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 02/16/2026

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 02/11/2026, with additional information gathered through 02/16/2026, Surveyors conducted 2 complaint investigations, and a verification visit at Care Partners Assisted Living II. Two of 3 previous deficiencies were corrected. Two complaints were substantiated. Five deficiencies were identified. Three of 5 deficiencies were repeat violations. See Statements of Deficiency (SOD) 3BKN12, dated 01/26/2023, SOD 3BKN13, dated 08/22/2023, LIDL12, dated 05/01/2025, and LIDL13, dated 09/05/2025. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 34	{N 000}		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 was assessed	N 381		

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

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N 381	Continued From page 1 for appropriate interventions upon a change in his/her needs. Resident 1 was found smoking cigarettes in his/her room. The provider did not conduct an assessment and develop a plan for intervention with Resident 1 and his/her legal representative. As a result, Resident 1 was restricted from his/her cigarettes and light, and smoking as s/he desired. Findings include: On 09/12/2025, the department received complaint information alleging resident needs were not being met. On 02/11/2026, Surveyors conducted a complaint investigation. At 9:50 AM, Surveyors interviewed Director A who described Resident 1 as not always making safe decisions and had been found smoking in his/her room multiple times. Director A said Resident 1's cigarettes and lighter were then taken away, which led Resident 1 to having behaviors and negative interactions with others related to obtaining cigarettes and lighters. Director A said it led to them having to not allow Resident 1 to smoke. On 02/11/2026, Surveyor reviewed Resident 1's face sheet and noted s/he moved to the facility on 09/19/2024 with diagnoses of epilepsy, anxiety, and depression. Resident 1 had an activated Power of Attorney for Healthcare, and was able to make his/her needs known. Surveyor reviewed Resident 1's individual service plan (ISP) with review date 10/07/2025 and noted "Smoker on 3 hour smoke. May needs help with transfers on bad days...got privalge [sic] taken	N 381		

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N 381	Continued From page 2 away due to smoking in room." On 02/12/2026, Surveyor reviewed Resident 1's smoking assessments completed by Director A: 10/07/2024 "2. When do you usually smoke? [handwritten] When I get a chance 3. Do you need any assistance smoking? [X] No ...Do you feel you are a safe smoker? [X] Yes ...Have you had any unsafe smoking incidents? [X] No ...Are there any physical limitations which have implications on your ability to smoke safely (arthritis, hand injury, paralysis)? [X] No ...1. Tell me where you are permitted to smoke. Response appropriate? [X] No 2. Where are you NOT permitted to smoke. Response appropriate [X] No ...Recommendations: [X] Resident can smoke safely and independently." Surveyor note: No additional notes regarding "response not appropriate." 05/23/2025 "1. How much do you smoke? [handwritten] 3-5 per day 2. When do you usually smoke? [handwritten] whenever 3. Do you need any assistance smoking? [X] No 4. Do you feel your are a safe smoker? [X] Yes 5. Have you had any unsafe smoking incidents? [X] Yes Specify: [handwritten] smoking in bathroom ...1. Observe the resident while smoking: Did the resident complete the following tasks safely and independently? If 'no', write the resident's action in the space beside ...Obtain cigarettes and a lighter? [X] No [handwritten] in med cart ...1. Tell me where you are permitted to smoke. Response appropriate? [X] No 2. Where are you NOT permitted to smoke. Response appropriate [X] No ...Recommendations: [X] Resident can smoke safely with the following minimal assistance from staff: [handwritten] when outside [X] Resident is an unsafe smoker ...[handwritten]	N 381		

