STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 On 08/26/2025, with additional information gathered through 09/05/2025, Surveyor conducted a verification visit and 2 complaint investigations at Care Partners Assisted Living II. Two of 2 complaints were substantiated. One of 2 previous deficiencies were corrected. Three deficiencies were identified. One deficiency is a repeat violation, see Statement of Deficiency (SOD) LIDL12, dated 05/01/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 32	{N 000}		
{N 352}	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received all prescribed medications in the dosage and at intervals prescribed by his/her practitioner. Resident 1 was identified as actively dying by hospice and received orders for nebulizer treatments, an antibiotic, and scheduled morphine and lorazepam on 08/10/2025. The orders did not get into the MAR timely or at all causing Resident 1 to not receive his/her treatment and comfort medications as ordered,	{N 352}		

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
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 352}	Continued From page 1 and passed away on 08/12/2025. This is a repeat deficiency, see Statement of Deficiency (SOD) LIDL12, dated 05/01/2025. Findings include: On 08/19/2025, the department received complaint information alleging end of life, comfort medications were not administered as ordered. On 08/26/2025, Surveyor conducted a complaint investigation and verification visit. At approximately 9:18 AM, Surveyor requested a list of residents who had been at end of life in the past 6 months. Director A listed Resident 1 had passed away on hospice on 08/12/2025. Surveyor reviewed Resident 1's record and noted s/he moved to the facility on 05/02/2024 with diagnoses of stage 3 kidney disease, chronic obstructive pulmonary disease (COPD), and anxiety. Resident 1 was on hospice and was identified as actively dying on 08/10/2025 and hospice ordered scheduled comfort medications. S/he passed away early afternoon on 08/12/2025. Surveyor reviewed and compared Resident 1's physician orders and August 2025 Medication Administration Record (MAR) and noted of Resident 1 not receiving prescribed medications as ordered. Hospice physician order dated 08/10/2025 10:25 AM: "1) Ipratropium Bromide & Albuterol Sulfate inhalation solution 0.5/3 mg use 1 vial for [4] times a day for wheezes and SOB [shortness of breath]	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 352}	Continued From page 2 2) Prophylactically treat for pneumonia with Augmentin 875 mg BID [twice daily] for 5 days 3) Continue with morphine and Lorazepam PRN [as needed] for SOB and anxiety." Surveyor noted a stamp on the order "Charted AUG 1[indecipherable] 2025" August 2025 MAR: Amoxicillin 875 mg tablet - take 1 tablet by mouth twice daily with food for 5 days for COPD sticker provided by the pharmacy. Handwritten/added to the MAR on 08/12/2025 at "8 AM" as noted 08/01/2025-08/11/2025 was crossed off. Handwritten starting on 08/12/2025 was "D/C'd [discontinued] 8/12/25 [Med Tech B]." Resident 1 did not get any doses of Amoxicillin antibiotic. Ipratropium- Albuterol 0.5-3(2.5) mg/3 mL - Inhale the contents of 1 vial per nebulizer four times daily sticker provided by the pharmacy. Handwritten/added to the MAR on 08/11/2025 as 08/01/2025-08/10/2025 was crossed off. Order was listed on the MAR 4 times and handwritten "8 AM, 12 PM, 4 PM, and 8 PM." Resident 1's 08/11/2025 8 AM dose listed "D/C'd 8/12/25 [Med Tech B]." Resident 1's 08/11/2025 12 PM dose listed nebulizer not administered as "All pills hold pre [sic; per] hospice." Resident 1's 4 PM dose was initialed with a circle but no notation added. Resident 1's 8 PM dose was initialed with a circle but no notation added. Resident 1 did not get any doses of ipratropium-albuterol nebulizer treatment. Surveyor noted a notation for 08/10/2025 8 PM by Med Tech C "all 8 PM [medications] held per hospice." Hospice physician order dated 08/10/2025 Time Not Listed:	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 352}	Continued From page 3 "1) Please give morphine every hour due to abdominal breathing and wincing with touch ...4) Give lorazepam every 4 hours for comfort/terminal restlessness." Surveyor noted a stamp on the order "Charted AUG 12 2025" August 2025 MAR - Handwritten by Med Tech B: "Morphine sol [solution] 100 mg/5 mL Take 1 mL every hr [hour] as needed for pain or SOB." No start date was listed, but Med Tech B signed out the morphine as being administered starting on 08/12/2025 at 7:40 AM, 8:40 AM, 9:40 AM, 10:40 AM. No scheduled or PRN morphine was administered in August prior to 08/12/2025. Lorazepam 1 mg tablet - Take 1 tablet by mouth every 4 hours as needed for anxiety or SOB. Med Tech B signed out the lorazepam as being administered on 08/12/2025 at 8:12 AM for anxiety. No scheduled or PRN lorazepam was administered in August prior to 08/12/2025. Resident 1's scheduled lorazepam and scheduled morphine orders were not added to the MAR. Albuterol HFA 90 mcg 8.5 g Albuterol Sulfate - Inhale 1 puff into the lungs every 6 hours as needed for SOB/COPD *MAY KEEP AT BEDSIDE.* Resident 1's inhaler was listed as PRN. Surveyor noted handwritten "D/C'ed 8/12/25 [Med Tech B]." Resident 1's inhaler was self-administered, but was listed on the MAR for ordering. There was no evidence to support if/when Resident 1's inhaler was to be refilled. On 08/28/2025 at approximately 9:04 AM, Surveyor interviewed Family Member E who	{N 352}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 352}	Continued From page 4	{N 352}		

