

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 07/15/2026
NAME OF PROVIDER OR SUPPLIER EAGLES REST AT PEPIN		STREET ADDRESS, CITY, STATE, ZIP CODE 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 07/08/2026, Surveyor conducted a verification visit and three complaint investigations at Eagles Rest at Pepin. An additional complaint was received on the date of survey and was investigated. Four of 4 complaints were unsubstantiated. The deficiencies identified in Statement of Deficiency XK2K15, dated 03/12/2026 were corrected. No deficiencies were identified. Census: 30	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE