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 10/08/2025

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 09/23/2025, Surveyors conducted a standard survey and verification visit for Statement of Deficiency (SOD) XK2K13 and SOD 6CN911. Data collection continued through 10/08/2025. Nine of 13 deficiencies identified in SOD XK2K13, dated 04/09/2025 were corrected. The deficiencies identified in SOD 6CN911, dated 05/20/2025 were corrected. Sixteen deficiencies were identified. Six of 16 deficiencies were repeat deficiencies. See SOD ZTUE11, dated 08/10/2023, SOD ZTUE12, dated 11/09/2023, and SOD XK2K13, dated 04/09/2025. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 22	{N 000}		
{N 196}	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, record review, and interview, the licensee did not ensure the provider, and its operation complied with all laws governing the facility. Findings include:	{N 196}		

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

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{N 196}	Continued From page 1 This is a repeat deficiency and is being cited for the fourth time. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023, SOD ZTUE12, dated 11/09/2023, and SOD XK2K13, dated 04/09/2025. The provider is licensed to care for 50 adults in the client groups developmentally disabled, terminally ill, irreversible dementia/Alzheimer's, advanced aged, and physically disabled. The provider was licensed on 12/05/2022. Between July 2023 and June 2025, the Department conducted 7 surveys at the facility. Six of 7 surveys were prompted by complaints. Complaint investigations resulted in the substantiation of 18 of 23 complaints related to programming, investigating caregiver misconduct, reporting, physical environment/safety, administration, resident rights, and care. The provider was issued a No New Admit Order on 09/14/2023, and 05/21/2025. See Statement of Deficiencies (SOD) ZTUE11, dated 08/10/2023, SOD ZTUE12, dated 11/09/2023, SOD XK2K11, dated 06/11/2024, SOD XK2K12, dated 10/18/2024, SOD XK2K13, dated 04/09/2025, and SOD 6CN911, dated 05/20/2025. The Department issued an Order to Comply with Requirements with the providers for 6 SODs that read, in part: "ORDER TO COMPLY WITH REQUIREMENTS ... effective immediately, the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the	{N 196}		

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{N 196}	Continued From page 2	{N 196}		

residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, within 45 days of receipt of this notice, the licensee shall achieve and maintain substantial compliance with all requirements. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request." See SOD 6CN911, dated 05/20/2025, SOD XK2K11, dated 06/11/2024, SOD XK2K12, dated 10/18/2024, SOD XK2K13, dated 04/09/2025, SOD ZTUE12, dated 11/09/2023, and ZTUE11, dated 08/10/2023.

The Notice and Order that accompanied SOD ZTUE11, dated 08/10/2023 included an order not to admit new or additional residents. The Special Orders read, in part: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b), EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS ... the licensee shall correct all violations identified in Statement of Deficiency (SOD) ZTUE11 and will achieve substantial compliance with all laws and administrative rules governing the facility and its operation prior to expiration of the facility's Probationary License. IF the licensee has not achieved substantial compliance with all laws and administrative rules governing the facility and its operation AND IF the violations identified in SOD ZTUE11 remain substantially uncorrected, the PROBATIONARY LICENSE for Eagles Rest at Pepin may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE ..."

The Notice and Order that accompanied SOD ZTUE12 extended the order not to admit new or additional residents until all violations were

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{N 196}	Continued From page 3	{N 196}		

corrected from SOD ZTUE12. Special Orders read, in part: "...the licensee shall comply with the requirements specified by Wis. Stat. ch. 50 and Wis. Admin. Code ch. DHS 83 that establish the standards for the operation of the Community Based Residential Facility in order to protect and promote the health, safety and welfare of the residents. AS SOON AS PRACTICABLE AND WITHOUT DELAY, the licensee shall achieve and maintain substantial compliance with all requirements prior to the expiration of the probationary license on 11/30/2023. All operational and resident records required as evidence of compliance with applicable rules will be available to department representatives upon request.

The Notice and Order that accompanied SOD XK2K13, dated 04/09/2025, included an order not to admit new or additional residents that read, in part: "Based on the results of the Department's investigation, and pursuant to Wis. Stat. § 50.03(5g)(b)7., EFFECTIVE UPON RECEIPT OF THIS NOTICE and ORDER, the Department of Health Services HEREBY ORDERS that Eagles Rest at Pepin NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in SOD #XK2K13 are corrected, compliance is verified by the Department, and this Order is rescinded in writing."

