STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017206	A. BUILDING: _____ B. WING _____	C 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS EAU CLAIRE WEST	5110 STONEWOOD DR EAU CLAIRE, WI 54703

(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 12/30/2025, Surveyors conducted 5 complaint investigations at Care Partners Eau Claire West. Data was collected through 01/06/2026. Three of the 5 complaints were substantiated. Eight deficiencies were identified. Six of the 8 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 861K11, dated 08/24/2021; SOD 861K12, dated 04/26/2022; SOD PBZQ11, dated 10/24/2022; SOD 861K13, dated 04/26/2023; SOD 861K14, dated 11/06/2023; and SOD EK9C11, dated 05/08/2025. Census: 54	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 provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or	N 158		

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N 158	Continued From page 1 misappropriation of property. The CBRF shall maintain documentation of any investigation. This Rule is not met as evidenced by: Based on interview and record review, the provider did not investigate and document all allegations of abuse. Resident 1 alleged Administrator A assaulted him/her. The provider did not investigate the allegation. Findings include: On 12/10/2025, the Department received a complaint alleging Administrator A was retaliating against a resident and law enforcement was called to the facility. On 12/30/2025, at approximately 3:30 p.m., Surveyor interviewed Administrator A and asked if law enforcement was called into the facility recently. Administrator A told Surveyor Resident 1 did call law enforcement into the facility regarding accusations that staff were not giving Resident 1 his/her medications. Surveyor requested the report. On 12/30/2025, the provider emailed the Department a self-report regarding law enforcement presence at the facility. The report included a written statement, dated 12/13/2025, signed by Administrator A. The statement read: "On Dec 12th 2025 Eau Claire PD (police department) were called to the Stonewood location after [Resident 1] called stating staff were not giving [him/her] [his/her] medications. Officers showed up and questioned staff about the medications. [Resident 1's] MAR (medication	N 158		

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N 158	Continued From page 2	N 158		

administration record) along with the pill packets were shown to police officers. [Resident 1] is also a dual caregiver resident meaning that no meds (medications) or cares are completed without another caregiver due to [his/her] history of false allegations against staff. [Resident 1] had additional concerns that [s/he] was not being taken care of to which the officers identified that if [s/he] felt unsafe that [s/he] could go-to the local hospital; [Resident 1] declined. The officers left the facility roughly 25 minutes after they arrived. The officer then called me to go over the situation and asked about an allegation that [Resident 1] had stating that I had 'assaulted [him/her].' [S/he] referenced a time in the dining room where [s/he] did not have enough ketchup on [his/her] burger. I told the officer that [Resident 1] then began to get loud and start yelling at staff and the residents at [his/her] table. I then situated myself next to [Resident 1] in an effort to give a barrier to a resident next to [him/her] who was then crying. The resident noted that [s/he] did not feel safe and I then grabbed [Resident 1's] wheelchair and turned [him/her] to set [him/her] up at the table next to [him/her]. The officer stated that [Resident 1] told them I was poking [him/her] and yelling at [him/her] - I identified to the officer that all my residents were in the dining room along with 5-6 other staff members who can vouch that there was no physical exchange between [Resident 1] and I. Once [Resident 1] was situated at the table I walked away and helped the staff serve. The officer noted [s/he] would put that in [his/her] report and let us know if [s/he] needed anything else."

On 01/05/2026 from 2:25 p.m. to 2:50 p.m., Surveyor interviewed Resident 1 on the phone. Surveyor asked Resident 1 to explain what happened the day s/he alleged Administrator A

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N 158	Continued From page 3	N 158		

assaulted him/her. Resident 1 said it was hamburger day. S/he said Caregiver D was going around with ketchup and mustard and asked residents if they wanted any. Resident 1 said s/he requested ketchup on his/her burger. S/he said when Caregiver D squeezed the bottle, only a little came out as the bottle was empty. Resident 1 said Caregiver D went back to the kitchen to get more ketchup and when s/he returned s/he went to everyone else at the table and did not put any more ketchup on his/her burger. Resident 1 said s/he put his/her hands in the air and looked at Caregiver D and questioned why s/he did not get any more ketchup. Resident 1 told Surveyor that Caregiver D looked at him/her and told Resident 1 that s/he did not say please. Resident 1 said, "I yelled, 'you're nuts.'" Resident 1 said Administrator A then came and grabbed his/her wheelchair, pulled him/her away and was poking him/her in the shoulder. Surveyor asked Resident 1 if anyone had ever talked to him/her about what happened. Resident 1 told Surveyor, "No." Resident 1 told Surveyor another resident at the table yelled to Resident 1, "I got your back."