voiced concern about Resident 1's end of life care. S/he said Resident 1 did not get scheduled morphine and lorazepam until the day s/he passed, and did not receive his/her antibiotic, despite hospice orders. Family Member E indicated s/he observed Resident 1 to be short of breath on 08/10/2025 and had asked staff about his/her inhaler and nebulizer treatment. Family Member E stated Resident 1's inhaler was evidently empty. S/he stated staff were able to set up the nebulizer machine, but unable to administer the nebulizer treatment due to "not having an order." Family Member E indicated Resident 1 had been on the nebulizer multiple times in the past related to his/her COPD, so s/he did not understand why it wasn't on the MAR.

On 08/26/2025 at approximately 9:50 AM, Surveyor interviewed Med Tech B who stated Resident 1 was on comfort medications prior to passing. Med Tech B stated Family Member E reported concern about Resident 1 not having his/her inhaler and nebulizer treatment. S/he indicated there was no order for nebulizer solution. Med Tech B stated Resident 1 kept his/her inhaler at bedside, so staff were unsure when/if s/he used it. Med Tech B indicated s/he did hear that his/her inhaler was empty, but s/he was not sure what happened. S/he said there were times where inhalers could be denied for refill if it's too early for them to be refilled, but s/he was unsure whether that was the case. Med Tech B was unsure how often Resident 1 needed his/her inhaler refilled. Surveyor noted Med Tech B was scheduled as working on 08/09/2025 6:00 AM - 2:00 PM, 08/10/2025 6:00 AM - 8:00 PM, 08/11/2025 6:00 AM - 2:00 PM, and 08/12/2025 6:00 AM - 8:00PM.

At approximately 10:20 AM, Surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 352}	Continued From page 5 Med Tech B who stated s/he was not even aware Resident 1 had an inhaler until it was said to be empty. Med Tech B said s/he was unsure whether or not refilling it was attempted or the schedule for refilling. S/he indicated it was the weekend, so s/he believed there were delays related to that. On 09/03/2025 at approximately 2:30 PM, Surveyor interviewed Director A. S/he stated s/he was not aware Resident 1 had an inhaler and acknowledged s/he did not get a refill of it when needed for symptoms. Director A acknowledged Resident 1's antibiotic and nebulizer treatment orders were not added to the MAR timely resulting in Resident 1 not receiving his/her antibiotic or nebulizer treatment despite symptoms. Director A acknowledged Resident 1's schedule comfort medications - lorazepam and morphine did not get put in the MAR, and Resident 1 did not receive lorazepam and morphine as scheduled on 08/10/2025 when s/he was determined actively dying, on 08/11/2025, or until 8 AM on 08/12/2025. Cross Reference N0431 83.38(1)(g) Health Monitoring	{N 352}		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 6	N 431		