The Notice and Order issued for SOD XK2K13 and SOD 6CN911 also included the following order:

"POSTING OF NOTICES
According to Wis. Admin. Code DHS §§ 83.13(3)(a) and 83.14(2)(h), each facility shall immediately upon receipt post next to its CBRF license, and in a public area that is visually and

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{N 196}	Continued From page 4 physically available, any citation/statement of deficiency, notice of revocation, notice of non-renewal, and any other notice of enforcement action. Citations and statements of deficiency shall remain posted for ninety (90) days following receipt. Notices of revocation, non-renewal, and other notices of enforcement action shall remain posted until a final determination is made. Therefore, the license shall immediately post this Notice and Order letter and it shall remain posted until a final determination is made." On 09/23/2025, upon verification of SOD XK2K13 and SOD 6CN911, neither SOD was posted in the facility. The current survey was prompted by two verification visits (SOD XK2K13, dated 04/09/2025, and SOD 6CN911, dated 05/20/2025) and a standard survey. Nine of 13 deficiencies were corrected in SOD XK2K13, and the deficiencies in SOD 6CN911 were corrected. The following concerns were identified throughout the course of the survey: - The provider did not post the two previous outstanding SODs, as directed in the Notice and Order letters issued. - Employees were not screened for communicable disease, including tuberculosis. - Employees did not receive department approved training timely. - Employees were not trained in task specific duties. - Residents were not screened communicable diseases, including tuberculosis. - Residents did not receive explanation of	{N 196}		

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{N 196}	Continued From page 5	{N 196}		

resident rights or grievance procedure upon admission.
- ISPs were not updated or accurate to resident needs.
- Scheduled psychotropic medications were not reviewed quarterly.
- The provider did not ensure equipment was stored in a clean manner and in good repair.
- Food was not stored properly or at safe temperatures.
- Rooms utilized for storage were not kept clean and orderly.
- Toxic substances were not securely stored.
- The furnace was not serviced within 3 years.
- Combustibles were not stored at least 3 feet from water heaters.
- Fire drills were not conducted quarterly.
- A background information disclosure form was completed approximately 4 months after the date of hire.

On 09/23/2025 at approximately 11:00 AM, Consultant C and RN H stated they were hired for consulting services at the facility. RN H informed Surveyor Licensee B was no longer responsible for facility operations and was currently responsible for overseeing the financial side of the business.

On 09/29/2025 at 11:25 AM, Surveyor interviewed Administrator A and Registered Nurse (RN) H via phone and asked what corrective measures had been implemented since the previous survey. RN H and Consultant C was hired to address operational concerns. RN H stated the biggest change made was with management and staff. RN H indicated they removed staff who were not providing cares that were safe and effective for residents and had put a focus on on-going training. RN H informed Surveyor they had

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{N 196}	Continued From page 6 changed several processes to increase communication with providers and better track new orders and changes. Administrator A stated, "We have new orientation sheets, for staff to check to know how to do certain cares. We just started it last night with NOC (overnight) shift." Cross Reference N0203 DHS 83.14(2)(h) Posting: License, Deficiencies, Revocations N0220 DHS 83.17(2)(a) Employees Screened For Communicable Disease N0239 DHS 83.20(2)(a)-(d) Department-Approved Training Courses N0247 DHS 83.22(1)-(4) Task Specific Training N0302 DHS 83.28(4)(a) Resident Health Screening And Documentation N0343 DHS 83.32(2)(a) Explanation Of Rights, Grievance Procedure N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes N0407 DHS 83.37(1)(h) Scheduled Psychotropic Medications N0446 DHS 83.41(1)(b) Equipment N0452 DHS 83.41(3)(b) Food Safety N0498 DHS 83.45(2) Storage Areas N0499 DHS 83.45(3) Toxic Substances N0504 DHS 83.46(1)(c) Heating System Maintenance N0507 DHS 83.46(1)(f) Combustibles N0525 DHS 83.47(2)(d) Fire Drills	{N 196}		
N 203	83.14(2)(h) Posting: license, deficiencies, revocations The licensee shall post the CBRF license, any statement of deficiency, notice of revocation and any other notice of enforcement action in a public	N 203		