On 01/06/2026, from 9:30 a.m. to 10:40 a.m., Surveyor interviewed Administrator A and Regional Nurse (RN) B. Surveyor asked Administrator A what date it was when Administrator A removed Resident 1 from the table in the dining room per the report submitted to the Department. Administrator A said that it occurred on 11/24/2025. S/he said Resident 1 accused him/her of kidnapping and assault. Surveyor asked if there was an investigation into Resident 1's allegations. Administrator A and RN B told Surveyor there was not. Administrator A stated the allegation was made as s/he was moving Resident 1 to the other table. Administrator A stated the allegation was not

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N 158	Continued From page 4 referencing a previous time but being made in the moment. RN B stated the accusation was frivolous, and they did not invest their time investigating it. The provider did not investigate when Resident 1 alleged Administrator A assaulted him/her. Cross Reference: N0164 DHS 83.12(4)(b) Reporting When Law Enforcement Is Called	N 158		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review, the provider did not report to the Department within 3 working days after Resident 1 called law enforcement personnel to the facility and alleged staff were not giving medications, providing cares and alleged Administrator A assaulted him/her. Findings include: On 12/10/2025, the Department received a complaint alleging Administrator A was retaliating against a resident and law enforcement was	N 164		

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N 164	Continued From page 5 called to the facility. On 12/30/2025, at approximately 3:30 p.m., Surveyor interviewed Administrator A and asked if law enforcement was called into the facility recently. Administrator A told Surveyor Resident 1 did call law enforcement into the facility regarding accusations that staff were not giving Resident 1 his/her medications. Surveyor requested the report. On 12/30/2025, the provider emailed the Department a self-report regarding law enforcement presence at the facility. The report indicated Resident 1 called law enforcement to the facility on 12/12/2025 for allegations that staff were not giving him/her his/her medications and s/he was not being taken care of. The report also indicated law enforcement interviewed Administrator A regarding allegations that s/he assaulted Resident 1. On 01/06/2026, from 9:30 a.m. to 10:40 a.m., Surveyor interviewed Administrator A and Regional Nurse (RN) B. Surveyor asked Administrator A if s/he was aware of the requirement to submit a report to the Department when law enforcement was called to the facility. Administrator A told Surveyor s/he was aware. S/he said the email was in draft form and s/he did not realize it was not sent to the Department. The provider did not report to the Department within 3 working days after law enforcement was called to the facility.	N 164		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan	N 386		

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N 386	Continued From page 6 Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on interview and record review, the provider did not develop a comprehensive individual service plan (ISP) for 1 of 3 residents reviewed that identified Resident 1's pain, his/her needs and desired outcomes related to pain, and services the provider would provide for his/her pain. This deficiency is being cited for the third time. See Statement of Deficiency (SOD) 861K11, dated 08/24/2021; and SOD 861K12, dated 04/26/2022. Findings include: On 12/10/2025 and 12/17/2025, the Department received a complaint alleging the provider was not assisting a resident with their needs and desired outcomes. On 12/30/2025, Surveyor reviewed Resident 1's record.	N 386		

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N 386	Continued From page 7 Resident 1 was admitted to the facility on 03/11/2024. S/he did not have a legal representative and was responsible for his/her own decision making. Resident 1 had multiple diagnoses including: epilepsy, meningioma brain, (tumor that grows from the membrane that surrounds the brain), radiculopathy lumbar (pain, numbness, weakness radiating from the lower back down the leg), chronic pain syndrome, neuropathy ulnar right (nerve damage to the ulnar nerve, which runs from the neck to hand, causing numbness, weakness and pain to the hand and fingers). A discharge summary, dated 11/03/2025, indicated Resident 1 had an order to receive oxycodone 5 milligrams, by mouth, scheduled 4 times a day for chronic pain. Resident 1's ISP, last reviewed 11/07/2025, did not include Resident 1's pain, his/her needs and desired outcome related to pain, or services the provider would provide to assist Resident 1 with his/her pain. The ISP read, in part: "[Resident 1] is encouraged to shower 2x a week. [S/he] will need level one assist by turning on the shower and washing lower extremities. [Resident 1] often refuses showers." The goal/outcome for bathing was documented as: "Resident will be clean daily through the next assessment." There were no approaches identified for staff to use when Resident 1 refused a shower. Surveyor reviewed Resident 1's shower/bath charting from 10/01/2025 to 12/29/2025. Staff documented Resident 1 received a bed bath on 10/08/2025 and 10/15/2025. On the following dates staff documented Resident 1 refused his/her shower: 10/01/2025, 10/04/2025,	N 386		

