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 11/09/2023

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 11/08/2023, Surveyors conducted a verification visit, seven complaint investigations and a self-report review at Eagles Rest at Pepin. Data collection continued through 11/09/2023. Three of 7 complaints were substantiated. Six deficiencies were identified. Three of 6 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 30	{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. This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. Findings include: The provider is licensed to care for 50 adults in the client groups advanced aged,	{N 196}		

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 11/09/2023

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 196}	Continued From page 1 developmentally disabled, terminally ill, irreversible dementia/Alzheimer's and physically disabled. The Department issued an Order to Comply with Requirements with the provider's last SOD, issued 09/14/2023, that read, in part: "ORDER TO COMPLY WITH REQUIREMENTS 1. Pursuant to Wis. Stat. § 50.03(5g)(b)3., 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 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." The Notice and Order that accompanied SOD ZTUE11, issued on 09/14/2023, also included the following order, that read: "ORDER NOT TO ADMIT NEW OR ADDITIONAL RESIDENTS 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 [facility name] NOT ADMIT ANY NEW OR ADDITIONAL RESIDENTS until all violations in Statement of Deficiency ZTUE11 are corrected, compliance is verified by the Department, and this Order is rescinded in writing." The Notice and Order also included special	{N 196}		

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 11/09/2023

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 196}	Continued From page 2 orders with the previous SOD which read, in part: "SPECIAL ORDERS 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 that [facility name]: PROBATIONARY LICENSE: 1. Based on the results of the Department's investigation, and pursuant to Wis. Stat. §§ 50.03(5g)(b)3. and (b)6., 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 [facility name] may be INVALID and the Department may NOT ISSUE A REGULAR LICENSE for [facility name], [facility address]. This NOTICE is provided in accordance with: - Wis. Stat. § 50.03(4m)(b), whereby, if the applicant for licensure as a community-based residential facility has not been previously licensed under this subchapter or if the community-based residential facility is not in operation at the time application is made, the department shall issue a probationary license. Prior to the expiration of a probationary license, the department shall evaluate the community-based residential facility. In evaluating the community-based residential facility, the department may conduct an inspection of the community-based residential facility. If, after the	{N 196}		

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 11/09/2023

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 196}	Continued From page 3	{N 196}		

department evaluates the community-based residential facility, the department finds that the community-based residential facility meets the applicable requirements for licensure, the department shall issue a regular license under sub. (4)(a)1.b. If the department finds that the community-based residential facility does not meet the requirements for licensure, the department may not issue a regular license under sub. (4)(a)1.b.
- Wis. Admin. Code § DHS 83.08(2), whereby the Department shall deny a probationary license or regular license to any applicant who does not substantially comply with any provision of Wis. Admin. Code ch. DHS 83 or Wis. Stat. ch. 50.
2. Pursuant to Wis. Stat. § 50.03(5g)(b)6., WITHIN 7 DAYS of receipt of this notice, the licensee shall provide Resident 1 ' s, Resident 2 ' s, Resident 3 ' s, Resident 5 ' s and Resident 6 ' s legal representative and case manager (if any), with a copy of Statement of Deficiency ZTUE11 and a copy of this Notice and Order letter. The licensee shall retain documentation, acceptable to the Department, to verify compliance with Order #2. Acceptable documentation will be a signed, certified mail receipt or a verification letter or email from each legal representative and case manager. The documentation required by Order #2 will be available to department representatives upon request."

The provider was issued a probationary license on 12/05/2022. The current survey was prompted by a verification visit survey to determine compliance for 16 deficiencies identified in Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023), 7 complaints, and a self-report review.

Three of 7 complaints were substantiated, and

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 11/09/2023

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 196}	Continued From page 4 the following concerns were identified throughout the course of the survey: -The provider admitted a resident to the facility after the No New Admit Order was issued on 09/14/2023. -Residents did not receive medication as prescribed. -Individual service plan (ISP) was not developed with the resident or resident's legal representative, as appropriate. -ISPs were not implemented and followed as written. -Admission agreement was not on file upon resident admission to the facility. -Written medication orders were not maintained in resident records. On 11/07/2023, the Department received a complaint about admissions. The provider was issued an order not to admit new or additional residents on 09/14/2023. On 11/08/2023 at approximately 8:00 AM, Surveyors requested a resident roster with dates of admission. Administrator A provided Surveyor with a roster. The roster showed Resident 1 had an admission date of 09/14/2023. Surveyor asked if the facility had any recent admissions. Administrator A stated, "We have a no new admit order, so it's been a while. [Resident 1] was the last." Administrator A informed Surveyor s/he was aware of the order not to admit new or additional residents and stated they had not admitted anyone since. Surveyor requested to review Resident 1's record and asked if Resident 1 received any medications. Administrator A stated, "Nope, [s/he] doesn't get any meds." On 11/08/2023 at approximately 8:30 AM,	{N 196}		