health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not monitor Resident 1 and Resident 2's physical health and document and communicate with their physician and record changes in their health status.

Resident 1 required blood sugar testing and blood pressure monitoring. Resident 1's blood pressure and blood sugars were not taken as ordered.
Resident 1 developed increased shortness of breath and cough leading to a change in condition and progression to end of life. Resident 1 was not repositioned as ordered. Resident 1 was left in bed in the same position from 08/11/2025 to 08/12/2025.

Resident 2 had a fall that resulted in increased pain to his/her hip. The facility did not maintain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 7	N 431		

communication with the provider about increased pain and did not monitor and track his/her pain to ensure it was managed.

Findings include:

On 06/30/2025 and 08/19/2025, the department received complaint information alleging residents' health was not being monitored and needs were not being met.

RESIDENT 1
Surveyor reviewed Resident 1's record and noted s/he moved into the facility on 05/02/2024 with diagnoses of chronic obstructive pulmonary disease (COPD), orthostatic hypotension, anxiety, depression, stage 3 chronic kidney disease, diabetes mellitus type 2, recurrent syncope, fibromyalgia, insomnia, lupus, hypertension, hypothyroidism, and tardive dyskinesia. Resident 1 was receiving hospice services.

Surveyor reviewed Resident 1's most recent individual service plan (ISP) with review date 06/06/2025. Resident 1 was able to make his/her needs known and required assistance with medication administration, health monitoring, assistance some days with some activities of daily living (ADLs), and redirection with his/her anxiety.
Surveyor note: Resident 1's ISP was not updated to reflect Resident 1's change of condition on 08/08/2025 as Resident 1 developed a cough and increased shortness of breath. At end of life, Resident 1 was bed bound, required full assistance from staff, and was on comfort cares. Resident 1 passed away on 08/12/2025.