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N 386	Continued From page 8 10/18/2025, 10/22/2025, 11/05/2025, 11/19/2025, and 11/26/2025. Surveyor reviewed staff documentation for Resident 1 from 10/14/2025 to 12/29/2025. 11/06/2025 - "Resident refused to come out for supper. States [s/he] is in too much pain to come down but refuses to go in to be checked out ..." 11/07/2025 - "Resident refused to come out for breakfast. Resident stated [his/her] wheelchair is too small/doesn't fit [him/her] which causes [him/her] pain and discomfort ..." 11/17/2025 - "Resident refused to come out for supper because [s/he] needed [his/her] pills to kick in and [s/he] didn't 'get them soon enough.'" 12/10/2025 - '[Resident 1] came down for supper. Didn't technically refuse [his/her] shower. Washed [his/her] pits and applied medication. [S/he] said [s/he] had too much pain to shower." On 01/05/2026 from 2:25 p.m. to 2:50 p.m., Surveyor interviewed Resident 1 on the phone. Resident 1 said his/her wheelchair caused him/her pain as it did not fit him/her properly. Resident 1 told Surveyor s/he was working with his/her managed care organization (MCO) to get a wheelchair that will fit him/her better and be more comfortable. Surveyor asked Resident 1 about his/her showers. Resident 1 told Surveyor staff told him/her s/he needs to take a shower when staff want him/her to shower. Resident 1 said it caused him a lot of pain to get in and out of the shower. Resident 1 said s/he told staff s/he would need to take a shower within the hour after s/he received a pain pill. Resident 1 said staff would not comply with this request and just mark that s/he refused the shower. Surveyor did not locate a pain assessment in Resident 1's record.	N 386		

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N 386	Continued From page 9 On 01/06/2026 from 9:30 a.m. to 10:40 a.m., Surveyor interviewed Administrator A and Regional Nurse (RN) B. Surveyor asked if Resident 1 had an ISP for his/her pain. Administrator A told Surveyor Resident 1 did not have any PRN (as needed) pain medications that would require staff to assess his/her pain. Administrator A told Surveyor Resident 1 did not complain of pain other than his/her wheelchair. Surveyor asked if a pain assessment was completed with his/her most recent comprehensive assessment. Administrator A told Surveyor s/he would have to look. Surveyor requested documentation if s/he located it. Surveyor asked about Resident 1's showers and if Resident 1 ever expressed a desire to have a shower within an hour after s/he received a pain pill. Administrator A said, "Nope, that never has been identified." Surveyor asked if Resident 1 was involved with his/her care conferences in order for him/her to express his/her desired needs and preferences. Administrator A said Resident 1 refuses. On 01/06/2025, at 1:08 p.m., Administrator A emailed Surveyor a pain assessment for Resident 1, dated 09/23/2025. The assessment indicated the data was collected from the resident and the medical record. The section for diagnoses associated with pain was left blank. The pain location was identified on the lower back diagram. The type of pain was chronic. The frequency of pain was daily. The intensity of pain was rated a 2 at present, 1 hour after medication, 3 hours after medication, at its worst and at its best. A handwritten note read: "Identifies that it is constant." The section asked what caused or increased pain: "Any movement". What relieved the pain: "medications". Nonverbal/noncognitive	N 386		

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N 386	Continued From page 10 signs of pain were identified as: frowning/scowling, resistive to care, and irritability. The provider did not develop an ISP related to Resident 1's pain.	N 386		
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: Based on record review and interview, the provider did not ensure the legal representative of a resident was involved in developing an individual service plans (ISP) for 1 of 1 resident (Resident 2) that had a legal representative. Resident 2's ISP was not signed by his/her activated health care power of attorney (HCPOA)	N 387		