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 11/09/2023

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 196}	Continued From page 5 Surveyor reviewed Resident 1's medication administration record (MAR) with Licensed Practical Nurse (LPN) E. LPN E informed Surveyor Resident 1 was prescribed Quetiapine at bedtime and stated staff administer the medication to Resident 1. Surveyor requested to see the MAR starting 09/14/2023, which was listed as Resident 1's admission date in the electronic charting system and on the staff roster provided by Administrator A. Resident 1 did not have a record of medication administration until 10/06/2023. Surveyor asked LPN E if Resident 1 was admitted with an order for Quetiapine. LPN E stated, "Yes, [s/he]'s been on it since [s/he] came." On 11/08/2023 at approximately 9:15 AM, Surveyor interviewed Cook C and Dietary Aide (DA) D and asked who the last resident admission was. Cook C and DA D confirmed Resident 1 was the last admission and informed Surveyor Resident 1 was admitted "the first week of October." On 11/08/2023 at approximately 10:25 AM, Surveyor contacted Resident 1's activated Power of Attorney for Health Care (POAHC) via phone and asked for verification of Resident 1's admission date. Resident 1's POAHC stated, "I know it was the 5th or 6th of October. [S/he] had to go get a physical and TB test before [s/he] could move in." On 11/08/2023 at approximately 11:50 AM, Surveyors reviewed additional paperwork in Resident 1's record which contradicted the "09/14/2023" admission (move-in) date listed in the facility's electronic charting system and roster. An office visit summary, dated 09/20/2023 read, in part, "Patient presents for a physical if [sic]	{N 196}		

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 11/09/2023

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 196}	Continued From page 6	{N 196}		

prior to entering assisted living facility at the [facility name]..." The office visit summary shows a physical exam and Tuberculosis screening was administered on 09/20/2023.

After several interviews and questions, Director of Staff (DS) B and Administrator A informed Surveyor that Resident 1 was accepted on 09/14/2023 and was supposed to move in that day but did not move in that day because Resident 1's spouse was in the hospital. Administrator A and DS B later confirmed Resident 1 moved in on 10/06/2023.

Surveyor discussed the concern with Administrator A and Licensee F that Resident 1's admission date was not clearly presented when initially asked for verification from the provider, and documentation provided showed an incorrect admission date for Resident 1, which corresponded to the date the provider was issued an order not to admit new or additional residents.

On 11/08/2023 at approximately 2:15 PM, Administrator A stated, "[S/he] came here to move in on that date and didn't because of [his/her] [spouse]." Administrator A stated s/he discussed going forward with the move with Licensee F and they both decided to allow admission on 10/06/2023 even though they were aware of the order not to admit new or additional residents as of 09/14/2023. Administrator A further stated, "We received payment on 09/14/2023 but I would have to check with Licensee F on dates."

On 11/08/2023 at approximately 1:15 PM, Surveyor interviewed Resident 1's POAHC and asked if s/he paid for services beginning 09/14/2023. Resident 1's POAHC stated, "I wrote

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 11/09/2023

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 196}	Continued From page 7 a check the day [s/he] moved in. The 5th or 6th of October, I can't remember which one of those dates." On 11/08/2023 at approximately 2:30 PM, Surveyor interviewed Licensee F and asked why s/he decided to move forward with the admission after receiving an order not to admit new or additional residents. Licensee F stated s/he thought it was a contractual agreement and thought the date they accepted Resident 1 to move in was considered the "admission date." Surveyor informed Licensee F that they did not have a signed or dated admission agreement on file for Resident 1. Cross Reference: N0310 DHS 83.29(2) Admission Agreement Include Services, Charges N0352 DHS 83.32(3)(h) Rights Of Residents: Receive Medication N0387 DHS 83.35(3)(b) Service Plan Development: Parties Involved N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0400 DHS 83.37(1)(a) Written Order For Medication, Supplements	{N 196}		
N 310	83.29(2) Admission agreement include services, charges The admission agreement shall be given in writing and explained orally in the language of the prospective resident or legal representative. Admission is contingent on a person or that person ' s legal representative signing and dating an admission agreement. The admission agreement shall include all of the following:	N 310		