Blood Pressures
Surveyor reviewed Resident 1's July and August

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 8 2025 Medication Administration Record (MAR) and noted "CHECK BLOOD PRESSURE TWICE A DAY" and "CHECK ORTHOSTATIC BLOOD PRESSURE ONCE A WEEK (TUES[day])." Surveyor noted Resident 1's MAR was blank for all 18 days in August and his/her orthostatic blood pressure was blank and without staff initials on Tuesday, 08/05/2025 and Tuesday, 08/12/2025. Surveyor noted Resident 1's twice daily blood pressure checks were discontinued on 07/15/2025. Surveyor reviewed Resident 1's June-August 2025 Blood Pressure Record and noted 13 days in June where Resident 1's blood pressure was not taken or recorded and 6 days in July through 07/15/2025 were not taken or recorded. Surveyor noted 2 of 3 Tuesdays in July where Resident 1's orthostatic blood pressure was not taken or recorded and 2 of 2 Tuesdays in August where Resident 1's orthostatic blood pressure was not taken. Blood Sugars Surveyor reviewed Resident 1's June-July 2025 MAR and noted Blood Sugar Diagnostic - Use to test blood sugars 3 times daily 7 AM, 11 AM, 4 PM, discontinued 07/15/2025. Resident 1's MAR indicated Resident 1's blood sugar was not taken or recorded 39 times in June and s/he refused approximately 28 times in June; Resident 1's blood sugar was not taken or recorded 17 times in July and s/he refused for it to be taken 15 times through 07/15/2025. Surveyor reviewed Resident 1's June-July 2025 Blood Sugar Record and noted a handwritten note indicating inaccurately that Resident 1's blood sugars were to be checked "3x weekly." End of Life Care / Repositioning	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 9 Surveyor reviewed Resident 1's hospice physician order dated 08/10/2025: "1) Please give morphine every hour due to abdominal breathing and wincing with touch. 2) Reposition every 2 hours for comfort and elevate heels of bed for skin breakdown prevention." Surveyor noted a stamped "Charted AUG 12 2025." On 08/28/2025 at 9:04 AM, Surveyor interviewed Family Member E who indicated upon visiting Resident 1 on 08/11/2025, s/he was in his/her own personal bed, not propped up, and appeared to be gasping for air. S/he said s/he propped Resident 1 up in bed and asked staff for medication for shortness of breath. Family Member E said the hospital bed was delivered to Resident 1's room and s/he asked staff if they would move him/her to the hospital bed. S/he said s/he left and came back later in the evening on 08/11/2025 and Resident 1 was still lying in his/her own personal bed, in the same position and had agonal breathing. Family Member E stated s/he asked staff to transfer Resident 1 to the hospital bed and for him/her to be repositioned as s/he was at end of life. S/he said hospice also provided education to staff about repositioning him/her and keeping his/her legs elevated. On the morning of 08/12/2025, Family Member E stated s/he arrived to the facility to check on Resident 1 and s/he was still in his/her personal bed, on his/her back, in the same position. S/he said Resident 1 had agonal breathing and was grimacing upon his/her visit. Resident 1 was then transferred to the hospital bed and positioned comfortably. "They didn't take care of [Resident 1]." On 08/26/2025 at 10:20 AM, Surveyor interviewed Med Tech C who verified Resident 1's hospital bed was delivered to Resident 1's room on 08/11/2025. Med Tech C indicated Resident 1	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 10	N 431		

remained in his/her personal bed and was not transferred to the hospital bed until 08/12/2025. Med Tech C stated there was no documentation to direct staff to reposition Resident 1 and so they did not chart on repositioning him/her.

On 08/26/2025 at approximately 9:34 AM, Surveyor interviewed Director A who stated s/he believed staff were told to reposition Resident 1, but s/he couldn't find any documentation to direct staff to do so or documentation that it was completed.

On 09/03/2025 at approximately 2:30 PM, Surveyor interviewed Director A who verified Resident 1's blood sugars and blood pressures were not always taken or documented. Director A acknowledged Resident 1 was not repositioned as ordered for end of life care.

RESIDENT 2
Surveyor reviewed self-report information sent to the department on 07/11/2025 [late reporting] involving Resident 2 having an unwitnessed fall on 06/12/2025 at approximately 2:00 PM, in an attempt to stand and adjust his/her thermostat in his/her room. Resident 2 pressed his/her call light and was found to be laying on his/her left hip. Director A wrote "At the time of fall, resident denied any pain and had baseline strength and ROM [range of motion]. Over the weekend [Resident 2] started complaining of pain and when staff asked [his/her] POA if we [provider] could send [him/her] out, the POA ...did not want [him/her] sent out and instructed staff to manage the pain with some acetaminophen ...This went on for a few days where [Resident 2] was in pain and [his/her] POA denied sending [him/her] out [to the ER] ...No bruising evident on lower body. As the pain increased and resident strength and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 11	N 431		

ROM decreased ...POA agreed to send [him/her] out ....[Resident 2] diagnosed with a left hip fracture, was admitted and on 6.18.25 [Resident 2] had surgery."
Surveyor note: Resident 2's fall occurred on 06/12/2025 and s/he was not medically evaluated until 06/18/2025.

Surveyor reviewed Resident 2's record and noted s/he was admitted to the facility on 07/05/2024 with diagnoses of arthritis, diabetes, cancer, Parkinson's disease, depression, and anxiety. S/he discharged from the facility on 06/18/2025. Resident 2 was not assessed and his/her ISP was not updated to reflect a change in Resident 2's mobility status, fall, pain, and pain management.