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N 387	Continued From page 11 to acknowledge their involvement in, understanding of, and agreement with the ISP. This is a repeat deficiency. See Statement of Deficiency (SOD) 861K14, dated 11/06/2023. Findings include: On 10/14/2025, the Department received a complaint alleging the provider was not collaborating with a resident's legal representative regarding the services being provided to a resident. On 12/30/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 10/24/2024. A certification of incapacity for Resident 2 was signed on 09/18/2024, activating Resident 2's power of attorney. The power of attorney documentation listed Person E as Resident 2's first choice for his/her health care agent and Person F as his/her second choice. Person F was identified as Resident 2's power of attorney for finance. Resident 2's ISP, last reviewed 10/24/2025, included a signature of participants section. Administrator A signed. There were handwritten notes that read: "paper copy given to resident" and "emailed to [Person F] on 10/25/25." Person E did not sign the ISP and there was no documentation to indicate Person E was involved, understood, or agreed with the ISP. Resident 2's face sheet identified Person F as the power of attorney. Person E was identified as	N 387		

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N 387	Continued From page 12 "local contact." On 12/30/2025, from 11:05 a.m. to 11:30 a.m., Surveyor interviewed Person E in Resident 2's room. Person E explained care concerns s/he had for Resident 2. Person E said s/he visited Resident 2 almost every day to ensure Resident 2 was being cared for. Person E said Resident 2 would often refuse meals, but said if you put food in front of him/her, s/he would eat. Person E said on Sunday (12/28/2025), s/he arrived around 8:45 a.m. S/he said Resident 2 was still sleeping in his/her chair. Staff told Person E Resident 2 did not want to get up for breakfast. Person E said when staff asked Resident 2 again, while Person E stayed out of the room, Resident 2 said s/he was ready to get up for breakfast. Person E voiced concerns that staff were not reapproaching or prompting Resident 2 to get up to eat. Person E said when Resident 2 did not eat s/he became weak, and breakfast was one of Resident 2's bigger meals for the day. Person E said Resident 2 had a fall around 4:00 a.m. a couple months ago and the alarm did not sound. S/he said s/he was not notified of the fall until s/he came in later that morning. The fall occurred on 10/11/2025, which was a Saturday. Person E said on Monday morning when Administrator A came into work, Person E asked Administrator A if s/he had anything to discuss. Person E said, "[S/he] had nothing to say." On 12/30/2025, at approximately 1:45 p.m., Surveyor interviewed Person E and asked if s/he was involved with developing Resident 2's ISP. Person E asked Surveyor what an ISP was. Surveyor showed Person E Resident 2's ISP. Person E said s/he had never seen anything like that since Resident 2 had been at the facility. Surveyor showed Person E that it was	N 387		

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N 387	Continued From page 13 documented a copy was sent to Person F. Person E said Person F was his/her sibling. S/he said Person F was power of attorney for finances, but s/he lived out of state. Person E said, "I am here every day." Person E was visibly upset with tears in his/her eyes. The provider did not ensure Person E, Resident 2's HCPOA, was involved in developing Resident 2's ISP.	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 2's individual service plan (ISP) was implemented as written. This deficiency is being cited for the third time. See Statement of Deficiency (SOD) 861K11, dated 08/24/2021, and SOD 861K12, dated 04/26/2022. Findings include: On 10/14/2025, the Department received a complaint alleging a resident fell and did not have fall interventions in place at the time of the fall. On 12/30/2025, Surveyors reviewed Resident 2's records. A fall incident report dated 10/11/2025, indicated Resident 2 had fallen at approximately 3:55 AM. The incident report read, in part, "staff were	N 388		

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N 388	Continued From page 14	N 388		

walking to the med (medication) room and heard resident yelling for help. When staff walked into residents [sic] room [s/he] was sitting on the floor." The incident report was filled out and initialed by Former Employee (FE) C. The report was then signed by Administrator A.

Resident 2's ISP, with an original date of 10/26/2024, read, in part:
"Safety Concerns (Alarms, Mats)"
Frequency of Service and Services Provided:
"Yes - resident has alarms (Pressure/posey [sic])"
Posey is a brand for an alarm.
Goal/Outcome: "Safety will be maintained in current environment."

On 12/30/2025, from 11:05 a.m. to 11:30 a.m., Surveyor interviewed Person E. Person E was Resident 2's activated health care power of attorney. Person E told Surveyor Resident 2 fell a couple months prior at approximately 4:00 a.m. S/he said staff were alerted to the fall by Resident 2 yelling. Person E told Surveyor s/he wondered why staff were not alerted to Resident 2's alarm sounding. Person E said s/he visited Resident 2 almost daily and previously came in and found the alarm not plugged in. Person E said staff told him/her that the alarm would not turn off, so they unplugged it. Person E said s/he explained to staff how to adjust the alarm to ensure Resident 2 was sitting on it properly. The alarm was a pressure alarm that Resident 2 sat on in his/her chair. The alarm would sound if Resident 2 was no longer sitting or applying pressure to the alarm.