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N 381	Continued From page 3 has smoked in bathroom." Surveyor reviewed provider document "Smoking Responsibility and Waiver of Liability Form" "To be signed upon admission and at least every six months thereafter by any resident who smokes or by the responsible party of such resident." Handwritten notes: "Updated - Needs to be Supervised ....Staff keep cigs [cigarettes] in med cart give 1 every 2 hrs. April 7th, 2025." Surveyor noted Resident 1 signed the document on 10/07/2024 (not upon update on 04/07/2025). No additional signatures upon updates to the form or acknowledgement signature by Resident 1's activated POAHC. On 02/11/2026 at 1:43 PM, Surveyor interviewed POAHC-B who said Resident was found smoking in his/her room, so then the provider took his/her cigarettes and "wouldn't give them to [him/her]." POAHC-B said s/he understood why they kept the lighters, but questioned why Resident 1 couldn't have his/her cigarettes. Surveyor clarified whether staff would not give Resident 1 his/her cigarettes and let him/her go outside and smoke, and POAHC-B said "Yeah, they took away [his/her] right to smoke..they wouldn't let [him/her] do anything." On 02/11/2026 at 2:13 PM, Surveyors interviewed Director A who said Resident 1's cigarettes were stored in the medication cart once s/he was found smoking in his/her bathroom and room. Resident 1 would reportedly then take or ask for cigarettes from other residents and stash them in his/her chair. Staff would then find Resident 1 smoking in his/her room. Director A said Resident 1 would call family members to bring him/her cigarettes and then they would smoke with him/her outside. Surveyor asked if staff withheld Resident 1's	N 381		

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N 381	Continued From page 4 cigarettes when s/he would ask for them and Director A said "Yes. We had to. I can't allow for [him/her] to smoke when [s/he] smokes in [his/her] room." Surveyor inquired whether interventions were implemented and trialed so that Resident 1 could still safely smoke outside and s/he said yes, but "nothing worked." S/he said they tried a Nicotine patch, but it was discontinued because s/he would smoke with it anyway. Surveyor inquired how long Resident 1 was not given his/her cigarettes and lighter upon request to smoke and Director A said, "Not long, like 30 days." Director A acknowledged appropriate interventions were not discussed and implemented upon assessment based on discussion with all parties. Cross Reference: N0389 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 381		
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.	N 389		

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N 389	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not revise Resident 1's individual service plan (ISP) when there was a change in his/her needs, abilities or physical or mental condition. Resident 1 had an increase of falls, had fall interventions implemented, was refusing medications, and had seizure activity. Resident 1's ISP did not reflect these changes in needs and interventions related to. This is a repeat deficiency. See Statement of Deficiency (SOD) 3BKN13, dated 08/22/2023. Findings include: On 09/12/2025, the department received complaint information alleging residents had frequent falls leading to emergency room evaluation. On 02/11/2026, Surveyors conducted a complaint investigation. At 9:50 AM, Surveyors interviewed Director A who stated Resident 1 had moved to an alternative placement from the facility on 10/17/2025. Director A described Resident 1 as falling 1-2 times/week. Resident 1 was reportedly not receptive to using his/her call light despite education and reminders from staff. S/he said Resident 1 refused medications often and then would have a seizure from not taking his/her medications, leading him/her to become lethargic, which would then contribute to his/her falls. Director A said Resident 1 had gone through physical therapy and just became more and more unsteady on his/her feet, which led to the change	N 389		

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N 389	Continued From page 6 to using a wheelchair. At 11:34 AM, Surveyors interviewed Assistance Director (AD) C who described Resident 1 as not being independent and depending on staff for most activities of daily living. S/he said s/he did not recall that s/he was a fall risk, but did recall there being more falls shortly prior to him/her moving from the facility. AD-C said Resident 1 used a call light connected to his/her wall primarily and staff would remind him/her to use it. AD-C said Resident 1 was known to self-transfer, which led to his/her falls prior to using a wheelchair. At 1:43 PM, Surveyor interviewed Power of Attorney for Healthcare (POAHC) B who said Resident 1 "fell so many times." S/he said Resident 1 was in a lot of pain and his/her legs "shake so bad." POAHC-B stated awareness of Resident 1 refusing medications in the past, but did not know s/he may have been having seizures as a result of not taking his/her medications. Surveyor reviewed Resident 1's face sheet and noted s/he moved to the facility on 09/20/2024 with diagnoses of anxiety, depression, epilepsy, and atrial fibrillation. Resident 1 was able to communicate his/her needs and had an activated Power of Attorney for Healthcare (POAHC). Surveyor reviewed Resident 1's pre-admission assessment "Admission Application" dated 09/13/2024 and completed by Director A. "Within the last six months, has the resident had instances of: ...[X] Falling." Surveyor reviewed a typed document provided titled "[Resident 1] Fall Risk" and signed by Director A dated 05/13/2025.	N 389		