Surveyor reviewed a fax sent to the physician by Director A on 06/12/2025 reporting Resident 2 had an unwitnessed fall in his/her room around 2 PM on 06/12/2025. "Staff got assistance and did ROM [range of motion] and took vitals - ROM - slight pain in left hip. Vitals - 120/73, pulse 74. Monitoring." No response noted from Resident 2's physician.

Surveyor reviewed Resident 2's "Head Injury Assessment" dated 06/12/2025. Resident 2 was assessed by caregivers daily for dizziness, increased confusion, blurred vision, nausea/vomiting, severe headache, and vitals every 4 hours for 72 hours. Surveyor noted the assessment did not include any assessment of pain or other anatomical assessment.

Surveyor reviewed handwritten nurse's notes from 06/16/2025 "Late Entry Staff called family on Monday June 16th to let them know that res [resident] was in a lot of pain due to the fall [s/he]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 12	N 431		

had over the weekend ....[staff were told] to give acetaminophen or pain pill ...[Resident 2] explained ...how laying in bed is the only thing to help get rid of some of the pain ...staff were told to give more acetaminophen and let it kick in. On Wednesday June 18th around dinner time ...res [sic] was still complaining of a lot of pain and now stating that [his/her] hip doesn't feel right."
No other nurse's notes were written for 06/12/2025-06/16/2025.

Surveyor reviewed Resident 2's June 2025 MAR and noted orders for:
Acetaminophen 500 mg tab - take 1-2 tabs by mouth twice daily as needed for pain. Surveyor noted Resident 2 was given acetaminophen 2 times - on 06/12/2025 at 4:25 PM and 06/16/2025 at 11:35 AM for hip pain, which were both effective. The MAR indicated s/he was offered acetaminophen on 06/18/2025 at 3:22 PM, in which s/he refused.
Tramadol HCl 50 mg tab - take 1 tablet by mouth twice daily as needed for chronic pain. Surveyor noted Resident 2 was given tramadol 4 times - on 06/12/2025 at 1:38 PM, 06/14/2025 at 6:03 PM, 06/17/2025 at 7:21 PM, and 06/18/2025 at 3:35 PM for pain.
Surveyor note: Resident 2 was not given any pain medication on 06/13/2025, 06/15/2025, 06/16/2025.

On 08/26/2025 at 9:50 AM, Surveyor interviewed Med Tech B. S/he described Resident 2 as sometimes being stiff upon rising and without staff assistance s/he would sometimes fall. Med Tech B said Resident 2 had an unwitnessed fall in his/her room and was complaining of pain. The POAHC denied Resident 2 to be sent to the hospital for evaluation and rather treat the pain with as needed (PRN) medication. Med Tech B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 13	N 431		

indicated s/he had contacted the POAHC back and forth multiple times throughout the weekend about Resident 2 being in pain. S/he would say that POAHC would say that s/he just needed to get up and move. Med Tech B said Resident 2 was definitely in pain and had bruising. S/he indicated Resident 2 was sent out and hadn't returned following rehabilitation. Med Tech B said staff were to complete 72-hour head assessment since s/he had an unwitnessed fall. Surveyor inquired whether they did pain management monitoring and Med Tech B said no.

At 10:20 AM, Surveyor interviewed Med Tech C who said Resident 2 had complained of pain quite often after his/her fall through the weekend. S/he said Resident 2 had Tylenol in the MAR and cart, so that's what they gave him/her. S/he indicated Resident 2 said s/he wanted to go to the doctor's, but didn't want to go by ambulance and didn't want to upset his/her POAHC. Med Tech C said Resident 2 was not walking the same following the fall and struggled to stand up and required assistance. Surveyor inquired whether they monitored Resident 2's pain in any way and s/he indicated they did a 72-hour head assessment, but nothing for pain. Surveyor inquired how often Resident 2 received Tylenol and Med Tech C could not recall.