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 11/09/2023

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 310	Continued From page 8 (a) An accurate description of the basic services provided, the rate charged for those services and the method of payment; (b) Information about all additional services offered, but not included in the basic services. The CBRF shall provide a written statement of the fees charged for each of these services; (c) The method for notifying residents of a change in charges for services; (d) Terms for resident notification to the CBRF of voluntary discharge. This paragraph does not apply to a resident in the custody of a government correctional agency; (e) Terms for refunding charges for services paid in advance, entrance fees, or security deposits in the case of transfer, death or voluntary or involuntary discharge; (f) A statement that the amount of the security deposit may not exceed one month ' s fees for services, if security deposit is collected; (g) Terms for holding and charging for a resident ' s room during a resident ' s temporary absence. This paragraph does not apply to a resident in the custody of a government correctional agency; (h) Reasons and notice requirements for involuntary discharge or transfer, including transfers within the CBRF. This paragraph does not apply to a resident in the custody of a government correctional agency. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide Resident 1's legal representative with an admission agreement upon admission; the agreement was not in writing, was not explained orally and was not signed or dated by the resident or their legal representative. Findings include:	N 310		

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 11/09/2023

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 310	Continued From page 9 On 11/07/2023, the Department received a complaint about admissions. The provider was issued an order not to admit new or additional residents on 09/14/2023. On 11/08/2023 at approximately 8:00 AM, Surveyors requested a resident roster with dates of admission. Administrator A provided Surveyor with a roster. The roster showed Resident 1 had an admission date of 09/14/2023. Surveyor asked if the facility had any recent admissions. Administrator A stated, "We have a no new admit order so it's been a while. [Resident 1] was the last." Surveyor requested Resident 1's admission agreement from Administrator A. Surveyors reviewed additional paperwork in Resident 1's record which contradicted the 09/14/2023 admission (move-in) date. After several interviews and questions, Surveyors were informed that Resident 1's first day in the facility was 10/06/2023. On 11/08/2023 at approximately 2:00 PM, Surveyors interviewed Administrator A and asked why Resident 1's admission agreement was not provided as previously requested. Administrator A stated, "There isn't an admission agreement on file, so I've emailed the [grandchild] to give to [his/her] [parent]." Administrator A informed Surveyor that the date of 09/14/23 was written in the record as Resident 1's admission date but later stated, "[S/he] (Resident 1) came here to move in on that date 09/14/2023. We did the pre-admission and [s/he] was going to move in that day but then [his/her] [spouse] got sick and was in the hospital so [s/he] didn't move in right away. [His/her] first day here	N 310		

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 11/09/2023

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 310	Continued From page 10 was 10/06/2023." The provider did not ensure Resident 1 had a signed admission agreement on record for review on 11/08/2023; approximately 1 month after Resident 1 was admitted to the facility.	N 310		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 and Resident 3 received medication in the dosage and at intervals prescribed by a practitioner. Findings include: This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. On 11/03/2023, the Department received a complaint related to medications. On 11/08/2023, Surveyor requested the medication administration records (MAR) for Resident 2 and Resident 3. Surveyor reviewed the medication administration records (MAR) for September 2023 to current.	{N 352}		

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 11/09/2023

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 352}	Continued From page 11 RESIDENT 2 EXAMPLE 1 Staff charted Resident 2 did not get the following medications on the following dates due to "med out" and not available at the facility: Otezla 30 mg tablet: Take 1 tablet by mouth twice daily (Dx: Psoriasis) - 10/13/23 7:00 AM "Out of building" - 10/19/23 8:00 PM "Out" - 10/22/23 8:00 PM "Out" - 10/23/23 7:00 AM "Out of Building" - 10/29/23 8:00 PM "Med is out" - 10/30/23 7:00 AM "med out" - 10/30/23 8:00 PM "out" - 10/31/23 7:00 AM "med out" On 11/08/2023 at approximately 12:55 PM, Surveyor interviewed Administrator A and asked why Resident 2's Otezla was not available. Administrator A stated, "[His/her] and [Resident 3] have meds whose manufacturers have specific pharmacies to dispense the meds so [pharmacy name] (facility's pharmacy) does not dispense the medication so we had to get new orders and scripts from the doctor and send to a designated pharmacy, then wait for shipment." EXAMPLE 2 On 11/09/2023, Surveyor obtained a document with the title, "Prehospital Care Report" from the emergency ambulance service for incident date 11/02/2023. The report read, in part: "Primary Impression: Respiratory - COPD (chronic obstructive pulmonary disease) Exacerbation. Secondary Impression: Maltreatment Adult Neglect Suspected. Dispatched for a 47 year old [gender] with	{N 352}		

