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 03/12/2026

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 03/11/2026, Surveyors conducted a verification visit and three complaint investigations at Eagles Rest at Pepin. Data collection continued through 03/12/2026. Fifteen of 16 deficiencies identified in Statement of Deficiency (SOD) XK2K14, dated 10/08/2025 were corrected. Two of 3 complaints were substantiated. Four deficiencies were identified. Two of 4 deficiencies were repeat deficiencies. See SOD ZTUE11, dated 08/10/2023, and SOD XK2K11, dated 06/11/2024. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 19	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form	N 158		

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 _____	R-C 03/12/2026

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 158	Continued From page 1 provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not investigate alleged caregiver misconduct and did not take immediate steps to ensure the safety of all residents after a report of caregiver misconduct was filed on 02/15/2026. The CBRF did not maintain documentation of investigation. This is a repeat deficiency. See Statement of Deficiency XK2K11, dated 06/11/2024. Findings include: This provider is licensed to serve up to 50 residents in the client groups terminally ill, irreversible dementia/Alzheimer's, advanced aged, physically disabled and developmentally disabled. Under Wisconsin DQA regulations in Chapter DHS 13, Publication (P-00976, dated 07/2024) titled, "Misconduct Definitions" (https://www.dhs.wisconsin.gov/publications/p00976.pdf), "Abuse" is defined as: An act or repeated acts by a caregiver or non-client resident, including but not limited to restraint, isolation, or confinement that, when contrary to the entity's policies and procedures, not a part of the client's treatment plan and done intentionally to cause harm. "Neglect" is defined as an intentional omission or intentional course of conduct by a caregiver or a non-client resident, including but	N 158		

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 03/12/2026

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 158	Continued From page 2	N 158		

not limited to restraint, isolation or confinement, that is contrary to the entity's policies and procedures, is not part of the client's treatment plan and, through substantial carelessness or negligence.

On 03/05/2026, the Department received a complaint regarding grievances.

On 03/11/2026, Surveyor requested to review grievances and requested documentation of any investigations conducted for caregiver misconduct in 2026 from Assistant Administrator (AA) B.

Surveyor reviewed the grievance binder, provided by AA B. Surveyor reviewed a grievance form written by Resident 1, dated 02/15/2026, "Seen [Resident 2] (elec (electric) [sic] wheelchair) stuck in bathroom and the buzzer was going off and I could hear [Resident 3] banging on the wall yelling for help with the buzzer going off. I walked down and asked if they were going to assist [Resident 2] and [Resident 3] who was [sic] half on the floor. Worker was not doing help [sic] to handicap [sic] resident [sic] 2-incidents: One [Resident 3] ... stuck yelling for nurse and when I went down to tell that [s/he] needed help- but they said [s/he] does this all the time. [s/he] [sic] was yelling for help & banging on the wall. [Administrator A] did nothing but showed favoritism. Nothing was done ... Both happened Night shift in 1st week of January 26 ..." Resident 1 identified Caregiver J was working.

The form documented follow-up completed on 02/17/2026 by Case Manager (CM) I, which read, in part, "I met with [Resident 1] in room on 02/17/2026 to discuss [his/her] concerns addressed above. [Resident 1] states that to

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 03/12/2026

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 158	Continued From page 3 [his/her] knowledge 'nothing is ever done to the ones who keep doing it'... states that [s/he] is tired of hearing lights go off for long periods of time knowing that someone is needing help ..." The bottom portion of the form was left blank, and the following areas were not completed: -Date of resolution -Investigation associate's review of resolution with resident & family. -Signature of associate -Administrator reviewed resolution -Signature of Administrator On 03/11/2026 at approximately 12:00 PM, Surveyor interviewed Administrator A and asked if there was any follow-up or investigation completed for Resident 1's grievance submitted on 02/15/2026. Administrator A stated CM I was responsible for grievance follow-up and s/he was unaware of the grievance up until 03/05/2026 or 03/06/2026 when s/he found the grievances on CM I's desk. Administrator A stated CM I was responsible for handling grievances but did not forward them to him/her timely. Administrator A stated the concerns were actively being investigated. Administrator A further stated CM I was scheduled one day per week with the current census. Administrator A stated Resident 1 did not identify any names when s/he followed-up with him/her, so s/he did not feel there was a named caregiver identified. Surveyor reviewed the grievance report where Resident 1 wrote, "[Caregiver J was aide]." On 03/11/2026, Administrator A provided Surveyor with a copy of an email, dated 03/05/2026, s/he had sent to Registered Nurse (RN) C, AA B, and Licensee H which stated s/he and AA B had followed up with residents who had	N 158		

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 03/12/2026

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 158	Continued From page 4 filed grievances, including Resident 1, reminded staff no phones were allowed at the desk, and that call lights are the responsibility of all staff and should be answered in a timely manner. On 03/11/2026 at approximately 3:00 PM, Surveyor interviewed Resident 1. Resident 1 stated s/he submitted a written grievance approximately 2 weeks ago regarding staff treatment of residents, including Caregiver J and Administrator A. Resident 1 shared his/her concern that the staff s/he reported were still working. Resident 1 stated s/he filed a grievance with CM I, and Administrator A followed up with him/her 4 days after. Resident 1 stated s/he felt like his/her concerns regarding staff treatment of residents was not investigated, and management did not follow-up timely. Documentation of an investigation was not available for review, and the provider did not ensure allegations of caregiver misconduct were investigated immediately.	N 158		
N 223	83.18(1) Employee records maintained and current. A separate record for each employee shall be maintained, kept current, and at a minimum, include: (a) Written job description including duties, responsibilities and qualifications required for the employee; (b) Beginning date of employment; (c) Educational qualifications for administrators; (d) Completed caregiver background check following procedures under s. 50.065, Stats., and ch. HFS 12; (e) Documentation of training, or exemption verification.	N 223		