At approximately 11:40 AM, Surveyor interviewed Director A who indicated Resident 2 had a fall on 06/12/2025 that led to him/her to be in growing pain as the days went on through 06/18/2025. S/he said it was his/her understanding that staff were administering acetaminophen/Tylenol to treat his/her pain as Resident 2's POAHC did not want him/her sent to the hospital for evaluation. Director A indicated Resident 2 was able to communicate clearly, was able to make his/her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 431	Continued From page 14 needs known, and was able to and did report pain when s/he had it. S/he said Resident 2 was very vocal about staff's approaches and whether or not something was uncomfortable. On 09/03/2025 at approximately 2:30 PM, Surveyor interviewed Director A who verified Resident 2 reported pain daily following his/her fall. Director A acknowledged staff did not monitor and document Resident 2's pain and medications in alignment with reports of him/her being in pain or to verify s/he did not need pain medication to manage pain. Cross Reference: N0352 83.32(3)(h) Rights Of Residents: Receive Medication	N 431		
N 491	83.44(2)(c) Interior floors, walls and ceilings. Every interior floor, wall and ceiling shall be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure every interior floor was clean and in good repair. The common area carpeting was stained, had fraying, and had visible debris throughout the facility. Findings include: On 08/19/2025, the department recieved complaint information alleging concerns with facility cleanliness. On 08/26/2025, Surveyor conducted a complaint	N 491		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 491	Continued From page 15 investigation. At approximately 9:20 AM, Surveyor observed from down the hall a laundry basket full of clothes and a full garbage bag sitting on the floor outside of resident room 10. At approximately 10:51 AM, Surveyor toured the facility and noted basic gray textured, thin commercial tile carpeting throughout the facility. Surveyor observed various darkened circular areas throughout the carpeting near the back entrance door leading to the patio and a 2-3 foot large darkened stain with splatter-like marks around it, in front of room 10. Surveyor observed multiple white fuzzy debris, other foreign debris, dust, and dirt throughout the carpet on each wing, in the living room area next to the dining room, and in the sitting area near the back patio. Surveyor noted near the back patio door at least 3 evident carpet squares (rectangles) with fraying on the edges. At approximately 9:50 AM, Surveyor interviewed Med Tech B who indicated s/he worked full time AM's at the facility. Surveyor inquired about the facility cleaning schedule and s/he said staff clean rooms daily and indicated there was an AM, PM, and NOC (night shift) cleaning schedule. Med Tech B stated AMs and PMs jointly vacuum the common areas and NOC staff have a sweep broom they can use to vacuum. Surveyor inquired when the common areas were last vacuumed and Med Tech B stated s/he did not know. At approximately 10:20 AM, Surveyor interviewed Med Tech C who indicated s/he worked full time AM's at the facility. Surveyor inquired about housekeeping and Med Tech C stated all staff help with cleaning on each shift. Med Tech C stated "we try to [clean common areas] at least once a week at least and as needed." Surveyor	N 491		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016353	A. BUILDING: _____ B. WING _____	R-C 09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 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 491	Continued From page 16 inquired when the last time the common area carpeting was vacuumed or shampooed and Med Tech C indicated s/he believed s/he did on the previous Thursday. (Surveyor note: Day of Survyor's visit was the following Tuesday) Med Tech C said s/he believed Maintenance recently shampooed the carpeting, but was unsure. Med Tech C verified seeing the large stain on the carpet outside of resident room 10 and was unsure what it was from. Med Tech C said some residents put their garbages and laundry outside when they want them picked up. At approximately 9:40 AM, Surveyor reviewed the facility cleaning schedule and noted the schedule spoke to resident rooms and bathrooms only. Surveyor inquired with Director A about common room cleaning and s/he said each shift was responsible for the upkeep of the common areas. On 09/03/2025 at approximately 2:30 PM, Surveyor interviewed Director A who acknowledged the common area carpeting was not clean and some of the carpeting tiles were in need of repair.	N 491		