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N 203	Continued From page 7 area that is visually and physically available. A statement of deficiency shall remain posted for 90 days following receipt. Notices of revocation and other notices of enforcement action shall remain posted until a final determination is made. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the statement of deficiency (SOD), and notice of enforcement action, was posted in a public area that is visually and physically available until a final determination is made. Findings include: 09/23/2025, at 9:31 AM, Surveyor interviewed Administrator A and asked if SOD XK2K13, dated 05/21/2025, and SOD 6CN911, dated 06/02/2025, was posted in a public area as a final determination was not made. Administrator A stated they were posted by the front door for 45 days and were subsequently removed. Administrator A stated the SODs were currently in the front office. Administrator A stated s/he was not aware they needed to be posted until a final determination was made and thought the requirement was 45 days.	N 203		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening	N 220		

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N 220	Continued From page 8 and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 employees were screened for clinically apparent communicable disease within 90 days before the start of employment. Findings include: On 09/23/2025, Surveyor reviewed employee records. Cook J had a hire date of 08/29/2025. The record did not contain documentation to show Cook J had been screened for clinically apparent communicable disease. At approximately 12:40 PM, Surveyors requested documentation to reflect Cook J was screened for communicable disease. At 3:08 PM, Surveyors were provided a copy of Cook J's communicable disease screen and were advised Registered Nurse (RN) D completed the screen with Cook J on the day of the survey while Surveyors were onsite.	N 220		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may	N 239		

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N 239	Continued From page 9 be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 employees obtained all department approved training as required. Caregiver L did not have training in fire safety, or first aid and choking within 90 days after starting employment. Caregiver L, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these	N 239		

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N 239	Continued From page 10 duties. Findings include: On 09/23/2025, Surveyor conducted a review of 4 employees to verify compliance with department approved training requirements. Surveyor requested training records from Administrator A for Caregiver L. Caregiver L had a hire date of 05/09/2025. Caregiver L's record contained evidence training for fire safety was completed on 08/18/2025; approximately 101 days after hire. Caregiver L's record contained evidence training for standard precautions was completed on 08/11/2025; approximately 94 days after hire. Caregiver L's record did not contain evidence of training or meeting an exemption for first aid and choking. On 09/23/2025, Surveyor verified the above information was current and accurate by reviewing the Community-Based Care and Treatment training registry. On 09/23/2025 at approximately 2:30 PM, Surveyor discussed the requirements with Registered Nurse (RN) H and RN D. RN D confirmed Caregiver L was not on the training registry for first aid and choking and did not meet an exemption for first aid and choking. RN D confirmed Caregiver L was responsible for performing job tasks that exposed him/her to blood or other bodily fluids, and did not meet an exemption for standard precautions training prior to assuming these job duties. RN D confirmed	N 239		

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N 239	Continued From page 11 Caregiver L did not receive fire safety training within 90 days.	N 239		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food	N 247		

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N 247	Continued From page 12 preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 4 employees obtained all task specific training. Cook J, who performed dietary duties, did not have training in dietary services within 90 days after assuming these job duties. Findings include: On 09/23/2025, at approximately 9:30 AM, Surveyors interviewed Administrator A. Administrator A stated Cook J was scheduled to work in the kitchen that day. At approximately 10:00 AM, Surveyors observed Cook J in the kitchen completing dietary tasks. At 12:40 PM, Surveyor requested dietary training for Cook J. Dietary Training The record for Cook J, hired on 08/15/2025, did not contain evidence of training upon hire or evidence of meeting an exemption for dietary training. At 3:03 PM, Administrator A provided Surveyor with a document titled, "User Learning [Cook J]." There were 16 titles related to dietary training on the list. The "completed" section of each training was blank. Administrator A stated Cook J was	N 247		