On 01/05/2026, at approximately 2:00 p.m., Surveyor interviewed Hospice Registered Nurse (HRN) G on the phone. HRN G confirmed s/he was Resident 2's hospice nurse and case

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manager. Surveyor asked if s/he had ever noticed Resident 2's alarm unplugged when s/he came to the facility for visits with Resident 2. HRN G told Surveyor s/he had found Resident 2's alarm unplugged multiple times and had brought that concern to Administrator A's attention.

On 01/05/2026, Surveyor reviewed hospice records for Resident 2. On 10/29/2025, HRN G documented: "Brought up concerns to [Administrator A] that chair alarm was unplugged again."

On 01/05/2026, at approximately 3:00 PM, Surveyor interviewed FE C. FE C stated s/he remembered Resident 2 had a chair alarm at the time of his/her fall. FE C stated s/he discovered Resident 2 had fallen after hearing him/her call for help. FE C stated s/he did not hear the chair alarm going off. FE C stated the alarm was plugged in, and s/he checked the batteries, which were working. FE C stated the chair alarm had not sounded due to it being positioned incorrectly on Resident 2's chair. FE C stated a staff member from the previous shift would have been the last one to toilet Resident 2 and would have been responsible for placing the chair alarm. FE C stated the provider did not train him/her on the placement of chair alarms.

The provider did not ensure Resident 2's ISP was implemented as written when Resident 2's pressure alarm was not being used properly at all times.

Cross Reference: N0431 DHS 83.38(1)(g) Health Monitoring

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N 389	Continued From page 16	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 review and revise 1 of 3 residents' individual service plans (ISP) reviewed (Resident 1), when there was a change in their needs. This deficiency is being cited for the fifth time. See Statement of Deficiency (SOD) 86K112, dated 04/26/2022; SOD PBZQ11, dated 10/24/2022, SOD 861K13, dated 04/26/2023, and SOD EK9C11, dated 05/08/2025. Findings include: On 10/14/2025 and 12/10/2025, the Department received complaints with allegations services were not provided appropriate to meet each residents' needs. On 01/05/2026 from 2:25 p.m. to 2:50 p.m.,	N 389		

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N 389	Continued From page 17 Surveyor interviewed Resident 1 on the phone. Resident 1 told Surveyor s/he reordered his/her own medications from the pharmacy. S/he said staff were supposed to tell him/her when s/he had a 7-day supply of the medication left to allow him/her enough time to reorder the medications. Resident 1 said staff did not tell him/her when there was 7 days left. S/he sometimes they would tell him/her when s/he only had a day left and then s/he had to pay to get it sent overnight. S/he said there were times s/he did not receive his/her scheduled oxycodone for pain, levetiracetam for seizures, and Trelegy inhaler for his/her COPD. Resident 1 told Surveyor his/her pain was "unbearable" when s/he went without his/her scheduled pain medication. From 12/30/2025 to 01/05/2026, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 03/11/2024. S/he had multiple diagnoses including seizure disorder, chronic pain syndrome, and chronic obstructive pulmonary disease (COPD). Resident 1 did not have a legal representative and made his/her own health care decisions. Resident 1's ISP, last reviewed, 11/07/2025, indicated the following related to Resident 1's medications: "Self administers own medication and staff supervises [sic] Does have some bedside orders" And "Medications administered by CBRF (community based residential facility) staff. Medical order from a practitioner is required." Resident 1's ISP indicated Resident 1 could make his/her needs known.	N 389		

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Surveyor reviewed Resident 1's medication administration record (MAR). In October 2025, staff documented Resident 1's oxycodone was not administered, because it was not available or not in the cart from 10/11/2025 to 10/14/2025. In November 2025, staff documented Resident 1's oxycodone was not administered as it was not in the cart from 11/21/2025 to 11/22/2025. On 12/04/2025 at 5:00 a.m., staff documented Resident 1's levetiracetam was not administered as it was not in the cart. On 12/14/2025, Resident 1's Trelegy inhaler was not administered, but there was no documentation to indicate why it was not administered. Staff circled their initials to indicate the inhaler was not administered, but did not document on the MAR the reason why it was not administered. There were several other dates and times where staff did not document on Resident 1's MAR if his/her oxycodone, levetiracetam, and Trelegy inhaler were administered or not as the MAR was left blank. The MAR indicated in the oxycodone order to "*Reorder when down to 7 days*"

Resident 1 was hospitalized 10/27/2025 to 11/03/2025 with a principal diagnosis of idiopathic generalized epilepsy intractable with status epilepticus (seizure lasting greater than 5 minutes or recurring seizures).