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 11/09/2023

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 352}	Continued From page 12 reported 02 saturation of 35% at 6:29, responded immediately, arrived on scene, patient was sitting on [his/her] roiling [sic] walker just inside the doors by the front desk. Patients [sic] lips were blue. Patient was wearing [his/her] nasal cannula attached to oxygen, however, [his/her] oxygen was turned off and the tank was empty. Applied pulse oximeter and obtained 02 saturation of 49%. Staff was told [his/her] tank was empty and not on and responded with 'okay,' they did not attempt to retrieve a full tank or assist in any way, one was getting the med-pass ready and the other was back and forth between residents and us. We had asked for a face sheet and documentation of meds given and [s/he] was having issues retrieving that information for us, [s/he] could only state that a duo-neb (nebulizer) was given but they had no documentation of what time other than during the overnight hours. We were however provided with a face sheet and paperwork from a May 2023 admittance to Mayo Clinic Hospital. Loaded patient onto cot and into rig, applied oxygen via nasal cannula at 4 liters-patient increased to 85%, while assembling duo-neb, applied duo-neb via mask and patients [sic] oxygen continually increased to a high of 95%. During this time EMTs (emergency medical technicians) were weighing out whether or not to transport as patient had become more stable, however after speaking with [Director at hospital] we determined that transport to [hospital name] was in the best interest of the patient as [s/he] has not been getting the care [s/he] needs at [facility name]. Patient has been prescribed a C-Pap but has no tubing to be able to use it. [Managed care organization (MCO)] is supposed to be in charge of making sure the patient has that and has not done so in several weeks, [Facility name] staff stated that if we were going to Durand that we could have them write a	{N 352}		

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 11/09/2023

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 352}	Continued From page 13	{N 352}		

prescription for the tubing to send to [name] Pharmacy as it could be delivered today. When EMTs were discussing non-transport, staff asked why and EMTs informed them that patients [sic] oxygen levels were stable that the patient needed a new portable oxygen tank or needed to be connected to the concentrator in their room. Staff informed EMT that patient should go because last time the patient was transported to a hospital, 54 pounds of fluid was removed from the patient's lungs. Again, confirming the decision to transport was in the best interest of the patient - as staff had not previously provided this information until the time that non-transport was considered and this information should've been documented and reported immediately. Obtained and monitored vitals en route [sic]. Physical assessment shows distention and firmness in the lower abdomen causing tenderness but not pain. Once the nebulizer was finished, moved patient over to a non-rebreather mask at 6 liters to keep oxygen levels stable, with the understanding that COPD patients [sic] should be on 2 liters, however given the respiratory distress the patient needed a lot more help recovering from the low oxygen levels."

Surveyor reviewed observation notes provided by Administrator A on 11/08/2023. The observation notes read as follows:

-11/03/23 at 8:30 AM: Resident sent out via ambulance on 11/2 for SOB (shortness of breath) and chest pain. O2 (oxygen) sats were low 60's. Resident sent to [hospital name] in [city]. Social worker called with update this morning and stated that [s/he] would be admitted at least 6 more days.
-11/03/23 at 8:45 AM: Sent message to [MCO] to request CPAP (continuous positive airway pressure) supplies.

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 11/09/2023

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 352}	Continued From page 14 -11/06/23 at 11:00 AM: Director called [respiratory company] and they will be sending [his/her] CPAP tubing in the mail. -11/06/23 at 11:00 AM: Clinic called and stated resident will most likely be returning to us tomorrow. RN asked about CPAP tubing- call placed to [company name] to reorder tubing. EMS stated no oxygen at facility- RA checked inventory and facility has O2 on hand for resident. Resident will return with new increased O2 orders. -11/07/23 at 10:45 AM: Social worker called from hospital - stated resident is ready to return but needs bipap tubing and [company name] is unable to deliver until Wednesday or Thursday. Social worker called [company name] and is able to get a tube today- resident will return to facility today. -11/07/23 at 7:00 AM: Resident returned from hospitalization 11/7- resident went to store and purchased soda and snacks. Resident is c/o stomach ache [sic] this am. -11/08/23 at 10:45 AM: Call placed to pharmacy to request new orders listed on after visit summary from recent hospitalization. Faxed pharmacy updated med list. Pharmacy will deliver new medications and update list. Resident 2 did not have tubing for CPAP treatments, as prescribed. Provider reports Resident 2 was sent to the hospital frequently for low oxygen levels and breathing concerns. RESIDENT 3 Staff charted Resident 3 did not get the following medications on the following dates due to "med out" and not available at the facility: Ingrezza 40 MG Capsule - Take 1 capsule by mouth daily scheduled at 7:00 AM:	{N 352}		