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N 247	Continued From page 13 scheduled to complete the trainings on the list. Administrator A confirmed the trainings had not been completed. Administrator A stated Cook J was recently rehired. When asked about any trainings completed from previous employment, Administrator A stated Surveyor had access to Cook J's employee record. At 3:45 PM, Surveyor interviewed Registered Nurse (RN) H regarding Cook J's dietary training. When asked if Cook J had evidence of dietary training in his/her file, RN H stated they did not have records to reflect dietary training completed by Cook J. On 09/29/2025, at approximately 11:30 AM, Surveyors interviewed Administrator A, RN D, and RN H via phone. Surveyors requested Cook J's original hire dates and job responsibilities prior to his/her rehire on 08/15/2025. At 2:09 PM, Surveyors received an email from Administrator A with multiple attachments. The attachment titled, "[Cook J] rehire information" indicated Cook J was originally hired on 11/08/2023 for an assistant director position. Cook J transitioned to Dietary Manager in July 2024 and submitted his/her resignation in April 2025. Cook J's responsibilities included, "Managed the kitchen, all personnel issues, menus, temps (temperatures), order, ensuring staff completed their tasks. New resident meeting to get preferences of food and beverage charts..." Cook J was originally hired to perform dietary tasks in July 2024 through April 2025. The provider was unable to provide evidence s/he received dietary training within 90 days after assuming those duties.	N 247		

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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 247	Continued From page 14 Cross Reference N0446 DHS 83.41(1)(b) Equipment N0452 DHS 83.41(3)(b) Food Safety	N 247		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident recently admitted was screened for clinically apparent communicable disease, including tuberculosis (TB) within 90 days before or 7 days after admission. This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. Findings include:	N 302		

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N 302	Continued From page 15 On 09/23/2025, Surveyor requested to review Resident 4's record. Resident 4 had an admission date of 05/27/2025. The record did not contain evidence Resident 4 was screened for clinically apparent communicable disease, including TB. At approximately 2:30 PM, Registered Nurse (RN) D confirmed Resident 4 did not have a communicable disease screen or TB test on file, and informed Surveyor s/he thought if the physician checks the "yes" box free of communicable diseases the resident did not need a TB test or further screening. At approximately 3:30 PM, Surveyor was informed RN D had completed a screening at approximately 3:00 PM on the date of survey.	N 302		
N 343	83.32(2)(a) Explanation of rights, grievance procedure. Explanation of resident rights, grievance procedure, and house rules. Before the admission agreement is signed by the resident or the resident ' s legal representative or at the time of admission, the CBRF shall provide a copy of and explain resident rights, the grievance procedure under s. HFS 83.33 and the house rules to the person being admitted, the person ' s legal representative, and family members of the person. The resident or the resident ' s legal representative shall be asked to sign a statement to acknowledge the receipt of an explanation of resident rights. The CBRF shall document the date and to whom the information was provided. This Rule is not met as evidenced by: Based on record review and interview, the	N 343		

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N 343	Continued From page 16	N 343		

provider did not obtain a signed statement acknowledging the provider explained resident rights, and house rules to residents, for 3 of 3 resident records reviewed.

Findings include:

On 09/23/2025, Surveyor reviewed resident records. Surveyor identified the following:

Resident 2 was admitted on 03/01/2025. Resident 2's record did not include documentation indicating resident rights, and house rules were explained to or signed by Resident 2 or Resident 2's legal representative upon admission.

Resident 3 was admitted on 12/17/2024. Resident 3's record did not include documentation indicating resident rights was explained to or signed by Resident 3 or Resident 3's legal representative upon admission.

Resident 4 was admitted on 05/27/2025. Resident 4's record did not include documentation indicating resident rights and house rules were explained to or signed by Resident 4 upon admission.

On 09/23/2025 at 2:24 PM, Registered Nurse (RN) H informed Surveyor house rules and resident rights are typically reviewed at the time of admission, and stated Administrator A was instructed to review and provide a copy of the house rules to Resident 4 on the date of survey. RN H stated s/he reviewed the provider's current admission agreement and it did not have a spot for resident signatures acknowledging the receipt of resident rights and house rules.

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{N 389}	Continued From page 17	{N 389}		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 resident individual service plans (ISP) reviewed was updated with changes in condition. This is a repeat deficiency. See Statement of Deficiency (SOD) XK2K13, dated 04/09/2025. Findings include: On 09/23/2025, Surveyor reviewed 3 resident records. Resident 2 was admitted on 03/01/2025 with diagnoses that included dementia. His/her ISP, signed 06/16/2025, read: "Resident's Needs: Resident has been identified as a fall risk. Resident has had around 3 falls in the last 12 months. Resident Desired Outcomes: To be free of falls."	{N 389}		