On 01/06/2026 from 9:30 a.m. to 10:40 a.m., Surveyor interviewed Administrator A and Regional Nurse (RN) B on the phone. Surveyor explained concerns related to Resident 1's medications. Administrator A told Surveyor Resident 1 reordered his/her own medications. S/he said staff were to tell Resident 1 when s/he had 7 - 10 days left of a medication so s/he can reorder the medication. S/he said at times Resident 1 does not order his/her medications on

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time. Surveyor asked if staff documented when they notify Resident 1 to reorder his/her medications. Administrator A said staff were supposed to document that. Surveyor asked if Resident 1's ISP indicated Resident 1 reordered his/her own medications and for staff to notify Resident 1 when s/he was down to 7 days. Administrator A said it did not. RN B asked Surveyor if that service was required to be in an ISP. Surveyor reviewed Wis. Admin. Code § DHS 83.35(3)(a) which reads, in part:
"The individual service plan shall include all of the following:
1. Identify the resident's needs and desired outcomes.
2. Identify the program services, frequency and approaches under s. DHS 83.38 (1) the CBRF will provide.
3. Establish measurable goals with specific time limits for attainment.
4. Specify methods for delivering needed care and who is responsible for delivering the care."

Surveyor reviewed staff documentation for Resident 1 from 10/14/2025 to 12/29/2025. Staff did not document when they notified Resident 1 that s/he had a 7-day supply left of medications.

Resident 1's ISP was not reviewed and revised when it was determined Resident 1 would reorder his/her own medications. The ISP did not indicate who was to notify Resident 1 and when they should notify him/her to reorder his/her medications.

Cross Reference: N0415 DHS 83.37(2)(d) Documentation Of Medication Administration

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N 415	Continued From page 20	N 415		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure medications were accurately documented in each residents' medication administration record (MAR) for 1 of 3 residents reviewed (Resident 1). Findings include: On 12/10/2025, the Department received a complaint alleging medications were not being administered as prescribed with concerns medications were being stolen. On 01/05/2026 from 2:25 p.m. to 2:50 p.m., Surveyor interviewed Resident 1 on the phone. Resident 1 told Surveyor staff did not always administer his/her medications on time. S/he said there were times s/he did not receive his/her scheduled oxycodone for pain, levetiracetam for seizures, and Trelegy inhaler for his/her COPD (chronic obstructive pulmonary disease).	N 415		

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N 415	Continued From page 21 From 12/30/2025 to 01/05/2026, Surveyor reviewed Resident 1's record. Resident 1's MAR indicated Resident 1 had multiple orders including: Oxycodone 5 milligrams (mg) scheduled 4 times a day at 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. Levetiracetam 250 mg scheduled 4 times a day at 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m. Trelegy Ellipta inhaler, 1 puff, daily. Resident 1's October MAR starting from 10/11/2025 at 5:00 p.m. through 10/16/2025 at 11:00 a.m. indicated Resident 1's scheduled oxycodone was not given. This was indicated by staff's initials with a circle around it. The documentation on the back side of the MAR did not include a reason the oxycodone was not given for the following dates and times: 10/12/2025 at 11:00 a.m. and 5:00 p.m. 10/14/2025 at 11:00 a.m. and 5:00 p.m. 10/15/2025 at 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. 10/16/2025 at 5:00 a.m. and 11:00 a.m. Resident 1's November MAR indicated Resident 1's scheduled oxycodone was not given on the following dates and times: 11/20/2025 at 5:00 p.m. 11/21/2025 at 5:00 a.m., 11:00 a.m., 5:00 p.m., and 11:00 p.m. 11/22/2025 at 5:00 a.m. and 11:00 a.m. This was indicated by staff's initials with a circle around it. The documentation on the back side of the MAR did not include a reason the oxycodone was not given for the following dates and times: 11/20/2025 at 5:00 p.m. 11/21/2025 at 11:00 p.m.	N 415		

