Wisconsin Department of Health Services

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 01/20/2026

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 01/20/2026, Surveyor conducted a desk review complaint investigation at Care Partners Eau Claire West. The complaint was substantiated. One deficiency was identified. Census: 54	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 had a living arrangement suitable to meet his/her needs before involuntarily discharging the resident. Resident 1 was admitted to the hospital for mental health/behavioral needs and upon discharge from the hospital, was not accepted back into the facility.	N 326		

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

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N 326	Continued From page 1 Findings include: The provider is licensed to serve up to 60 residents in the client groups physically disabled, terminally ill, advanced age, and irreversible dementia/Alzheimer's disease. On 01/09/2026, the Department received a complaint alleging the provider would not allow a resident to return home from the hospital. On 01/20/2026, at approximately 8:30 AM, Surveyor interviewed Administrator A via phone. When asked about any involuntary discharge notices issued in December 2025 or January 2026, Administrator A stated Resident 1 was issued an involuntary discharge notice. When asked about the circumstances surrounding that notice, Administrator A stated Resident 1 was issued the notice on 12/31/2025 after Resident 1 had gone to urgent care without informing staff. Resident 1 obtained a prescription of a controlled substance at the urgent care visit and did not inform staff. The prescription was filled on 12/25/2025 and staff found the empty bottle in Resident 1's garbage can on 12/26/2025. When staff approached Resident 1 about finding the prescription bottle, Resident 1 stated s/he did not trust staff and s/he kept it in his/her room. Administrator A stated it became a health and safety risk because Resident 1 was knowingly obtaining medications without informing staff. Administrator A stated on or around 01/08/2026, Resident 1 had suicidal ideation and went to the emergency room (ER). Administrator A stated the provider informed the hospital and Resident 1's managed care organization (MCO) that the provider was not equipped to handle that level of mental health and the provider felt Resident 1 posed an immediate threat to his/herself and	N 326		

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N 326	Continued From page 2	N 326		

others. Administrator A stated the provider could not ensure a safe environment for Resident 1 given his/her mental health needs. The provider did not accept Resident 1 back to the facility. When asked if Resident 1 appealed the discharge notice, Administrator A stated Resident 1 did appeal, and they had not received a decision from the Department yet. Administrator A stated the 30 day notice given to Resident 1 was not the reason s/he was no longer at the facility. Administrator A stated they sent information to the Department on 01/07/2026 or 01/08/2026. The Department sent a letter in response indicating the provider could not discharge Resident 1 while the appeal was under review. Surveyor requested records for Resident 1 from Administrator A.

At 8:58 AM, Surveyor received an email from Administrator A with records for Resident 1.

Resident 1 was admitted on 12/02/2025 with multiple diagnoses including anxiety, depression, borderline personality, and dementia. Resident 1 was his/her own legal decision maker and was given a 30-day discharge notice by the provider on 12/31/2025. The notice read, in part, " ...there is an imminent risk of serious harm to the health or safety of the residents. [Resident 1] has been secretly picking up medications, keeping them in [his/her] room and not informing staff about these medications. We have no choice but to issue this notice. [Resident 1's] last day of residency with Care Partners in Eau Claire, WI will be January 30, 2026 ...We will do everything we can to help with the relocation process ..."

A "Resident/Visitor Incident Report," dated 01/07/2026, read, in part, "[Resident 1] began stating that [s/he] had thoughts of harming

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[his/herself] and needed to be seen for mental health." Under a section titled, "Immediate Director follow-up & comments," there were handwritten comments indicating a registered nurse (RN) was contacted due to safety risk and Resident 1 was unable to return to facility.

The email included a forwarded email, dated 01/09/2026, addressed to the Department of Human Services (DHS). The email read, in part, "However, I want the appeal team to be aware that [Resident 1] has not been in the facility since [s/he] left on 1/7/26. [S/he] was having thoughts of harming [his/herself] and not wanting to be alive anymore thus [s/he] requested to go out for mental health and suicidal ideations...It was determined that [Resident 1] was a significant safety risk to [his/herself] and that Care Partners West would not be a safe environment for [him/her] given these suicidal tendencies. My staff are not mental health professionals equipped to handle those types of mental health needs nor can we ensure a controlled safe environment given that there is a level of independence and privacy within a CBRF (Community Based Residential Facility); especially with respecting resident rights. Care Partners West notified [Hospital] and [MCO] that we were no longer able to meet [Resident 1's] level of care need within our facility thus we could not accept [him/her] back."

The provider did not ensure Resident 1 had a living arrangement suitable to meet his/her needs before involuntarily discharging the resident.