STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016157	A. BUILDING: _____ B. WING _____	R-C 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOONA	887 BRIAR LANE ALTOONA, WI 54720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 11/06/2025, Surveyor conducted a complaint investigation and verification visit at Care Partners Assisted Living Altoona I. Data collection continued through 11/10/2025. The complaint was substantiated. Two deficiencies were identified. Two of 2 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) 3GB711, dated 08/11/2021 and SOD SUG611, dated 03/26/2021. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 16	{N 000}		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a written report was sent to the department when law enforcement was called to the CBRF (community based residential	N 164		

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

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N 164	Continued From page 1	N 164		

facility) in response to an incident that jeopardized the health, safety, or welfare of residents on 10/17/2025.

This is a repeat deficiency. See Statement of Deficiency (SOD) 3GB711, dated 08/11/2021.

Findings include:

On 11/04/2025, the department received a complaint alleging illegal substances were found at the facility.

On 11/06/2025, at approximately 11:20 AM, Surveyor interviewed Director B. When asked about any recent law enforcement interventions, Director B stated a backpack was found outside near the woods, between the 2 licensed facilities, both operating under the same licensee. Director B stated we were in the "memory care" facility and next door was the "assisted living" facility. Director B stated there was some paperwork and what appeared to be drugs inside of the backpack. Director B stated the police were contacted. Director B stated Caregiver D found the backpack and immediately notified Director B. Director B stated there was a piece of paper with a name on it inside of the backpack. When asked if the incident was reported to the department, Director B stated s/he would call Registered Nurse (RN) F to confirm. After speaking with RN F, Director B stated a report was not sent to the department because police did not have direct contact with the residents.

At approximately 11:45 AM, Surveyors requested the staff schedule for both facilities.

At approximately 1:10 PM, Surveyor interviewed Caregiver G. Caregiver G stated a coworker's

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N 164	Continued From page 2	N 164		

significant other would come to the facility. Caregiver G could not recall the name of the coworker. Caregiver G stated Director B was told about it and s/he had not heard of the significant other since then.

At approximately 2:10 PM, Surveyor reviewed the staff schedules. Caregiver E was primarily scheduled on the memory care side. Caregiver D was scheduled on the memory care side 6:00 AM - 2:00 PM the day the backpack was found.

At approximately 2:20 PM, Surveyor interviewed Caregiver D. Caregiver D stated s/he found a backpack outside in the grass and gave it to Director B. Caregiver D stated there was a piece of mail with a name on it and it was believed to be the name of Caregiver E's significant other.

On 11/10/2025, Surveyor requested police records from the Altoona Police Department.

At 9:32 AM, Surveyor reviewed the police records that included the following:

-An officer report for a "Drug Incident" reported on 10/17/2025. Under a "Circumstances" subsection, it read, in part, "DTMA DRUG-MARIJUANA, DTCO DRUG-COCAINE." The address identified was the licensed facility directly next door. The report included multiple supplemental narratives including an interview with Caregiver E. Caregiver E stated s/he had dated the person identified to have the mail in the backpack. S/he stated his/her significant other was not an employee but would be around him/her and would help take out the garbage. Caregiver E stated s/he had ended the relationship with the person.

The provider did not ensure a written report was

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N 164	Continued From page 3 sent to the department when law enforcement was called to the CBRF to investigate a drug incident on 10/17/2025.	N 164		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure toxic substances were securely stored. This is a repeat deficiency. See Statement of Deficiency (SOD) SUG611, dated 03/26/2021. Findings include: The provider is licensed to care for 20 residents in the client groups advanced aged, irreversible dementia/Alzheimer's disease, physically disabled, and terminally ill. On 11/04/2025, the department received a complaint alleging the provider had an uncontrolled issue with bugs in the facility. On 11/06/2025, at 12:07 PM, Surveyor interviewed Resident 1 in his/her bedroom. When asked if Resident 1 had any environmental concerns, Resident 1 stated s/he had some bugs on the floor recently. Surveyor observed a can of Raid sitting on Resident 1's dining table. The can read, "Ant Killer" on the front label.	N 499		

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N 499	Continued From page 4 At approximately 12:10 PM, Caregiver A entered Resident 1's room to assist him/her to the dining area for lunch. When asked about the can of Raid, Caregiver A stated s/he brought that to Resident 1's room. Caregiver A took the can of Raid and exited the room with Resident 1. At approximately 3:00 PM, Surveyor interviewed Director B and Director C regarding the can of Raid observed in Resident 1's room. Director B and Director C were taking notes and acknowledged the concerns related to the storage of toxic chemicals.	N 499		