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N 415	Continued From page 22 11/22/2025 at 11:00 a.m. Resident 1's MAR indicated his/her oxycodone doses scheduled for the following dates and times were blank: 10/19/2025 at 11:00 p.m. 11/06/2025 at 5:00 a.m. 11/08/2025 at 5:00 a.m. 11/19/2025 at 11:00 p.m. 12/05/2025 at 5:00 p.m. 12/22/2025 at 11:00 a.m. 12/24/2025 at 11:00 a.m. There were no initials indicating staff administered the medication on those dates and times. There was no documentation on the back to indicate why those dates and times were blank. The controlled medication record indicated the doses of oxycodone not signed off on the MAR were taken out of count. Resident 1's MAR indicated his/her levetiracetam doses scheduled for 10/18/2025 at 6:00 p.m. and 11/25/2025 at 12:00 a.m. were blank. There were no initials indicating staff administered the medication. There was no documentation on the back to indicate why those dates and times were blank. Resident 1's MAR indicated his/her Trelegy Ellipta inhaler for 12/13/2025 was blank. There were no initials indicating staff administer the medication. There was no documentation on the back to indicate why those dates and times were blank. On 01/06/2026 from 9:30 a.m. to 10:40 a.m., Surveyor interviewed Administrator A and Regional Nurse (RN) B on the phone. Surveyor explained concerns related to Resident 1's medications. Administrator A told Surveyor	N 415		

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N 415	Continued From page 23 Resident 1 reordered his/her own medications. S/he said staff were to tell Resident 1 when s/he had 7 to 10 days left of a medication so s/he can reorder the medication. S/he said at times Resident 1 did not order his/her medications on time. Surveyor explained concerns that there were blanks on Resident 1's MAR for some of his/her scheduled medications. Administrator A said the medication card would identify if the staff administered the medication or not. S/he said it was standard protocol for staff to initial when they administered a medication. S/he explained if a medication was not administered, staff should circle their initials and explain the reason the medication was not administered on the back of the MAR.	N 415		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and	N 431		

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fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not document all communication with each residents' health care providers and did not record changes in the residents' record for 1 of 3 residents reviewed (Resident 2).

Resident 2 fell. S/he had complaints of pain and developed a bruise and scrape to his/her back. Staff did not document their communication with Resident 2's hospice provider or document changes in Resident 2's skin.

This was a repeat deficiency. See Statement of Deficiency (SOD) 861K12, dated 04/26/2022.

Findings include:

On 10/14/2025, the Department received a complaint that a resident fell with complaints of pain.

On 12/17/2025, the Department received a complaint alleging staff documentation was not accurate.

On 12/30/2025, from 11:05 a.m. to 11:30 a.m., Surveyor interviewed Person E. Person E was Resident 2's activated health care power of attorney. Person E told Surveyor Resident 2 fell approximately 2 months prior at around 4:00 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017206	A. BUILDING: _____ B. WING _____	C 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS EAU CLAIRE WEST	5110 STONEWOOD DR EAU CLAIRE, WI 54703

(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 431	Continued From page 25 S/he said later on the day of the fall, Resident 2 was leaning forward in his/her wheelchair while they were playing cards. Person E explained in the evening Resident 2 was complaining of pain and Resident 2 had tears in his/her eyes. Person E said Caregiver D was working at the time. Person E said Caregiver D told Person E s/he did not have any morphine in his/her medication cart to administer to Resident 2. Person E said s/he called hospice to inform them Resident 2 was having pain from the fall. Person E said by the time they were able to get the morphine delivered, Resident 2 had fallen asleep, and Resident 2 was no longer expressing pain. On 12/30/2025, Surveyor reviewed Resident 2's record. A fall incident report, dated 10/11/2025, indicated Resident 2 fell at approximately 3:55 a.m. The incident report read, in part, "staff were walking to the med (medication) room and heard resident yelling for help. When staff walked into residents [sic] room [s/he] was sitting on the floor." The incident report was filled out and initialed by Former Employee (FE) C. The report was signed by Administrator A. Surveyor reviewed staff documentation for Resident 2. Documentation did not indicate Resident 2 fell. The notes read as follows: 10/10/2025 p.m. shift - "No new concerns." 10/11/2025 a.m. shift - "No concerns [s/he] is very happy today." 10/11/2025 p.m. shift - "No new concerns." 10/12/2025 p.m. shift - "No new concerns." 10/12/2025 NOC (overnight) shift - "No new concerns." 10/13/2025 p.m. shift - "Resident came down to supper, didn't eat anything, but had a full glass of	N 431		