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 11/09/2023

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 352}	Continued From page 15 -11/01/23 OTHER "med out" -11/02/23 REFUSED "Waiting on pharmacy to deliver" -11/03/23 REFUSED "med out- call placed to psych doctor 10/30, waiting for call back" -11/04/23 OTHER "med out" -11/05/23 OTHER "med out" -11/06/23 OTHER "med out" -11/07/23 OTHER "med out" Resident 2 and Resident 3 did not receive medications/treatments in the dosage and at intervals prescribed by his/her practitioner as they were not available in the facility to administer.	{N 352}		
{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. This Rule is not met as evidenced by:	{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 11/09/2023

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 16 Based on record review and interview, the provider did not ensure Resident 1 and the resident's legal representative, as appropriate, were involved in developing the individual service plan (ISP) when ISPs were not available or did not contain the resident or the resident's legal representatives' signatures acknowledging their involvement in, understanding of, and agreement with, the plan. This is a repeat deficiency. See Statement of Deficiency (SOD) ZTUE11, dated 08/10/2023. Findings include: RECORD REVIEW On 11/08/2023, Surveyor requested a resident roster and asked Administrator A for recent admissions. Resident 1 had an admission date of 09/14/2023 on the face sheet and resident roster received from Administrator A. After further record review and interview, it was identified Resident 1 moved into the facility on 10/06/2023. Surveyor requested Resident 1's 30- day comprehensive ISP. The ISP received from Administrator A was not signed or dated by any party. INTERVIEW On 11/08/2023 at approximately 10:30 AM, Surveyor interviewed Resident 1's activated Power of Attorney for Health Care (POAHC) via phone and asked if s/he had reviewed or signed an ISP. Resident 1's POAHC stated s/he did not recall seeing a written plan of care and did not sign any papers related to an ISP.	{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 11/09/2023

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 17 The provider did not have a signed or dated 30-day ISP for Resident 1, who was admitted to the facility on 10/06/2023.	{N 387}		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 4's individual service plan (ISP) was followed for shower/bathing assistance. Findings include: On 10/27/2023, the Department received a complaint regarding resident care and hygiene. RECORD REVIEW On 11/08/2023, Surveyor requested the facility shower schedule and Resident 4's record, including the ISP. Resident 4 had an admission date of 07/25/2023. Administrator A provided Surveyor with a copy of Resident 4's current ISP. The ISP was not signed or dated by any party and read, in part: "Bathing - Full Assistance Schedule: Daily @ As Needed. Resident's Needs: Resident requires full assistance from staff to complete bathing tasks. Resident's Desired Outcomes: To maintain good personal hygiene." Surveyor requested Resident 4's	N 388		

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 11/09/2023

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 388	Continued From page 18	N 388		

shower/bathing/skin audit documentation from Administrator A. Surveyor reviewed the document with the title "Care History for [Resident 4] From 09/08/2023 thru 11/08/2023." The documentation showed 2 entries for the following dates:

-10/31/23 at 10:11 AM: Bathing Full Assistance Asked resident to bathe or take a shower. Resident refused.
-10/06/23 at 12:45 PM: Bathing - Full Assistance Skin Condition? Nothing observed.

No other entries were available for review.

Surveyor reviewed the shower schedule provided by Administrator A. The shower schedule showed Resident 4 was scheduled for showers on Mondays and Thursdays each week.

INTERVIEW

On 11/08/2023 at approximately 11:40 AM, Surveyor interviewed Director of Staff (DS) B and asked about Resident 4's bathing assistance. DS B stated, "[Resident 4] was sent in for a blister on heel last week, no new orders. Sent in twice for that. Was on a UTI (urinary tract infection) antibiotic. [Managed Care Organization (MCO)] has us washing [his/her] feet now since last week due to a concern from when [s/he] went in."

On 11/09/2023, Surveyor sent Administrator A an email with follow-up questions related to Resident 4's shower documentation and asked why only 2 showers were documented (1 refused) from 09/08/23-11/08/23.