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N 389	Continued From page 7 "1. 2-hour checks 2. Call light and pendent [sic] on or near [him/her] at all times. Reminder to use for help. 3. Readjust in wheelchair when slumping. 4. Encourage [Resident 1] to use [his/her] wheelchair to prevent falls with [his/her] walker." Surveyor reviewed a 6 month sample of Resident 1's fall reports and noted 7 incident reports for falls from 08/19/2025-10/24/2025: 08/19/2025 unwitnessed, laying on floor in room 08/20/2025 unwitnessed, lost balance 09/03/2025 unwitnessed, fell over garbage can 09/11/2025 another resident reported Resident 1 was on his/her knees in his/her room, unwitnessed, ER visit for rib contusion, bilateral renal masses, liver mass, and lumbar back strain 09/17/2025 unwitnessed, sitting on floor 09/20/2025 unwitnessed, on knees 10/24/2025 witnessed, wheeling backwards quickly and tipped backwards in wheelchair Surveyor reviewed Resident 1's individual service plan (ISP) with review date 10/07/2025. Surveyor noted the following: "Safety Concerns (Alarms, Mats): Resident has no safety alarms or mats in use right now ...no changes ... Mobility: [Resident 1] is independent with [his/her] 4WW [wheeled-walker] mobility [sic]. [S/he] needs reminders to use [his/her] walker, will sometimes forget where [s/he] put it ...indep[endent] 4WW/ self-propels w/ [with] w/c [wheelchair] ...no change ... Verbal: [Resident 1] has not shown a history of becoming verbally aggressive ...will get verbally [sic] when [s/he] don't [sic] want to take meds ... Other: Smoker on 3 hour smoke May need help with transfers on bad days ..."	N 389		

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N 389	Continued From page 8 Surveyor note: Resident 1's ISP was not updated to reflect Resident 1 being a fall risk, his/her recent falls, fall interventions, medication refusals, seizures, and seizure management. On 02/11/2026 at 2:13 PM, Surveyors interviewed Director A who acknowledged Resident 1's ISP was not updated to reflect changes in Resident 1's fall risk needs, seizures, and medication refusals. Director A said s/he just received training the previous week on updating ISP and verified s/he knows now s/he should have updated Resident 1's ISP. Cross Reference: N0381 83.35(1)(a) Pre-Admission And Ongoing Assessments	N 389		
N 410	83.37(1)(k) Medication error or adverse reaction. Medication error or adverse reaction. 1. The CBRF shall document in the resident ' s record any error in the administration of prescription or over-the-counter medication, known adverse drug reaction or resident refusal to take medication. 2. The CBRF shall report all errors in the administration of medication and any adverse drug reactions to a licensed practitioner, supervising nurse or pharmacist immediately. Unless otherwise directed by the prescribing practitioner, the CBRF shall report to the prescribing practitioner, supervising nurse or pharmacist as soon as possible after the resident refuses a medication for 2 consecutive days. This Rule is not met as evidenced by:	N 410		