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N 431	Continued From page 26	N 431		

apple juice."
10/13/2025 NOC shift - "No concerns, slept through the night."
10/14/2025 a.m. shift - "resident came out for both meals but didn't eat."
10/14/2025 p.m. shift - "Resident came down for dinner and ate ¾'s of [his/her] dinner."
10/14/2025 NOC shift - "No new concerns."

On 01/05/2026, at approximately 2:00 p.m., Surveyor interviewed Hospice Registered Nurse (HRN) G. HRN G confirmed s/he was Resident 2's hospice nurse and case manager. Surveyor asked about Resident 2's fall and complaints of pain. HRN G said s/he "briefly recalled" the fall. S/he said it was suspected Resident 2 hit his/her back on the recliner when s/he fell. HRN G said s/he was not certain why Resident 2 did not have morphine available at the time. S/he said morphine would have been ordered when Resident 2 was admitted to hospice as that was a standard order for a hospice patient. HRN G said it would be up to the assisted living facility to fill the medication. Surveyor asked HRN G if communication between hospice and the assisted living facility was documented in Resident 2's hospice notes. HRN G said they did document the communication. Surveyor requested Resident 2's hospice records.

On 01/05/2026, Surveyor reviewed Resident 2's hospice records.

On 10/11/2025, HRN H documented a triage note. The note indicated s/he received a call from Person E at 6:26 p.m. The note read: "[Person E] calls back to verbalize [staff] had gotten ahold of [him/her]. [S/he] verbalized staff got pt (patient) up to the bathroom & pt was in pain. [S/he] said [his/her] leg hurt, however no injuries on [his/her]

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N 431	Continued From page 27 legs. [S/he] does have a large bruise & a scrape on [his/her] lower back - suspected from the unwitnessed fall this morning. [Staff] said to [Person E] that they want to give [him/her] pain meds (medications), however there is nothing in the cart to give. [S/he] is wondering how this can be in [his/her] med list & not have it available to give [his/her] [family member]?" The intervention was listed as: "Will try to get a script (prescription) sent to [him/her] for morphine for pain & call [Person E] back." On 10/11/2025, HRN H documented the following progress note: "1835 (6:35 p.m.) - attempted to call [facility] multiple times without answer. 1840 (6:40 p.m.) - [Person E] pt [family member] calls back with a phone number to directly speak with [staff], CP (Care Partners) staff. 1842 (6:42 p.m.) - Call to [staff] to confirm an injury and no pain meds. 1848 (6:48 p.m.) - message to [Doctor I] for new script order for morphine. 1902 (7:02 p.m.) - Call to [pharmacy] to ask if they can deliver morphine tonight & they can. 1906 (7:06 p.m.) - Call to [Person E], pt [family member] to confirm that morphine was ordered & pharmacy will deliver yet this evening. 1909 (7:09 p.m.) - Call to [Staff] at facility to verbalize morphine was reordered & it will be delivered for pt tonight." On 10/14/2025, HRN G documented: "[Resident 2] was in the bathroom upon arrival. [Person E] present. [Resident 2] does have a bruise on [his/her] upper back from [his/her] fall. It is yellow in appearance. [Resident 2] reports [his/her] leg is not bothering [him/her] but [his/her] back is sore. Unable to rate [his/her] pain ..."	N 431		

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N 431	Continued From page 28 On 01/06/2026, from 9:30 a.m. to 10:40 a.m., Surveyor interviewed Administrator A and Regional Nurse (RN) B. Surveyor asked if staff were to document communication they have with a resident's health care provider. Administrator A confirmed staff were to document that communication. Surveyor asked Administrator A if s/he was aware of the bruise Resident 2 sustained after his/her fall. Administrator A said s/he was not. Surveyor reviewed hospice notes in comparison to staff notes. The staff notes did not include documentation of Resident 2's complaints of pain. The staff notes did not include documentation of communication with Resident 2's hospice provider regarding Resident 2's morphine. The staff notes did not document the bruise and scrape to Resident 2's back. Administrator A said staff were to notify him/her when a resident had a change in condition and staff were to document these changes.	N 431		