STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 From 11/04/2025 through 11/05/2025, Surveyors conducted four complaint investigations and a self-report review at Care Partners Assisted Living 1. Five deficiencies were identified. Three (3) of 4 complaints were substantiated. Census: 17	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 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 take immediate steps to protect	N 158		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

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N 158	Continued From page 1	N 158		

all residents or conduct thorough investigations after receiving allegations of abuse.

During the afternoon of 08/06/2025, Administrator A received allegations Caregiver J abused Resident 2. Administrator A did not begin an investigation and did not take immediate steps to protect residents. Caregiver J worked 08/06/2025, 6:00 PM - 08/07/2025, 6:00 AM.

On 08/06/2025 at 10:12 PM, Administrator A received an allegation Caregiver J abused Resident 3 earlier in the shift. Administrator A did not begin an investigation and did not take immediate steps to protect residents. Caregiver J completed the shift.

Administrator A suspended Caregiver J and began an investigation the morning of 08/07/2025. During the investigation Administrator A did not document or conduct interviews with caregivers and delegated resident interviews to a caregiver who did not have responsibilities for investigations.

Findings include:

The Department received a complaint alleging resident abuse.

RECORD REVIEW
Prior to conducting the onsite visit, Surveyor reviewed Department records. The records included a Misconduct Incident Report (MIR) submitted by Regional Registered Nurse (RN) E on 08/15/2025. The MIR documented allegations received on 08/06/2025 and a summary report authored by Administrator A. The report read in part,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

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N 158	Continued From page 2 -08/06 around 2:30 PM, Caregiver H reported an allegation of abuse to Administrator A. Caregiver H explained the previous night during 2nd shift, s/he was assisting Caregiver J and Caregiver B in showering Resident 2. Caregiver H said s/he witnessed Caregiver J become physically aggressive with Resident 2 by pushing him/her into the shower chair and making threats to "drown" Resident 2. Caregiver H told Administrator A s/he was "scared to say anything that night due to [Caregiver J] taking out [his/her] aggression/ frustration out on the residents or [on Caregiver B]." Administrator A wrote, "I thanked [him/her] for letting me know and told [him/her] I would look into this situation." -08/06 around 2:45 PM, Caregiver B reported an allegation of abuse to Administrator A. "[Caregiver B] stated something has been bothering [him/her] ...when [s/he] worked last night with [Caregiver J] and [Caregiver H] an incident happened...[s/he] couldn't stomach it anymore and [s/he] needed to tell me." Caregiver B reported Caregiver J was aggressive and made verbal threats of harm to Resident 2 during a shower. Administrator A wrote, "I thanked [him/her] for the information and asked why [s/he] didn't report this to me right away and [s/he] stated [s/he] was scared of [Caregiver J] as [s/he] scares people." -08/06 at 10:12 PM, Administrator A received a call from Caregiver H, "[S/he] sounded like [s/he] was crying and was terrified...[s/he] said [s/he] had witness [sic] [Caregiver J] being aggressive with another resident. I told [him/her]...to calm down so I could understand [him/her]." Caregiver H provided more information about an incident of physical abuse s/he witnessed involving Caregiver J and Resident 3 (Resident 3). Administrator A wrote, "I explained to [Caregiver	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 3 H] that I would look into this in the morning when I get to work." -08/06 at 11:28 PM, "I (Administrator A) got a text from [Caregiver B] stating ' I'd like to discuss what happened with [Resident 3] and what I witnessed on my shift again tonight. It is something I did not feel comfortable with..." Administrator A wrote, "I did not get this text until I work up the next morning." -08/06 at 6:16 AM, Administrator A received a text from Caregiver K (1st shift staff) reporting new bruising on Resident 3. -08/07 at 8:27 AM, Administrator A informed RN E "of the investigation I was starting once I go to work." At 8:40 AM, Administrator A began calling staff to request written statements "in regards to working with [Caregiver J] from August 1st to the 7th." -08/07 at 10:23 AM, Administrator A sent a text to Caregiver J, "There is an internal investigation going on therefore, you are suspended until the investigation is over." -08/07 at 11:00 AM, Caregiver J arrived at the facility and wanted to talk to Administrator A about the investigation. Administrator A said s/he was still collecting information and would contact him/her later. -08/07 at 3:00 PM, Administrator A reported the allegations to law enforcement, after being encouraged to do so by adult protective services who was at the facility for a routine visit. -08/07 at 3:57 PM, Administrator A sent a text to Caregiver J to "come get the questions I had	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

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N 158	Continued From page 4	N 158		

ready for [him/her]." At 6:03 PM, Caregiver J arrived at the facility to "pick up the questions I had ready for him/her. Told [him/her] to come back tomorrow at 10:00 AM so we can discuss the investigation." The MIR included the questions provided to Caregiver J. Examples included, "Why are you belittling residents? Mocking? Where is there [sic] dignity?" and "How can you justify talking to the residents they [sic] way you have been? Threatening to give them a black eye, stating you are going to drown them while they are in the shower." In Caregiver J's written responses s/he denied the allegations and wrote s/he "never" talked to a resident like that.

-The MIR included "Questions that where [sic] asked to residents." There were seven questions total and resident responses were documented. The forms did not identify the person who competed the questions with the residents.