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N 410	Continued From page 9 Based on record review and interview, the provider did not ensure the prescribing practitioner, supervising nurse or pharmacist were notified as soon as possible after a resident refused a medication for 2 consecutive days for Resident 1 and Resident 2. RESIDENT 1 On 02/11/2026, Surveyor reviewed Resident 1's August 2025 MAR (medication administration record). Surveyor noted Resident 1 was prescribed fluticasone - SALM 500-50mcg- inhale 1 puff into lungs daily. Further review of the MAR revealed Resident 1 refused this medication on 08/26 and 08/27. RESIDENT 2 On 02/11/2026, Surveyor reviewed Resident 2's November and December 2025 MAR and January and February 2026 MAR. Surveyor noted Resident 2 was prescribed lidocaine patch for cervical disc disorder with myelopathy. Review of the MAR revealed Resident 2 refused the lidocaine patch for 2 consecutive days on the following dates: November 2025: 11/04 through 11/06 and 11/21, 11/22 through 11/30 December 2025: 12/01 through 12/04 and 12/06 through 12/31 January 2026: 01/05 through 01/07, 01/12 through 01/14, 01/17 through 01/22 and 01/27 through 01/29 February 2026: 02/09 through 02/11 On 02/11/2026, at 2:13PM, Surveyors interviewed Director A regarding the medications refused for 2 consecutive days for Resident 1 and Resident 2.	N 410		

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N 410	Continued From page 10 Director A advised s/he would need to check with the residents' physicians to see if the notification was made. On 02/12/2026, Surveyor reviewed a fax dated 02/11/2026. The fax was sent from Director A to Resident 2's physician. The fax noted, "[Resident 2] would like Lidocaine patch switched to PRN (as needed) as [s/he] only uses them once in a while." No additional information was provided regarding Resident 1.	N 410		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure at the time of medication administration, the person administering the medication initialed the administration record for Resident 1 and Resident 2.	N 415		

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N 415	Continued From page 11 This requirement is being cited for a fifth time. See Statement of Deficiency (SOD) 3BKN11 dated 09/22/2022, 3BKN12 dated 01/26/2023, 3BKN13 dated 08/22/2023 and LIDL12 dated 05/01/2025. Findings Include: On 09/12/2025, the department received a complaint alleging medication administration records (MARs) were not documented accurately. RESIDENT 1 On 02/11/2026, Surveyor reviewed Resident 1's October 2025 MAR. Surveyor noted several dates were not initialed on the MAR at the time of medication administration. The medications and dates were as follows: Amlodipine Besylate 10mg - 1 tab daily 10/26, 10/28, 10/29, 10/30, 10/31 Duloxetine HCL DR 20mg - 1 cap daily 10/26, 10/28, 10/29, 10/30, 10/31 Eliquis 5mg - 1 tab twice daily 1st dose: 10/26, 10/28, 10/29, 10/30, 10/31 2nd dose: 10/5, 10/26, 10/28, 10/29, 10/30, 10/31 Famotidine 20mg - 1 tab twice daily 1st dose: 10/26, 10/28, 10/29, 10/30, 10/31 2nd dose: 10/5, 10/26, 10/28, 10/29, 10/30, 10/31 Fiber Therapy Powder-PSYLLI - dissolve 1 teaspoon in 4-8oz of liquid and drink daily 10/26, 10/28, 10/29, 10/30, 10/31 Finasteride 5mg - 1 tab by mouth daily 10/26, 10/28, 10/29, 10/30, 10/31	N 415		

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N 415	Continued From page 12 Fluticasone - SALM 500-50mcg- inhale 1 puff into lungs twice daily 1st dose: 10/26, 10/28, 10/29, 10/30, 10/31 2nd dose: Lacosamide 100mg - 1 tab twice daily 1st dose: 10/26, 10/28, 10/29, 10/30, 10/31 2nd dose: 10/5, 10/26, 10/28, 10/29, 10/30, 10/31 Lidocaine Patch 4% - apply patch to knee every 24 hours for knee pain 10/26, 10/28, 10/29, 10/30, 10/31 Losartan Potassium 100mg - 1 tab daily 10/26, 10/28, 10/29, 10/30, 10/31 Atorvastatin 40mg - 1 tab daily 10/15, 10/26, 10/27, 10/28, 10/29, 10/30, 10/31 RESIDENT 2 On 02/11/2026, Surveyor reviewed Resident 2's October, November and December 2025 MAR. Surveyor noted several dates were not initialed on the MAR at the time of medication administration. The medications and dates were as follows: Nystatin Powder 100,000U/GM - apply topically to affected areas three times daily 2nd dose: 10/07, 10/10, 10/22, 10/30, 10/31, 11/01, 11/04, 11/05, 11/06, 11/07, 11/12, 11/13, 11/14, 11/18, 11/19, 11/20, 11/21, 11/25, 11/26, 11/27, 11/28, 11/29, 11/30, 12/03, 12/09, 12/10, 12/11, 12/15, 12/19, 12/24, 12/28 3rd dose: 11/04 Acetaminophen 500mg - 2 tabs twice daily 2nd dose: 11/17, 12/23	N 415		