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{N 389}	Continued From page 18 The ISP did not include interventions to prevent Resident 2 from falling. Resident 2's record included evidence of 10 falls between the dates 06/23/2025 (7 days after his/her last ISP update) and 09/19/2025. Resident 2 sustained injuries from 5 of these falls (06/23/2025, 06/24/2025, 06/28/2025, 07/31/2025, and 09/15/2025). One incident report (dated 09/19/2025) included an intervention to prevent future falls that read, "Staff to remind resident how to use call light and the importance of calling for assistance before getting out of bed." On 09/29/2025 at 11:25 AM, Surveyors interviewed Administrator A, RN D, and RN H regarding Resident 2's fall interventions. RN H stated caregivers provided reminders to Resident 2 to use his/her walker, they checked on Resident 2 frequently, and they posted a sign in Resident 2's room that read, "Call. Do not fall."	{N 389}		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication.	N 407		

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N 407	Continued From page 19	N 407		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure scheduled psychotropic medications were reviewed at least quarterly for 2 of 2 residents reviewed (Resident 1 and Resident 2).

Findings include:

On 09/23/2025, Surveyor reviewed resident records.

Resident 1 was admitted to the facility on 04/05/2024. Resident 1's record indicated s/he was prescribed various scheduled psychotropic medications since admission:
- buspirone from 04/04/2024 through 12/30/2024
- sertraline from 10/20/2024 through 11/04/2024
- quetiapine from 09/17/2024 through 09/23/2025 (active medication)

Resident 1's record included evidence of 2 psychotropic medication reviews, dated 09/05/2024 and 08/05/2025. The review in 2024 was completed by Registered Nurse (RN) K and the review in 2025 was completed by RN D.

Resident 2 was admitted to the facility on 03/01/2025. Resident 2's record indicated s/he was prescribed scheduled psychotropic medication (citalopram for depression) at admission. On 08/19/2025, Resident 2 began taking bupropion hydrochloride 300 mg daily. According to Resident 2's active medication list and September 2025 medication administration record (MAR), these medications were being administered to Resident 2 daily. Resident 2's record did not include evidence his/her scheduled

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N 407	Continued From page 20 psychotropic medications were reviewed quarterly in 2025. On 09/29/2025 at 11:25 AM, Surveyors interviewed Administrator A, RN D, and RN H. RN D stated resident primary care physicians were responsible for reviewing resident psychotropic medications for desired responses and side effects. RN D stated if the primary care physician was unable to review the medications, then RN D tried to set them up with a psychiatrist. Surveyor requested evidence of quarterly psychotropic reviews for Resident 1's and Resident 2's for the last 12 months (September 2024 through September 2025). On 09/29/2025 at 2:07 PM, Surveyors received an email from Administrator A with Resident 1's 2 psychotropic reviews noted above and 1 psychotropic medication review for Resident 2, dated 09/24/2025. Resident 1's and 2's scheduled psychotropic medications were not reviewed by an RN, pharmacist, or practitioner at least quarterly.	N 407		
{N 446}	83.41(1)(b) Equipment. Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider	{N 446}		

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{N 446}	Continued From page 21 did not ensure all equipment was stored in a clean manner and in good repair. This is a repeat deficiency. See Statement of Deficiency (SOD) XK2K13, dated 04/09/2025. Findings include: On 09/23/2025 at approximately 10:00 AM, Surveyors toured the provider's kitchen. Surveyors identified the following concerns: -Freezer door seal was not tight. -Fluctuating refrigerator temperatures documented on the log. At approximately 10:04 AM, Surveyor opened the freezer door and observed a ziplock bag with 5 hot dogs. The hot dogs were not frozen. Surveyor discussed the concern with Cook J. Cook J stated the freezer's door handle had been fixed, but acknowledged a possible issue with the seal on the door. Cook J confirmed the hot dogs were not frozen. Cook J opened 2 containers of ice cream that had melted and were in a liquid consistency (not frozen). Two boxes of bread were also near the freezer door containing several loaves of bread that were not frozen. Cook J stated deliveries were scheduled on Wednesdays so the bread had been delivered approximately 5-6 days prior. At approximately 12:10 PM, Surveyors interviewed Consultant C. Consultant C stated an outside agency was on-site and replacing the seal on the freezer door at that time. Consultant C stated s/he had also turned down the temperature on the refrigerator as several temperatures were noted to be above 40 degrees. Consultant C stated they put in a service ticket for the	{N 446}		