-The MIR included a written statement authored by Caregiver G on 08/08/2025 which included additional allegations of mistreatment. For example; (1) "[Caregiver J] and I were doing cares and [Resident 2] was pulling [his/her] garments back up. That made [Caregiver J] mad. [Caregiver J] smacked [Resident 2] open handed on [his/her] bare thigh." (2) "I...walked into the living room, [Resident 2] was on the ground flopping around. [Caregiver J] seemed annoyed says [sic] to me, "that will teach [Resident 2] a lesson to sit still." (3) "This week [Caregiver J] was more distraught and frustrated then [sic] usual...[his/her] voice was loud and obnoxious... [Caregiver J] told me, "...sometimes you have to get gangster!'" Caregiver G wrote, "I'm sorry, I didn't know what to do. [Caregiver J] scares me sometimes." Surveyor noted the statement did not include dates of the alleged incidents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 5 On 11/04/2025, Surveyor revived the provider's policy titled "ABUSE/MISCONDUCT" dated 12/12/2012. It read in part, "...Care Partners...believes that all people deserve dignified, loving care with services provided to maximize their potential for living and independence. Our plan shall assure protection of each resident from possible abuse...procedures to ensure appropriate implementation and continuation of this plan; systems for reporting abuse...REPORTING INCIDENTS (ACTUAL, SUSPECTED, ALLEGED) . All employees, volunteers and any other individual involved in resident's care are required to immediately report any known or suspected resident abuse to the Director...Upon learning of an incident of alleged misconduct, the Director shall take whatever steps are necessary to ensure that residents) are protected from subsequent episodes of misconduct while a determination on the matter is pending." INTERVIEWS Surveyor interviewed Caregiver G on 11/05/2025 at 6:55 AM. Caregiver G said s/he wrote the aforementioned statement after being asked by Administrator A to provide a written statement about anything s/he "felt uncomfortable with" while working with Caregiver J in the previous week. Caregiver G said Administrator A did not ask any follow up questions about dates, times or to request more detail about the information s/he provided. Caregiver G confirmed s/he had concerns about Caregiver J in the weeks preceding the 08/06/2025 incidents. S/he said the last "2 weeks got really ugly...there was aggression." Caregiver G said s/he didn't report sooner because "[Caregiver J] was an intimidating [person]...I felt scared. I didn't know if	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 6 [Administrator A] would believe me..." Surveyor interviewed Administrator A and RN E on 11/05/2025 at 10:15 AM. The managers confirmed Administrator A has primary responsibility for conducting misconduct investigations, along with support from RN E, and their policy requires immediate steps be taken to ensure residents are protected from subsequent episodes of abuse while the matter is pending. Administrator A said s/he had not received training in conducting investigations and felt ill equipped in navigating the situation with Caregiver J. RN E was surprised by that and said s/he thought Administrator A was trained when s/he took the administrator course. During the interview, Administrator A acknowledged the following: -On 08/06 between 2:30-2:45 PM, Caregivers H and B reported to Administrator A they witnessed Caregiver J abuse and threaten Resident 2 the previous evening. Administrator A did not take immediate steps to protect residents or begin an investigation. -On 08/06, Caregiver J worked 6:00 PM - 6:00 AM. Four hours into the shift, Administrator A received a new allegation Caregiver J abused Resident 3 and s/he did not take immediate steps to protect residents or begin an investigation. Caregiver worked the remainder of 3rd shift. -On 08/07, at 8:40 AM, Administrator A began the investigation -On 08/07, Caregiver J attempted twice to talk to Administrator A about the concerns but Administrator A did not interview Caregiver J. Administrator A explained s/he was afraid of Caregiver J. -Administrator A's process is to request a written	N 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 7	N 158		

statement from the caregivers instead of conducting interviews. S/he did not conduct an interview with Caregiver G to follow up on the other incidents of misconduct in the written statement. Resident interviews were delegated to a caregiver who does not have responsibility for conducting misconduct investigations.

During the interview, Regional RN E told Surveyor s/he reviewed Administrator A's investigation prior to submitting it to the Department. RN E said "in general" s/he thought the investigation was good but Administrator A could have benefited form more specific guidance with formulating written questions. For example, RN E said the questions for Caregiver J were "leading." Surveyor asked RN E if during his/her review of Administrator A's investigation, s/he had concerns about the delay in protecting residents or beginning an investigation. RN E said, "I did not pick up on that detail."

SURVEYOR NOTE
The Department published a resource for providers titled, "WISCONSIN BACKGROUND CHECK AND MISCONDUCT INVESTIGATION PROGRAM MANUAL" which reads in part, "All entities regulated by DQA must conduct a thorough internal investigation and document the findings for all allegations or incidents at the entity. A thorough internal investigation may include: Collecting and preserving any physical and documentary evidence...; Interviewing alleged victims and witnesses; Collecting other corroborating/disproving evidence; Involving other regulatory authorities who can assist (e.g., local law enforcement...)These steps should be taken as part of the entity's initial attempt to determine what, if anything, happened and to determine the complete factual circumstances surrounding the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 158	Continued From page 8 alleged incident...Protection of Clients - Immediately upon learning of the incident, the entity must take necessary steps to protect clients from possible subsequent incidents of misconduct or injury...Notifying Law Enforcement - In addition to DQA reporting requirements, entities are required to notify local law enforcement authorities in any situation where there is a potential criminal offense." Source: https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf, retrieval date 11/11/2025. Cross Reference: N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment	N 158		
N 348	83.32(3)(d) Rights of Residents: Free from mistreatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Freedom from mistreatment. Be free from physical, sexual and mental abuse and neglect, and from financial exploitation and misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 2 and Resident 3 were free from physical and emotional abuse. On 08/05/2025, Caregiver J was physically aggressive with Resident 2 while providing a	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 348	Continued From page 9	N 348		

shower and sprayed Resident 2 in the face with water while threatening to drown him/her. Residents 2 had diagnoses to include Alzheimer's with agitation and dysphagia (difficulty swallowing.)

On 08/06/2025, Caregiver J forcefully grabbed Resident 3 by the arm, pulled him/her to the nearest chair, pushed him/her into the chair and then continued to push Resident 3 down into the chair to prevent him/her from getting up. Resident 3 sustained bruising on his/her biceps and chest. During the incident, Caregiver J mocked Resident 3 and threatened to punch him/her in the face. Resident 3 had diagnoses to include dementia and did not speak English.

Findings include:

The Department received a complaint alleging resident abuse.

The provider is licensed to serve up to 20 residents who may be of advanced age, physically disabled, terminally ill, have developmental disabilities or irreversible Alzheimer's/dementia.

RESIDENT 2:
Prior to conducting the onsite visit, Surveyor reviewed Department records. The records included a Misconduct Incident Report (MIR) submitted by Regional Registered Nurse (RN) E on 08/15/2025.

According to the MIR, on 08/06/2025 between 2:30-2:45 PM, Administrator A received allegations that Caregiver J abused Resident 2 the evening of 08/05/2025. The MIR included handwritten statements by the 2 caregivers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 348	Continued From page 10 detailing the abuse they witnessed: Caregiver B's written statement: -On 08/05/2025 at approximately 8:30 PM, Resident 2 needed a shower after an episode of bowel incontinence. Caregiver B and Caregiver H tried to shower Resident 2 but s/he was "struggling and not cooperating" so Caregiver J assisted. During this, [Caregiver J] was "slightly aggressive and impatient with the Resident stiffening and not transferring easily." Shortly after the 1st shower, Resident 2 soiled him/herself again requiring another shower. Caregiver B, Caregiver H and Caregiver J provided the 2nd shower. Resident 2 was stiffening his/her legs, leaning forward and not sitting in the shower chair "properly." Caregiver B wrote, "I witnessed [Caregiver J] grab the shower head and spray the Resident aggressively in the face, eyes and mouth while shouting 'I'm going to drown your [expletive] if you don't let go ...[Caregiver J] had already shoved me out of the way ..." Caregiver H placed him/herself between Caregiver J and Resident 2 and Caregivers H and B finished the shower without Caregiver J. After the incident Caregiver B assessed Resident 2 and noted "something was wrong" because Resident 2 was "shaking, wouldn't make eye contact...and would not unball [sic] [his/her] fists." Caregiver B informed Caregiver J of the observations and "[Caregiver J] laughed at my concerns." Caregiver H's written statement: -On 08/05/2025 at approximately 8:30 PM, Resident 2 soiled him/herself and needed staff assistance with a shower ...During the shower Caregiver H witnessed Caregiver J become "borderline aggressive as [s/he] appeared	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 348	Continued From page 11	N 348		