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 02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING II	5101 N FRENCH RD APPLETON, WI 54913

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N 415	Continued From page 13 Metformin HCL ER 500mg - 2 tabs twice daily 2nd dose: 11/17 Lidocaine Patch 5% - apply 1 patch in the morning and off at bedtime 11/04 Montelukast SOD 10mg - 1 tab daily at bedtime 11/04 Quetiapine Fumarate 30mg - 2 tabs at bedtime 11/04 Hydroxyzine HCL 25mg - 1 tab daily 12/20, 12/21, 12/23 On 02/11/2026, at 2:13PM, Surveyors interviewed Director A regarding documentation of medication administration. Director A reported s/he has been working with caregivers and provided training to ensure MARs are documented correctly. Additionally, Assistant Director C has been directored to review MARs for accuracy. Director A acknowledged the findings.	N 415		
{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, wall and ceiling were clean and in good repair. This is a repeat violation. See Statement of Deficiency (SOD) LIDL13, dated 09/05/2025.	{N 491}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 491}	Continued From page 14 Findings include: On 02/11/2025 at approximately 10:34 AM, Surveyors the hallway connected the common area to the back left wing of resident rooms from entrance and was on the opposing wall of the kitchen. Surveyors observed a 0.34 square foot fabric run in the carpeting spanning from the hallway wall to the middle of the hallway. Next to the carpeting run was a orange-rust like coloring stain that spanned 0.18 square feet in length and 0.07 square feet in width. Surveyors noted the floor visibly dipped and had an approximate 2.4 degree pitch the middle of the hallway to the baseboard of the wall. The carpeted base board had a 0.003 square foot gap from the floor that spanned 4 square feet along the wall. Surveyor observed a 1 square foot brown half circle, water-like remnant on the 2 by 2 square foot ceiling tile located above and approximately 3 feet over from the carpet stain. At 10:45 AM, Surveyor observed 3 inch by 3 inch grouted tile floor in the kitchen. Under the sink located to the left of the kitchen entrance and the other side of the wall from the hallway, Surveyor observed the black grout around the tiles was partially to fully white with a dried soap scum like appearance around at least 7 visible tiles, under and in front of the dishes sanitizer, and spanning to the middle of the industrial sink overhang. Surveyor noted debris, dust, and food particles under the sink and dishes sanitizer. Surveyor looked at the kitchen ceiling and noted approximately 14- 4 square feet white ceiling tiles which were covered in gray and black smoke like residue above the sink and dishes sanitizer area. At 2:13 PM, Surveyors interviewed Director A who	{N 491}		

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{N 491}	Continued From page 15 said there was a second (dishes) sanitizer in the kitchen, on the other side of the hallway wall that leaked and it came through the wall to the hallway side. Director A said that sanitizer had since been removed from the kitchen. Surveyor inquired whether there was a fire or heavy smoke in the kitchen at some point and Director A said "I know what you're talking about; a [oil] fryer was used in the kitchen and caused a ton of smoke." Director A acknowledged awareness that the kitchen ceiling was blackened with residue, the kitchen floor was unclean, and the hallway carpeting and wall was damaged and stained from the dishes sanitizer leaking.	{N 491}		