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{N 446}	Continued From page 22 refrigerator and took it out of service. Cross Reference N0452 DHS 83.41(3)(b) Food Safety	{N 446}		
{N 452}	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure food was stored under sanitary conditions for the prevention of food borne illnesses. The temperature of the refrigerator was not at or below 40 degrees Fahrenheit. This had the potential to affect 20 of 20 residents residing in the facility.	{N 452}		

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{N 452}	Continued From page 23 This is a repeat deficiency. See Statement of Deficiency (SOD) XK2K13, dated 04/09/2025. Findings include: The provider is licensed to care for up to 50 residents in the client groups developmentally disabled, terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 09/23/2025, at approximately 10:00 AM, Surveyors toured the provider's kitchen. Surveyors identified the following concerns: -A refrigerator with a digital thermometer on the top right corner indicated a temperature of 46 degrees Fahrenheit (F). The refrigerator had a posting on it that read, "Bread/Buns. Meats. Meats Pulled." There was a piece of tape on the right-side door that contained a handwritten number 2 on it. Surveyor reviewed a document titled, "Fridge and Freezer Temp (Temperature) Log" for September 2025. There were 6 columns corresponding to different freezers and refrigerators in the kitchen area. Each had a temperature logged for "AM (Morning)" and "PM (Afternoon)." In the column identified as the "Meat" refrigerator, the temperature read at or above 40 degrees F on 43 different occasions between 09/01/2025 and 09/23/2025. At approximately 10:05 AM, Surveyors interviewed Cook J. Surveyors shared concerns with the temperature observed on the meat refrigerator. When asked what the process was if a problem was identified with a refrigerator, Cook J stated s/he would move the food inside of the refrigerator to another refrigerator and inspect it.	{N 452}		

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{N 452}	Continued From page 24 At approximately 12:30 PM, Surveyors interviewed Consultant C regarding the refrigerator temperatures. Consultant C stated the provider submitted a service ticket for the refrigerator and they were taking the refrigerator out of service. The food was taken out of the refrigerator and moved to a different location. According to the United States Department of Agriculture, "Leaving food out too long at room temperature can cause bacteria to grow to dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40° F and 140° F, doubling in number in as little as 20 minutes. This range of temperature is often called the 'Danger Zone.'...Keep hot food hot-at or above 140° F...Keep cold food cold-at or below 40° F." (Source: United States Department of Agriculture-Food Safety and Inspection Service, Danger Zone, 06/28/2017, https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/danger-zone-40f-140f (retrieval date 09/05/2024).) Cross Reference N0446 DHS 83.41(1)(b) Equipment	{N 452}		
N 498	83.45(2) Storage areas. Storage. The CBRF shall maintain storage areas in a safe, dry and orderly condition. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure storage areas were kept safe and orderly.	N 498		

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N 498	Continued From page 25 Findings include: The provider is licensed to care for 50 residents within the client groups terminally ill, irreversible dementia/Alzheimer's disease, advanced aged, developmentally disabled, and physically disabled. On 09/23/2025 at approximately 10:35 AM, Surveyor toured the facility. The facility had multiple unlocked rooms that were being used as storage. In the 300 hallway, there were 4 rooms and 1 closet that were used for storage. Each area lacked organization; the items in each area appeared to have been tossed or placed into the areas without order. The rooms were so full of items that Surveyor was unable to walk through the room without climbing or stepping over items. The rooms contained trip hazards and dangerous materials such as floor cleaning machines, broken screens, window coverings, construction materials, drill bits, nail guns, power tools, unlabeled spray bottles, wire, cables, etc. At approximately 12:30 PM, Surveyor and Consultant C toured the basement storage area. The stairs had broken glass on them from what appeared to be a long florescent light bulb. Surveyor observed many cardboard boxes at the base of the stairs that appeared to have been thrown down the stairs or tossed into a pile. Some of these boxes contained holiday decorations. The storage area appeared to have no organization. At 4:25 PM, Surveyor discussed the concerns above with Administrator A, Registered Nurse (RN) H, and RN D. RN H stated s/he believed the doors were locked.	N 498		