frustrated with [Resident 2] stiffening [his/her] body." Caregiver H explained Resident 2 was again incontinent and needed another shower. While Caregivers H, B and J were showering Resident 2, Resident 2 was "leaning forward" in the shower chair and "would not bend [his/her] legs. I witnessed [Caregiver J] push with such force it turned [Resident 2] sideways in the shower chair. While walking to the laundry room, I overheard someone say, 'I'm going to drown you.' When I returned...I witnessed [Caregiver J] handle [Resident 2] aggressively where I felt the need to place myself between [him/her] and the resident."

On 11/4/2025 at 10:28 AM, Surveyor reviewed Resident 2's record. Resident 2 was elderly, was admitted to the facility on 06/28/2023, had an activated power of attorney (POA) for health care, received hospice services and passed away on 08/18/2025. Resident 2 had diagnoses to include dysphagia and Alzheimer's disease with agitation. Resident 2 had a history of falls and resisting cares and showers. Resident 2's individual service plan (ISP) was not updated based on assessment to identify interventions to help encourage acceptance of cares.

RESIDENT 3:
During the aforementioned review of the MIR, Surveyor noted a second incident of abuse by Caregiver J the evening of 08/06/2025.

Caregiver B's written statement:
-On 08/06/2025 between 9-10:00 PM, Resident 3 was actively exit seeking. Caregiver B described Caregiver J's response, "[Caregiver J] yells at [Resident 3] to sit down and grabs [Resident 3] by [his/her] bicep forcefully and pulled [him/her] over to the nearest chair. [Caregiver J] pushed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 348	Continued From page 12	N 348		

resident down aggressively and with enough force, [Resident 3] bounced into the back of the chair cushion." Caregiver B wrote that Caregiver J then prevented Resident 3 from moving and "kept pushing [Resident 3] back down." Caregiver B wrote after the incident s/he witnessed Caregiver J say to [Resident 3], "'If you don't sit, I'll give you a black eye.' To which I told [Caregiver J] the resident understands English, which [Caregiver J] just laughed and mocked [Resident 3], saying 'I hope [Resident 3] understands.'" Caregiver B wrote that during this interaction, Caregiver J was "getting in [Resident 3's] face and motioning a punch while slowly saying, 'Black eye.'" Caregiver B wrote, "I clocked out at 9:30 (PM) and immediately reported the incident to [Administrator A]." Surveyor note: Resident 3's primary language was not English.

On 11/04/2025 at 8:54 AM, Surveyor interviewed Caregiver F. Caregiver F said Caregiver J tried to implement his/her "parenting style" on the residents which included "stern talking to, finger pointing and demeaning behavior. You don't want to see that. It's a memory care building. They can't comprehend what they are doing." Caregiver F said residents would complain to him/her about Caregiver J being "very rude and loud" and described him/her as being demeaning. Caregiver F said s/he reported the concerns to Administrator A near the end of July 2025 and Administrator A said s/he "would work on it."

Caregiver F recalled at the start of his/her shift on 8/07/2025 at approximately 6:00 AM, s/he observed Resident 3 kneeling down at the front door praying. Caregiver F said s/he observed Caregiver J pull Resident 3 up by his/her arms abruptly and Resident 3 "started crying in pain." Caregiver F said, "Then I saw what looked like a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 348	Continued From page 13	N 348		

hand print on [his/her] left forearm. It looked bright red and purple, like it's fresh." Caregiver F said s/he assessed Resident 3 and found other bruises "all over" his/her chest and 4-5 quarter size/shaped bruises on each bicep. Surveyor observed Caregiver F tear up when s/he reflected on Caregiver J's treatment of Resident 3 and said, "I loved [Resident 3]."

On 11/04/2025 at approximately 4:00 PM, Surveyor reviewed Resident 3's record; s/he was elderly, was admitted to the facility on 07/23/2025 and passed away on 10/18/2025. Resident 3 had diagnoses to include dementia, had an activated POA for health care and received hospice services. Resident 3's ISP documented a history of falls and wandering and communication deficits because s/he did not speak English. The only tool for communication identified in the ISP was a picture board. An undated hospice document in the record read, "Convey patience and respect through your posture and facial expressions. BE GENTLE AND CALM [sic]....Pay close attention to verbal and non verbal - you may not understand what is being said but watch [sic] what [s/he] is saying...Maintain a soft, gentle tone."

COURT RECORDS:
On 11/04/2025, Surveyor reviewed online court records and found Caregiver J is a defendant in Outagamie County Court Case Number 2025CF00952 filed 08/27/2025. Caregiver J is charged with four counts:

1. 940.198(3)(b) Physical Abuse of Elder Person - Recklessly Cause Bodily Harm, Felony I
2. 940.295(3)(a)1 Intentionally Abuse Patients-Cause Bodily Harm, Felony I
3. 940.295(3)(a)2 Recklessly Abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 348	Continued From page 14 Patients-Bodily Harm, Misdemeanor A 4. 940.285(2)(a)2 Recklessly Subject an Individual at Risk to Abuse - Cause or Likely to Cause Bodily Harm, Misdemeanor A On 11/04/2025, Surveyor obtained a copy of the associated criminal complaint which detailed the aforementioned incidents of abuse against Resident 2 and Resident 3. ADMINISTRATOR A INTERVIEW: Surveyor interviewed Administrator A and RN E on 11/05/2025 at 10:15 AM. The managers confirmed Surveyor's review of the MIR filed 08/15/2025. Surveyor asked Administrator A if anyone reported concerns to him/her about Caregiver J prior to 08/05/2025. Administrator A said s/he "recalled a conversation" near the end of July 2025 with a caregiver who had concerns, but s/he could not remember who the reporting caregiver was and s/he did not document the conversation. Administrator A said the reporting caregiver shared concerns about Caregiver J being "overly loud" and "in [Resident 3]'s face" while in the living room. Administrator A said, "And my reply (to the reporting caregiver) was, '[S/he] is not deaf [s/he] can hear you, [s/he] can understand you even though [his/her] native language is [not English]." Administrator A said, "I don't know if I reached out to Caregiver J about it or not." During the interview, Administrator A confirmed that after s/he was informed of abuse allegations on 08/06/2025 s/he did not take immediate steps and Caregiver J worked that same night 6:00 PM - 6:00 AM. S/he acknowledged during that shift, Caregiver J abused Resident 3. Administrator A agreed in hindsight this was a missed opportunity	N 348		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 348	Continued From page 15 to intervene and protect residents from further incidents of abuse, as was the lack of investigation when concerns were first reported at the end of July 2025. Cross Reference: N0158 DHS 83.12(2)(a) Caregiver: Investigation Abuse & Neglect N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 348		
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 ensure Individual Service Plans (ISPs) were updated to identify needs and interventions. Resident 2's ISP was not updated to identify needs and services related to fall prevention, intrusive wandering, behaviors impacting others	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 16	N 389		

