensee B expressed concerns with Resident 6 turning on the heat during the	N 503		

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 _____	R-C 10/18/2024

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 503	Continued From page 5	N 503		

summer months and stated s/he froze up the air conditioning units by adjusting the thermostats. Licensee B further stated that the portable unit in use by Resident 6 was a "heat pump unit, similar to in-wall units," so s/he thought it was acceptable.

On 10/10/2024 at 12:47 PM, Surveyor requested the device manual from Licensee B via email.

On 10/11/2024, Licensee B provided Surveyor with a copy of the manual via email. The manual read, in part:

"Warning"... "DO NOT modify the length of the power cord or use an extension cord to power the unit. DO NOT share a single outlet with other electrical appliances. Improper power supply can cause fire or electrical shock."

"Caution"... "This appliance is not intended for use by persons (including children) with reduced physical, sensory or mental capabilities or lack of experience and knowledge, unless they have been given supervision or instruction concerning use of the appliance by a person responsible for their safety."

Surveyor reviewed Resident 6's face sheet. The face sheet listed "unspecified dementia, severe with psychotic disturbance" as a diagnosis.