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N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were securely stored. This is a repeat violation. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. Findings include: The provider is licensed to care for 50 residents within the client groups terminally ill, irreversible dementia/Alzheimer's disease, advanced aged, developmentally disabled, and physically disabled. On 09/23/2024 at 10:35 AM, Surveyor toured the building. The room tabled "chemical storage" was not locked. Surveyor observed the following toxic substances. Each item had precautionary statements ranging from "keep out of reach of children" to "Danger: Corrosive": - Over 15 single gallons of paint and multiple 5-gallon buckets of paint - Multiple gallon-jugs of AlkaKleen, a corrosive heavy duty foaming cleaner - Floor finish remover - D-Germ disinfectant spray - Multiple cans of Smoke Check, an aerosolized substance used to check fire protection systems At approximately 10:37 AM, Surveyor entered an	N 499		

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N 499	Continued From page 27 unlocked laundry area. The laundry area had multiple 5-gallon containers of laundry chlorine de-stainer. The containers read, "Danger: Keep out of reach of children.... Danger: Corrosive." Surveyor checked the chemical storage area and the laundry area multiple times throughout the survey. The doors remained unlocked, and the toxic substances remained available to anyone who entered the rooms. At 4:26 PM, Surveyor interviewed Administrator A, Registered Nurse (RN) H, and RN D. Administrator A stated all chemicals should be stored in the locked housekeeping closet in the 400 hallway. Administrator A stated the laundry room door was typically left unlocked.	N 499		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was	N 504		

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N 504	Continued From page 28 serviced at least once every 3 years. Findings include: On 09/23/2025, at 2:00 PM, Surveyor requested to see the most current furnace inspection. On 09/24/2025, at 2:17 PM, Surveyor received an email from Registered Nurse (RN) H with an attachment. The attachment read, in part, "[Heating Agency] is continuing to look for a furnace report from 2022. They reported to me that the account was reassigned and they had to have a senior management personnel look into the older records. If we receive today [sic] I will submit to you. We do have [Heating Agency] coming out for the 2025 furnace inspection on Monday the 29th at 8:00am." As of 09/29/2025, the provider had not submitted any further documentation to reflect the furnace was inspected in 2022.	N 504		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation, interview, and record review the provider did not ensure combustibles were stored at least 3 feet away from 3 of 5 water heaters in the facility. Findings include: On 09/23/2025 at approximately 12:30 PM, Surveyor and Consultant C observed the facility's	N 507		

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 10/08/2025

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

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N 507	Continued From page 29 5 water heaters. There was a wooden shelf with combustible materials (cardboard boxes) on it within 1 foot from kitchen water heater. The water heater in the 400 hallway had a cleaning cart stored within 5 inches of the water heater. There was combustible materials (fabric, flammable chemicals, and paper products) on the cleaning cart. There was also a bulletin board with papers hanging on the wall within 3 feet of the water heater. The water heater in the basement was surrounded by cardboard boxes that held various things like holiday decor. The boxes were stored without any apparent organization within 3 feet of the water heater. There was also a set of movable wooden steps within 3 feet of the water heater. Consultant C stated s/he was not aware of the requirement to keep combustible materials at a distance of at least 3 feet from the water heaters. Consultant C stated s/he would address the issue immediately. At approximately 2:00 PM, Consultant C provided Surveyor with a document indicating s/he educated staff on 09/23/2025 on the requirement to keep combustible items at least 3 feet from the water heaters. The document indicated the provider would be completing regular audits to ensure compliance was maintained. Consultant C stated s/he removed the combustible materials noted above.	N 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 525	Continued From page 30	N 525		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct fire evacuation drills at least quarterly, and did not conduct at least one fire evacuation drill annually that simulated the conditions during usual sleep hours for calendar year 2023 and 2024. Findings include: The provider is licensed to care for up to 50 residents in the client groups developmentally disabled, terminally ill, physically disabled, advanced aged, and irreversible dementia/Alzheimer's. On 09/23/2025, Surveyor reviewed the provider's	N 525		

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 10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 525	Continued From page 31 safety records. Surveyor did not locate any fire drills for 2023 and 2024. At 2:24 PM, Surveyor interviewed Registered Nurse (RN) H. When asked about the fire drill and evacuation records for 2023 and 2024, RN H stated s/he was still looking for the records. On 09/24/2025, at 2:17 PM, Surveyor received an email from RN H with a document attached. The document stated, in part, "We were unable to find any fire drill records from previous years."	N 525		