and resistance to care.

Resident 4 had mental health diagnoses with a history of behaviors including verbal and physical aggression, unclothing self in common areas, suicidal ideation and wandering with actual elopement from the facility. Resident 4's ISP was not updated based on assessment to identify interventions to meet his/her needs in these areas.

This is a repeat deficiency. See SOD GCLZ13 dated 09/26/2022, SOD GCLZ14 dated 03/01/2023, and SOD XF5S11 dated 08/23/2024.

Findings Include:

RESIDENT 2:

On 10/22/2025, the Department received a complaint alleging concerns about intrusive resident wandering.

On 11/5/2025 at 10:28 AM, Surveyor reviewed Resident 2's record which included his/her face sheet, fall reports, observation notes and ISP.

Resident 2 was admitted to the facility on 6/28/2023, with diagnoses that included Alzheimer's disease with agitation, insomnia, and dysphagia. Resident 2's record indicated s/he passed away on 8/18/2025.

Fall Incident Reports March 2025 - August 2025

-03/19: "Staff heard a loud thud and [Resident 2] saying, 'Help me.' Staff quickly approached ...and helped [Resident 2] up off of the floor..."
-04/06: "Staff was walking with [Resident 2] and [Resident 2] turned around and tripped over

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 17 [his/her] foot and slipped onto [his/her] bottom. Then turned onto [his/her] arm and got rug burn ..." -07/12: "Was helping [Resident 2] when [s/he] got wobbly and began to fall when I caught [him/her] with my body. [S/he] soon slid a bit when me and my coworker helped [him/her] up and into a wheelchair ..." -07/13: "Staff walked into [Resident 2]'s room and found [Resident 2] seated on floor against his/her air conditioning unit. Resident stated [s/he] had fallen trying to get up from [his/her] chair. Bleeding from the right elbow. Both hands seemed to be swollen ..." -07/16: "[Resident 2] was walking and lost [his/her] balance and landed on left shoulder ..." -07/17: "Staff went to get [Resident 2] and saw [Resident 2] on [his/her] knees on the floor in [his/her] bathroom asking for help ..." -07/24: "[Resident 2] was found on the floor hanging on to the wheelchair. Helped [Resident 2] back to wheelchair..." -07/28: "[Resident 2] rolled out of bed. [Resident 2] was incontinent and had to be fully changed ..." -08/04: "[Resident 2] was napping when I left front living room. When I came back few minutes, [Resident 2] was off [his/her] chair on floor on buttock and against chair." -08/07: "Staff saw [Resident 2] stand. They ran out. Right as they got there to [him/her], [s/he] tumbled over." -08/09: "[Resident 2] tried to stand up from Broda chair and fell due to severe problems with gait." Observation notes March 2025 - July 2025 documented agitation, wandering, restlessness, resistance to cares and behaviors impacting other residents. Examples include: -02/20: "Staff went into [Resident 2]'s room at	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 18 5:00 AM to get [Resident 2] dressed, [Resident 2] was not in [his/her] room and was found in another resident's room." -02/21: "[Resident 2] is very agitated today. Kept going into other resident rooms ... Making statements, 'Someone is going to get shot.' ..." -03/09: "[Resident 2] was fighting with other residents. Very agitated and broke chairs in the back living room." -04/24: "[Resident 2] was found in another resident's room after lunch." -05/03: "[Resident 2] was eating off of other plates at lunch." -05/12: "[Resident 2] was going room to room moving the chairs around in the back and getting very angry." -05/31: "Staff attempted to get [him/her] showered. [Resident 2] was extremely combative and barely let staff change [his/her] brief and pants." -06/01: "[Resident 2] attempted to move furniture while other residents and staff were sitting on the furniture." -07/24: "NOC (3rd shift) ...When putting resident to bed resident was combative and punched writer in jaw." -07/29: "NOC (3rd shift) - "[Resident 2] trys [sic] to get up 8 hours of shift. Meds don't work. Very restless, lots of anxiety ..." Resident 2's ISP read in part: Wandering - Frequency of Service and Service Provided- "[Resident 2] likes to walk around the building. [S/he] likes to exit seek and try to hop the fence to leave. [S/he] will enter in any room that is open and get into anything such as food, chemicals, clothes, and storage." Goal/Outcome- "[Resident 2] will be safe daily through the next assessment." 6 Month Progress Review Changes	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 19	N 389		

dated 6/2025-"[Resident 2] still tried to enter resident rooms, wander facility." Annual Evaluation Changes dated 7/2025- no change. No interventions were identified.

Well Being - Frequency of Service and Service Provided- "[Resident 2] likes to walk around the building..." Goal/Outcome- "[Resident 2] will be happy daily through the next assessment." 6 Month Progress Review Changes dated 6/2025- no change. Annual Evaluation Changes dated 7/2025- "[Resident 2] would move and break furniture." No interventions were identified.

Aggressive/Combative - Frequency of Service and Service Provided- "[S/he] has become aggressive and combative with cares, showers, changing, during all times of the day. See interventions". Goal/Outcome- "[Resident 2] will be happy in the environment daily through the next assessment." 6 Month Progress Review Changes dated 6/2025- see attachment. Annual Evaluation Changes dated 7/2025- no change.

Verbal - Frequency of Service and Service Provided- "[S/he] has shown to be verbally aggressive to staff and others. See interventions." Goal/Outcome- "[Resident 2] will be happy in the environment daily through the next assessment." 6 Month Progress Review Changes dated 6/2025- no change. Annual Evaluation dated 7/2025- no change.