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 03/12/2026

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 223	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Case Manager (CM) I's record was maintained. Findings include: On 03/05/2026 the Department received a complaint regarding grievances. On 03/11/2026, Surveyor requested to review CM I's record. CM I had a hire date of 11/19/2025 per the employee roster provided by Administrator Assistant (AA) B. CM I's record did not contain a written job description. On 03/11/2026 at approximately 12:00 PM, Surveyor interviewed Administrator A. Administrator A stated CM I was responsible for grievances and various other tasks, and had recently been reduced to one day per week due to the current census. Administrator A confirmed CM I did not have a written job description maintained in his/her employee record. On 03/12/2026 at approximately 1:30 PM, Surveyor interviewed CM I via phone and asked what his/her job responsibilities were. CM I stated s/he did not receive a job description upon hire but had received one earlier that day. CM I stated, "When I was hired they told me I would be handling grievances, and I do not have any experience doing that. I reached out to Registered Nurse (RN) C and asked what to do if I received a grievance about the Administrator, and s/he told me to send them to [him/her]. I did that and now they're telling me to send them to both [RN C] and [Administrator A]. I have not received any kind of training on this.	N 223		

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 03/12/2026

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 223	Continued From page 6 Administrator A gave me a form for 're-training,' and I told [him/her] I was never trained so I did not sign the form that said they were 're-training' me on. They went over it (verbally) with me. I am not a HR (human resource) person, and I don't pretend to be. I submitted a grievance from [Resident 1] about [Caregiver J] and [Administrator A] but never received any kind of training."	N 223		
{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 ZTUE11, dated 08/10/2023 and SOD XK2K14, dated 10/08/2025. 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 03/11/2026, at 11:15 AM, Surveyor toured the building. The room labeled "Laundry. Notice. Not an exit" was not locked. Surveyor observed the following toxic substances. Each item had	{N 499}		

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 03/12/2026

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 499}	Continued From page 7 precautionary statements ranging from "keep out of reach of children" to "hazards to humans and domestic animals": - 3-gallon jugs of ultra bleach. - 5-gallon jugs of laundry chlorine de-stainer When facing the back of the room, there was a gray metal door on the right side of the building leading to the outside that was unlocked and did not have an alarm. At approximately 11:17 AM, Surveyor entered an unlocked laundry area labeled "Laundry room. Keep door closed and locked at all times." The door had keypad access on it but had not latched securely. Surveyor observed the following toxic substances: -Ultra bleach -Bio-Suds enzyme detergent At approximately 4:05 PM, Surveyor interviewed Administrator A, Administrative Assistant (AA) B, and Registered Nurse (RN) C. RN C stated the areas with the toxic chemicals should have been locked.	{N 499}		
N 509	83.46(2)(a) Ventilation. All rooms and areas shall be well ventilated. Ventilation is not required in a refrigerated storage room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all rooms were well ventilated for 3 of 3 bathing/shower rooms.	N 509		

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 03/12/2026

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 509	Continued From page 8 Findings include: On 03/04/2026, the Department received a complaint regarding the physical environment. On 03/11/2026, at approximately 10:30 AM, Surveyor toured the building with Caregiver D. Caregiver D stated the bathing and shower rooms did not have adequate ventilation and got very "hot and steamy" while assisting residents with showers. Caregiver D informed Surveyor that Resident 1 has "almost passed out" due to the heat and steam during showers and they prop the door open during showers. Caregiver D informed Surveyor the rooms all had heaters, but they were not in use since "the fire." On 03/11/2026, at approximately 10:50 AM, Surveyor interviewed Caregiver E about the bathing and shower rooms. Caregiver E stated, "They get warm. Most residents use the 200-hall shower room." On 03/11/2026 at 2:30pm, Surveyor observed the 200-hall shower room with Caregiver F and Caregiver G. Caregiver G informed Surveyor it was his/her 2nd day of training. Surveyor asked if there was proper ventilation while assisting residents with bathing needs as Surveyor observed a box on the ceiling, but no switch was observed to turn on a fan. Caregiver F stated the shower room gets "very steamy and hot" so staff "prop open the door and use a 'privacy screen' to keep the air flowing" during showers. Caregiver F stated the privacy curtain is stored in the room with the bathtub (located directly next to shower room). Surveyor observed the privacy curtain, white fabric on a metal frame with wheels. Caregiver F and G acknowledged the curtain could easily be moved by anyone walking by as	N 509		

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 03/12/2026

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 509	Continued From page 9 the shower room door was in a high traffic area. Surveyor observed a box on the ceiling, but there was no switch to activate. A wall heater was observed in both shower/bathing rooms, but Caregiver F stated they do not use the heaters. Caregiver F confirmed the majority of residents use the 200-hall shower room for showers. Surveyor observed the 400-hall shower ceiling also had a box unit, but no switch activate. On 03/12/2026 at approximately 1:00 PM, Surveyor interviewed Administrator A and Registered Nurse (RN) C about the bath/shower room concerns related to ventilation. RN C stated Licensee H checked the fans in the bathing rooms and stated there was "movement of air being pulled up." RN C further stated they would connect with someone to inspect to see if they were not operating at full capacity. RN C stated per Licensee H, the fans are "always on so there is no switch and were working when tested."	N 509		