On 11/09/2023 at 12:41 PM, Administrator A stated, in part, "[Resident 4] refuses showers." Administrator A confirmed the 2 entries provided

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 11/09/2023

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 388	Continued From page 19 were the only charting available. Surveyor also inquired about why Resident 4's MCO requested staff to wash his/her feet and asked why that was not included in the ISP. Administrator A stated, "[S/he] isn't compliant with showers or [his/her] stockings. When [s/he] propels [him/herself] around, [his/her] feet will get dirty. [MCO] is aware of [his/her] noncompliance and requested us to offer at least washing [his/her] feet." Surveyor reviewed the ISP for staff assistance with washing Resident 4's feet. The ISP did not include this care task. DS B stated washing his/her feet was not updated in the ISP because it was not an order. Documentation provided showed Resident 1 was offered and refused 1 bath/shower and received 1 bath/shower from 09/08/2023-11/08/2023.	N 388		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure written practitioner's orders were maintained in Resident 2's record. Findings include:	N 400		

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 11/09/2023

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 400	Continued From page 20 On 11/03/2023, the Department received a complaint regarding resident care. On 11/08/2023, Surveyor requested to review Resident 2's medication administration record (MAR) for September 2023 to current, and observation notes, and asked for signed medication orders for Resident 2's oxygen (O2) and albuterol treatments. Administrator A and Director of Staff (DS) B informed Surveyor that Resident 2 returned the previous day from hospitalization. DS B stated Resident 2 went out due to O2 level of 35. DS B informed Surveyor APS (adult protective services) was at the facility on 11/03/23 due to a complaint from Emergency Medical Services (EMS). DS B stated, "EMS gave Resident 2 a breathing treatment and [Resident 2] improved, so they weren't going to transport but we insisted they transport Resident 2." DS B informed Surveyor that Resident 2 was on 3 liters of oxygen at the time s/he had an oxygen reading of 35 and returned with updated orders for a range of oxygen to be administered by staff if Resident 2's oxygen levels drop. Surveyor requested Resident 2's oxygen and breathing treatment orders at the time of transport on 11/02/23 and a copy of the new oxygen order as reported by DS B upon discharge from hospital on 11/07/2023. On 11/08/2023 at 12:25 PM, Administrator A provided Surveyor with observation notes and a one-page medication list and stated, "This is not an actual order, just paperwork with the order from the hospital but it's not the updated order we were told [s/he] would have for the oxygen range.	N 400		

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 11/09/2023

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 400	Continued From page 21	N 400		

[Resident 2] came back yesterday and [DS B] took the call with the updated order. We haven't received the order yet."

Surveyor reviewed observation notes provided by Administrator A. The observation notes read as follows:

-11/03/23 at 8:30 AM: Resident sent out via ambulance on 11/2 for SOB (shortness of breath) and chest pain. O2 (oxygen) sats were low 60's. Resident sent to [hospital name] in [city]. Social worker called with update this morning and stated that [s/he] would be admitted at least 6 more days.
-11/03/23 at 8:45 AM: Sent message to [MCO] to request CPAP (continuous positive airway pressure) supplies.
-11/06/23 at 11:00 AM: Director called [respiratory company[and they will be sending [his/her] CPAP tubing in the mail.
-11/06/23 at 11:00 AM: Clinic called and stated resident will most likely be returning to us tomorrow. RN asked about CPAP tubing- call placed to [company name] to reorder tubing. EMS stated no oxygen at facility- RA checked inventory and facility has O2 on hand for resident. Resident will return with new increased O2 orders.
-11/07/23 at 10:45 AM: Social worker called from hospital - stated resident is ready to return, but needs bipap tubing and [company name] is unable to deliver until Wednesday or Thursday. Social worker called [company name] and is able to get a tube today- resident will return to facility today.
-11/07/23 at 7:00 AM: Resident returned from hospitalization 11/7- resident went to store and purchased soda and snacks. Resident is c/o (complaining of) stomach ache this am.
-11/08/23 at 10:45 AM: Call placed to pharmacy

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 11/09/2023

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 400	Continued From page 22 to request new orders lsited on after visit summary from recent hospitalization. Faxed pharmacy updated med list. Pharmacy will deliver new medications and update list. On 11/09/2023 at 12:41 PM, Administrator A stated via email, "I placed a call to [Resident 2]'s doctor and the pharmacy requesting a copy of the signed orders to be sent to us. I will send them to you when they come."	N 400		