Communication Skills - Frequency of Service and Service Provided- "cannot express [his/her] needs and wants." Goal/Outcome- "[Resident 2] will communicate wants and needs daily through the next assessment." 6 Month Progress Review Changes dated 6/2025- no change. Annual Evaluation Changes, dated 7/2025, no addition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 20	N 389		

information documented. No interventions were identified.

This ISP was silent to the risk of falls or interventions to prevent them.

The record included an undated document titled, "Resident Behavior Management Plan". It included: Behavioral Symptoms- "aggressive towards staff: toileting, changing clothes, helping to bed/waking up, redirecting, biting, spitting, scratching, hitting/punching, destroying furniture- moving it- dumping over [sic] -smashing against wall." Possible Precipitators- "not being able to communicate (with) staff - not being able to do what [s/he] wants - over stimulated [sic]." Interventions- "redirect with activity, different staff - reapproach later." The form contained a standard, typed statement at the bottom, "If above is unsuccessful may administer appropriate as needed medication as prescribed."

Surveyor noted the interventions of offering an activity reapproaching with a different staff member were not individualized for Resident 2's varied behaviors listed in this section. In addition, during interviews with Caregiver G (11/05/2025 at 6:55 AM and Administrator A 11/05/2025 at 4:14 AM), both confirmed at times there is only 1 caregiver working in the facility during 3rd shift; therefore the intervention of having a different caregiver approach was not always available.

The record also included subsection of documentation from 2024. The section contained a document titled "Member Information" date stamped 10/06/2024. The document included specific information about needs and detailed interventions associated with Resident 2's behavior patterns of being resistive to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 21	N 389		

cares/showers due to progression of dementia, increased anxiety and unpredictable moods. Interventions included; provide structure and clear expectations, set up shower prior to bringing him/her to shower, approach by saying the day and reminding it is his/her day to shower and at what time the shower will be completed, point out where all items are one at a time, talk through each step, provide one step projects such as building blocks and Legos to keep anxiety down, provide a job or task he/ can complete such as sweeping or organizing, show respect and honor by thanking him/her for allowing you to assist, praise his efforts, redirect with things s/he can click with such as an old joke or a memory that brings him/her joy, talk about his/her long time job, smile and speak in a pleasant tone, and use simple statements like "Please comb your hair now." Surveyor noted these interventions were not included in Resident 2's current ISP.

On 11/04/2025 at 10:00 AM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 2 had frequent falls and behaviors to include turning over furniture, being combative with staff and frequently wandering into other residents' rooms.

On 11/04/2025 at 2:34 PM Surveyor interviewed Caregiver K. Caregiver K indicated Resident 2 had tendency to wander and enter other residents' rooms, stating, "We had to keep most of the doors locked because of that. Other residents didn't like it. They would yell at [him/her] to get out, but [s/he] didn't understand." Caregiver K said Resident 2 was always "getting into something." Caregiver K confirmed Resident 2 was at risk for falls and had a fall mat near his/her bed. S/he also said near the end of Resident 2's life his/her mobility changed and s/he was in a wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 22 On 11/05/2025 at 6:55 AM, Surveyor interviewed Caregiver G. Caregiver G said Resident 2's needs changed over the summer of 2025. Caregiver G said Resident 2 "declined" and needed to use a wheelchair and "that's when it got real [sic] tricky." Caregiver C explained Resident 2 would attempt to self-propel in the wheelchair and move his/her feet very fast. This would cause him/her to slide off the chair and land on the ground. On 11/04/2025 at 1:10 PM, Surveyors interviewed Administrator A. Administrator A verified ISPs should be comprehensive and identify the resident's needs and individualized interventions connected to each need. Administrator A acknowledged Resident 2's individual service plan did not identify the history of falls or interventions to prevent future falls. S/he also acknowledged it did not include specific interventions for times when Resident 2 exhibited behaviors that impacted other residents and did not contain individualized interventions for resistance to dressing and showering. Administrator A explained when the ISP noted "see interventions" it was cross referencing the Resident Behavior Management Plan. Administrator A said s/he was unsure when that plan was created or last updated and stated, "It should be dated." Administrator A also explained the documented titled "Member Information" was an older behavior plan developed by an outside agency and acknowledged it would have been beneficial to ensure the current ISP included more detailed interventions similar to the interventions in the Member Information document.	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 23 RESIDENT 4: The Department received a complaint alleging concerns related to elopement risk. On 11/04/2025 at 9:56 AM, Surveyor reviewed portions of Resident 4's record. The record documented diagnoses to include schizophrenia. Surveyor noted the following progress notes in Resident 4's chart indicating the following: 11/07/2025- eloped from facility and found in the community by police, returned to the facility. 05/18/2025- Resident 4 called 911 due to having suicidal ideation 05/30/2025- eloped from the facility and was found and brought back to the facility by police. 09/16/2025-Handwritten document that indicated an outline of the following: -If physically aggressive or combative call police, be sure to tell them about Resident 4's mental illness, they will take [him/her] to the hospital. -Call guardian-get consent for admission if needed. If the on call is not (unsure of person who is referenced) follow up with him/her in the morning. -Dr. stated that Resident 4 could restart medications at any time. No need for medical clearance. -Law enforcement/staff can call crisis if needed Surveyor noted signature at the bottom of handwritten document and was unable to determine who wrote this guide/intervention list. Surveyor reviewed Resident 4's ISP and noted the following: -Wandering: Resident 4 has a history of wandering in facility. Resident 4 is very social and	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 24	N 389		

wanders around but not into other rooms. Resident 4 has eloped in the past. Last elopement was 11/07/2024. Not allowed outside by self. No interventions were listed. This category was not updated after the 05/30/2025 elopement.

-Well Being: Resident 4 has some anxiety regarding staying busy and active during the day. Staff will ensure Resident 4 is involved in activities. See Behavioral Management Plan. Surveyor noted no indications on Behavioral Management plan regarding anxiety and interventions for Resident 4 to stay busy. Surveyor noted no interventions indicated in ISP Well Being goal.

-Aggressive/Combative: Resident 4 has shown no signs of aggression or combativeness. If any behavioral changes occur, staff will fill out an incident report. Surveyor noted no incident reports in Resident 4's facility chart regarding aggressive/combative behaviors. Surveyor noted handwritten note from 9/16/2025 as only mention of aggressive/combative interventions. Surveyor further noted the needs and potential interventions from the 09/16/2025 document were not included in R's ISP.

-Verbal: Resident 4 has no history of becoming verbally aggressive. Resident 4 makes needs known. Surveyor noted progress notes between May of 2025 through September of 2025 documented Resident 4's use of vulgar language and profanity towards staff. Surveyor noted no interventions for this behavior were included in ISP.

The ISP was silent to needs or interventions for suicidal ideations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 389	Continued From page 25 On 11/04/2025 at 10:15 AM, Surveyor interviewed Administrator A and Regional Registered Nurse (RN)-E. Administrator A indicated that in September of 2025, Resident 4 voiced having the right to refuse medications and did refuse to take mental health medications causing Resident 4 to become very aggressive, abusive, and have suicidal ideations where Resident 4 was sent to the hospital for evaluation. RN-E stated when Resident 4 takes medications, Resident 4's behaviors are more manageable, further explaining that some behaviors are due to Resident 4 having a history of hearing voices telling Resident 4 to do certain things, such as elopements to find a new home. On 11/05/2025 at 2:36 PM, Surveyor interviewed Administrator A and RN-E. Administrator A indicated that the last elopement Resident 4 had was in May of 2025, further verifying that when Surveyor requested Resident 4's ISP, Administrator A noticed that Resident 4's ISP had not been updated with interventions from the last elopement, and that 15 minute checks should be included as an intervention in Resident 4's ISP but that intervention was not included. Administrator A confirmed Resident 4 has a mental health diagnosis and has a history of verbal and physical aggression. Administrator A acknowledged the ISP did not include information regarding these needs or associated interventions. During the interview, Surveyor and RN-E reviewed the handwritten note dated 09/16/2025 located in Resident 4's record. RN-E looked at form and did not know what the form was about, further indicating that the signature was from Resident 4's psychiatric nurse and indicated the	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

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N 389	Continued From page 26 form is something that must have been given to staff when Resident 4's psychiatric nurse visited Resident 4 at the facility during the time of increased behaviors and Resident 4 was refusing medications. At that time Administrator A indicated that the form was created when Resident 4 had stopped taking mental health medications and had complaints of stomach pain and vomiting, as well as suicidal ideation and went to the hospital. Administrator A further indicated that Resident 4 became combative at the hospital or with police and was returned to the facility with psychiatric nurse visit scheduled to come see Resident 4. Administrator A confirmed not receiving the document and that these interventions that were written down to assist Resident 4 were not included into Resident 4's ISP to assist with behaviors and that the suicidal ideations and aggressive behaviors should be in Resident 4's ISP and Resident 4's ISP should have been updated during these changes in condition and were not. Cross reference N0348 DHS 83.32(3)(d) Rights of Residents: Free From Mistreatment Y3244 CH 50.09(1)(l) Care	N 389		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

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N 452	Continued From page 27 maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored, prepared, distributed or served under sanitary conditions for the prevention of food borne illnesses. The facility did not ensure that hot foods were held at a temperature of 140-degree Fahrenheit (F) until served to residents. Findings include: On 11/05/2025, Surveyor reviewed the facility's policy titled "Temperatures food and beverage" dated 12/12/2012 which indicated foods are to be served at the following temperatures: Hot foods 140 degrees or above. These are important to follow to assure foods are being served at the correct temperatures. Procedure: The temperatures are to be checked and recorded twice per week, alternating meals. Food temperatures need to be recorded on the Food Temperature Log. These records must be retained until the next licensing survey. On 11/04/2025 at 8:20 AM, Surveyor observed a resident council meeting being conducted by	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

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N 452	Continued From page 28 Activity Personnel (AP)-L. Surveyor observed Resident(R) 5, Resident 6 and Resident 7 speaking during resident council with AP-L regarding food concerns, with Resident 7 indicating that food is "still cold" further indicating that the food is served cold, and this has been addressed during resident council several times. AP-L at that time indicated Resident 7 to remember what to do if the food is too cold when served? Where at that time Resident 7 indicated that asking staff to reheat the food in the microwave, then indicating that the food remains cold or doesn't taste good when it is reheated. AP-L at that time indicated that staff need to get in the habit of plugging in the hot box, where Resident 6 indicated that the food is in a plugged-in hot box and is still served cold. At that time Surveyor observed Resident 5 indicate agreement with Resident 7 indicating the food is cold and even when cut up it can't be eaten because it's hard and over or undercooked, and the temperature is unappealing. Surveyor observed Resident 6 at that time, indicating that the food is cold, and unappetizing, explaining that the food tastes like "dog food" and is never served hot or tasting good. On 11/04/2025 at 9:00 AM, Surveyor interviewed Resident 5 who indicated to Surveyor that residents are served cold food, the food is never served hot enough and is unappetizing. On 11/04/2025 at 9:09 AM Surveyor observed posted menu to indicate lunch meal service for 11/04/2025 to be French onion smothered pork chop with mashed potatoes and gravy, green beans and lemon desert. At that time, Surveyor interviewed Caregiver (C)-N who indicated food is served for lunch at 12:00 PM and the facility kitchen that cooks the food is next door. C-N	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

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N 452	Continued From page 29 further indicated the food is delivered in a "hot box" that keeps the food warm while staff serve the food and is delivered around 11:45 AM. On 11/04/2025 at 10:14 AM, Surveyor interviewed Resident 6 who indicated that food is served cold and is unappetizing. Resident 6 further indicated that the food can be reheated but isn't heated to an appetizing temperature still. Resident 6 further indicated telling Activity Personnel (AP)-L during meetings, as all residents do and nothing changes, AP-L is to tell Administrator A, but nothing ever changes. On 11/04/2025 at 11:50 AM, Surveyor observed "hot box" to be delivered to the facility kitchen. Surveyor observed "hot box" to be plugged in. At 11:56 AM, Surveyor observed food service to begin as C-N took the steam table containers, containing lunch meal service food items from the "hot box" and place them on the kitchen countertop and begin plating foods for service to residents leaving plates with lunch meal service foods on the kitchen countertop for other caregiver to pick up and serve to residents in the dining room. Surveyor observed seven plates on the kitchen countertop waiting for service at 12:00 PM, and at that time, Surveyor requested temperature of foods that were being served to residents be obtained. Surveyor obtained temperature of lunch meal service food items utilizing a food thermometer provided by Surveyor as C-N indicated that the facility did not have a thermometer in the kitchen. Surveyor began obtaining temperature with C-N confirming the temperature of the foods through food thermometer as follows: French onion smothered pork chop at 113 degrees Fahrenheit(F)	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 452	Continued From page 30 Green Beans at 135 degrees F Mashed potatoes at 140 degrees F. Surveyor at that time interviewed C-N who indicated not having knowledge of the required food safety temperature of hot foods being served to residents, as well as confirming that residents have frequently made complaints of food being cold. On 11/04/2025 at 12:10 PM, Surveyor interviewed Resident 5 who was observed in the dining room with lunch plate approximately 75% full. Resident 5 indicated that staff at the facility have been told by resident's multiple times that the food is cold and unappetizing and "nothing changes." Resident 5 indicated could not eat food, as the food was tough and served cold. On 11/04/2025 at 12:15 PM Surveyor interviewed Resident 6 who was in the dining room eating lunch. Resident 6 indicated to Surveyor that the food was cold, and the pork chop was hard and unappetizing. On 11/04/2025 at 12:18 PM, Surveyor interviewed Resident 7, observed in the dining room finishing up lunch, who indicated that the food was cold and did not want to eat the food, and did not want to have it reheated as this is not appetizing to have food reheated constantly, further explaining "half the time the food reheated isn't hot either". On 11/04/2025 at 12:48 PM Surveyor further interviewed Resident 7 at Resident 7's request, who indicated that the food is cold, and it shouldn't be served like that. Resident 7 further indicated that s/he sometimes won't eat it because it just isn't good cold, and if it is reheated that is gross, we shouldn't have to eat leftovers,	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 452	Continued From page 31	N 452		

further explaining that it doesn't always taste good when reheated and sometimes the food is reheated and still does not taste good. Resident 7 indicated speaking at resident council meetings and letting staff know frequently that the food is cold and nothing changes.

On 11/04/2025 at 2:34 PM, Surveyor interviewed C-K who indicated that the food is served cold, further indicating belief that this could be due to staff not plugging in the hot box when the food arrives, further indicating that foods are microwaved at resident's request, further stating that it is unfortunate when resident get cold food.

On 11/05/2025 at approximately 9:30 AM, Surveyor reviewed resident council meeting minutes for August, September, October and November of 2025. Surveyor noted the following:

-Resident council dated 08/08/2025 indicated food: Discussion of old food concerns left blank. Food: still coming over cold.
-Resident council dated 09/023/2025 indicated: discussion of old concerns left blank. Food: potatoes are hard and cold; food is coming cold.
-Resident council dated 10/07/2025 indicated: discussion of old concerns left blank. Food: always cold, potatoes not done, veggies not done.
-Resident council dated 11/04/2025 indicated: discussion of old concerns Left blank. Food is still cold.

On 11/05/2025 at 2:36 PM, Surveyor interviewed Administrator A and RN-E who confirmed there have been several complaints regarding food with regards to temperatures and appropriate textures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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 452	Continued From page 32 Cross Reference: Y3244 CH 50.09(1)(l) Care	N 452		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on observation, record review and interview the provider did not ensure Resident 2 received adequate and appropriate care within the capacity of the facility to meet his/her dietary needs. Resident 8 required staff assistance with cutting foods. On 11/02/2025, Resident 8 was served food that was not cut up, choked and subsequently passing away. Findings include:	Y3244		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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
Y3244	Continued From page 33 The Department received a complaint about cold food. On 11/04/2025 at 8:20 AM Surveyor observed a resident council meeting being conducted by Activity Personnel (AP)-L. Surveyor observed Resident 6, Resident 5 and Resident 7 speaking during resident council with AP-L regarding food concerns, with Resident 7 indicating that "they need to cut up our food, we continue to say this." Resident 7 further explaining that food, especially meats and vegetables, are too tough to eat. AP-L indicated to Resident 7 foods being cut up would be discussed with staff. At that time Surveyor observed Resident 5 indicate agreement with Resident 7 that the food is hard to eat, cold and even when cut up it can't be eaten because it's hard and over or undercooked, Surveyor observed Resident 6 at that time, indicating food is hard to eat because the food is "tough". On 11/04/2025 at 10:14 AM, Surveyor interviewed Resident 6 who indicated food is undercooked, it is tough and hard to eat. Resident 6 said "potatoes are undercooked and hard as a rock" and showed Surveyor that Resident 6 has not teeth and does not wear dentures. Resident 6 explained s/he will spit the food out regularly because s/he can't chew it and is afraid of choking. Resident 6 volunteered to Surveyor, "I don't want to be like [Resident 8] ...[s/he] choked on something and died." Resident 6 said this happened recently during mealtime. Resident 6 said, "[Resident 8] needed [his/her] food cut up ...every once in a while [s/he]'d choke." Resident 6 went on to say, "The food here would be good if they knew how to cook it but sometimes it doesn't get cooked all the way through, your potatoes, broccoli, asparagus hard substance foods don't	Y3244		

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	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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
Y3244	Continued From page 34	Y3244		

get cooked all the way through. We (residents) told them about it. Everybody here has talked about it, [AP-L] takes report. If (Surveyors) were out here today when we had the meeting with [AP-L] (Surveyor) would hear the people come together, even (Resident 7) we all asked and talked to [AP-L] about the cook, and it isn't cooked all the way through a lot of people are choking or they're not eating. I for one don't eat it, I get $100 a month from Social Security, and got to take that money to go buy food".

On 11/04/2025 at 10:48 AM, Surveyor interviewed Caregiver F (C-F) who confirmed over the weekend Resident 8 choked on a pork chop during a meal and died. C-F indicated that Caregiver G (C-G) and Caregiver M (C-M) were working and served lunch during the choking incident. C-F further indicated that Resident 8 had been declining, would eat too quickly, and always required food to be cut up, especially meats. C-F said a different resident choked in the past so s/he has been "nervous" about it happening again.

On 11/04/2025 at 12:10 PM, Surveyor interviewed Resident 5 who was observed in the dining room with lunch plate approximately 75% full. Surveyor observed meal to consist of mashed potatoes, green beans and pork chop. Surveyor observed Resident 5's pork chop to be cut up. Surveyor interviewed Resident 5 who indicated the pork chop was too hard to eat, even with being cut up, and was only able to eat mashed potatoes and a few green beans. Resident 5 further indicated that despite having to ask for food to be cut up and even if in small pieces the food such as potatoes, vegetables and especially meats are always tough and difficult to eat. Resident 5 further indicated that staff at the facility have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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
Y3244	Continued From page 35	Y3244		

told by residents multiple times about difficulty with eating foods due to the foods needing to either be cut up or cooked softer and "nothing changes."

On 11/04/2025 at 1:45 PM, Surveyor reviewed portions of Resident 8's facility records. Resident 8 was admitted to the facility on 09/13/2024 with diagnosis including Alzheimer's. Resident 8's Admission Application, dated 08/29/2024 indicated Resident 8 had communication/speech problems indicated Resident 8 will mutter yes or no, is able to feed self with cues, as well as Resident 8 has a court appointed guardian for all health and financial decisions. Resident 8's Step Assessment Tool dated 08/19/2024 indicated Resident 8 required some assistance or assist of one for Activities of Daily Living (ADLs) and set-up assistance and cutting of meat for dining, and heavy impairment in all areas regarding mental status. Resident 8's Step Assessment Tool dated 12/09/2024 indicated Resident 8 required total assistance for ADLs and set-up assistance and cutting of meat for dining, and heavy impairment in all areas regarding mental status.

On 11/05/2025 at 5:59 AM, Surveyor interviewed C-G who indicated being employed at the facility since March of 2025 on NOC (overnight) shifts and 11/02/2025 was the first time C-G worked a day shift. C-G indicated that Resident 8 required assistance at night, so C-G explained knowing that Resident 8 did not communicate very well, as Resident 8 would "scream" for assistance at night, further explaining Resident 8 did not use a call light and C-G was not sure that Resident 8 knew how to use a call light. C-G further indicated "belief" that Resident 8's care card indicated Resident 8's food was required to be cut up. C-G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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
Y3244	Continued From page 36	Y3244		

verified that caregivers use the care cards for residents to know what cares are required for residents. C-G indicated belief that co-worker C-M cut up the food for residents as C-G indicated not cutting up foods for residents on that day, did not look at all the plates, further explaining not knowing the normal routine for who cuts foods and who all needed foods cut as C-G never worked a day shift and did not know the normal routine. C-G indicated the meat for the lunch meal that day was a pork chop. C-G indicated serving plates to residents and then leaving to bring the juices to the table during that time of serving juices to residents C-G indicated Resident 7 "screamed" out loud to C-G "[Resident 8] is choking" and C-G ran to Resident 8 attempting back thrusts, calling for C-I to come and assist, starting the Heimlich and calling both 911 and Director (D)-A. C-G indicated both C-G and C-M attempted the Heimlich maneuver until Emergency Medical Services (EMS) arrived and brought Resident 8 into the hospital. C-G confirmed to Surveyor s/he talked with residents after the incident with residents stating the meat is always hard, further stating that residents indicated if they didn't serve residents hard meat all the time this wouldn't have happened.

On 11/05/2025 at 9:15 AM, Surveyor continued with review of Resident 8's facility records, reviewing Resident 8's Individual Service Plan (ISP). Surveyor noted ISP dated 10/13/2024 and last reviewed date 10/22/2025 indicated: staff will need to cut up food, encourage Resident 8 to sit closer to food, using rimmed plate. Surveyor further noted Resident 8's record included a care card utilized and signed out by caregivers to ensure Resident 8's needs are met. The care card was inconsistent with the ISP and indicated eating as "independent with a general diet".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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
Y3244	Continued From page 37	Y3244		

Surveyor reviewed the care card and noted it did not identify the need to cut up food or use a lipped plate.

On 11/05/2025 at approximately 9:30 AM, Surveyor reviewed resident council meeting minutes for August, September, October and November of 2025. Surveyor noted the following:
--Resident council dated 08/08 indicated food: still coming over cold, potatoes are not cooked.
--Resident council dated 09/23 indicated: discussion of old concerns left blank. Food: potatoes are hard and cold, food is coming cold.
--Resident council dated 10/07 indicated: discussion of old concerns left blank. Food: always cold, potatoes not done, veggies not done.
--Resident council dated 11/04 indicated: discussion of old concerns Left blank. Food: needs to be cut up into smaller pieces. Food is still cold.

On 11/05/2025 at 9:58 AM, Surveyor interviewed C-M who verified working the day shift on 11/02/2025 when the incident of choking occurred with Resident 8. C-M indicated s/he plated the food in the facility kitchen and handed the plates to co-worker C-G who served them to residents. C-M verified not knowing who cut up foods for residents, explaining not knowing where the information for who required assistance with cutting up foods or dietary needs is located for residents. At that time C-M confirmed not cutting up any foods for residents while plating foods on 11/02/2025. C-M indicated after plating the foods for residents C-M went to start noon medication pass when hearing C-G yell for help in the dining room, going to the dining room and finding that Resident 8 was choking. C-M indicated starting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

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CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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
Y3244	Continued From page 38	Y3244		

the Heimlich maneuver to attempt to dislodge food, that C-G did mouth sweep and unable to dislodge food and was unsuccessful. C-M indicated both 911 and D-A were contacted and attempts continued to remove lodged food in Resident 8 until EMS (Emergency Medical Services) arrived and took over, bringing Resident 8 to the hospital. C-M indicated being informed that a piece of pork chop was found lodged in Resident 8's throat and that Resident 8 passed away due to choking on the pork chop.

On 11/05/2025 at 2:36 PM, Surveyor interviewed Administrator A and Registered Nurse (RN)-E who indicated that a residents preadmission tools and assessments such as the step assessment are used during the first thirty days of a residents stay until an ISP is developed to ensure residents receive care appropriate to their needs. RN-E at that time confirmed that the assessments and ISP are used to develop a "Kardex" or "Care Card" that caregivers use and sign off on to ensure residents receive the care that they require. Administrator A confirmed that on 11/02/2025, Resident 8 had an incident of choking during lunch and subsequently passed away. Administrator A verified being informed that imaging was conducted, and a piece of pork chop was found lodged in Resident 8's throat causing Resident 8 to choke and was unable to be dislodged causing Resident 8 to pass away. Administrator A confirmed s/he submitted a self-report to the Department on 11/04/2025. S/he interviewed both caregivers working that day about their response to the choking incident but did not investigate the root cause of the choking. Administrator A stated his/her investigation did not include a determination of whether C-G or C-M assisted Resident 8 with eating or cutting up foods for Resident 8 on that date. Administrator A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016352	A. BUILDING: _____ B. WING _____	C 11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING I	5031 N FRENCH RD APPLETON, WI 54913

(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
Y3244	Continued From page 39 and RN-E confirmed that care card does not indicate that food should be cut up. They also confirmed the assistance that Resident 8 required for feeding was not included in the care card or updated on Resident 8's ISP. Administrator A and RN-E further confirmed that the care card, ISP and Step Assessment tools did not all contain the necessary updated information in one spot for all staff to know what assistance that was required to safely assist Resident 8 with feeding, as well as all care needs. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	Y3244		