STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014663	A. BUILDING: _____ B. WING _____	R-C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ANTIGO II	1415 10TH AVENUE ANTIGO, WI 54409

(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 05/28/2025, Surveyor conducted a standard licensure survey, verification visit, self-report (x2) investigation and complaint investigation at Care Partners Assisted Living Antigo II. Data collection continued through 05/29/2025. The complaint was unsubstantiated. Two deficiencies were identified. One of the 2 deficiencies was a repeat violation. See Statement of Deficiency (SOD) M9WS11, dated 06/26/2024. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 12	{N 000}		
N 165	83.12(4)(c) Reporting incidents with serious injury A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any incident or accident resulting in serious injury requiring hospital admission or emergency room treatment of a resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 3 working days after Resident 1 fell and required emergency room treatment. Findings include: The facility is licensed to serve up to 16 residents	N 165		

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
	0014663	A. BUILDING: _____ B. WING _____	R-C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ANTIGO II	1415 10TH AVENUE ANTIGO, WI 54409

(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 165	Continued From page 1 in the client groups advanced aged, irreversible dementia/Alzheimer's disease, and terminally ill. On 01/13/2025, the Department received a complaint alleging Resident 1 fell in December 2024, broke a collar bone, and staff to pulled Resident 1 on the side of his/her broken collar bone. On 05/28/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 10/17/2013. Resident 1was discharged on 05/12/2025. A physician fax, dated 12/11/2024, noted, in part, "Resident had a fall on 12-09-2024 around 11:48 p.m. in [his/her] room. Staff called [emergency medical technicians (EMT)] for a lift assist. [S/He] has about an inch sized abrasion on [his/her] forehead. [S/He] was gotten [sic] up and put back to bed without issues. Staff to monitor abrasion. On 12/10/2024 at 8:50 a.m. resident was walking down the hallway and fell by [his/her] doorway. [S/He] was laying [sic] on [his/her] left side and it seemed swollen and bruising. [EMTs] were notified. [S/He] also stated [s/he] hit [his/her] head. [S/He] was taken to the [emergency room (ER)] and ended up with a fractured clavicle on [his/her] left side and a possible fx (fracture) with hemorrhage in left maxillary sinus-feels that it may be from chronic nasal mass. [Guardian] will set up follow up with ortho (orthopedic doctor). Staff to continue to monitor." Medical records indicated Resident 1 received treatment for a "Left clavicle fracture, [AC] separation (acromioclavicular joint separation)." Resident 1 received a sling for his/her shoulder and was instructed to have a follow-up appointment within a week with the orthopedic doctor. On 05/29/2025 at approximately 2:07 PM, Surveyor interviewed Director A via telephone.	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014663	A. BUILDING: _____ B. WING _____	R-C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ANTIGO II	1415 10TH AVENUE ANTIGO, WI 54409

(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 165	Continued From page 2 Surveyor asked Director A about Resident 1's fall on 12/10/2024. Director A verified that Resident 1 fell and was sent to the ER on 12/10/2024. Director A confirmed that Resident 1 was treated for a left shoulder fracture, was given a sling to wear, and was instructed to follow up with an orthopedic doctor within one week. Director A reported that Director A sent a self-report of Resident 1's fall to his/her regional office on 12/11/2024 and not to the Department. Director A indicated that his/her regional office should have sent the self-report to the Department. On 05/29/2025, Surveyor reviewed the provider's self-report file. The self-report file did not contain a self-report for Resident 1's fall on 12/10/2025. The provider did not report to the Department within 3 working days after Resident 1 fell and required emergency room treatment.	N 165		
{N 432}	83.38(1)(h) Medication administration. 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: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014663	A. BUILDING: _____ B. WING _____	R-C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ANTIGO II	1415 10TH AVENUE ANTIGO, WI 54409

(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 432}	Continued From page 3 provider did not ensure Resident 1 was provided with medication administration appropriate to the resident's needs. This is a repeat deficiency, see Statement of Deficiency (SOD) M9WS11, dated 06/26/2024. Findings include: The facility is licensed to serve up to 16 residents in the client groups advanced aged, irreversible dementia/Alzheimer's, and terminally ill. On 05/28/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 10/17/2013. Resident 1 was discharged on 05/12/2025. According to nurse's notes, dated 05/12/2025, Caregiver B noted, in part, "Staff was passing out morning meds (medications) to residents this morning [sic] Staff accidentally popped out another Resident's [sic] medication and gave it to this Resident [sic] Staff did not notice Error [sic] had occurred until it was to [sic] late and Resident [sic] had taken the medication [sic] Staff immediatelly [sic] checked Resident's [sic] allergy list to make sure Resident [sic] wasn't allergic to anything [s/he] had been given, [sic] Resident [sic] was not allergic to anything given [sic] Staff took Resident's [sic] vitals and continues to monitor Resident's [sic] vitals and if any changes in Resident [sic] Staff contacted facility director and Resident's [sic] [family member]." According to a Physician Fax, dated 05/12/2025, the provider noted, "Staff had accidentally given resident another resident's medications around 7:30 a.m. Staff monitored vitals up until the time [s/he] moved to a new facility today per previous plans. [S/He] stated [s/he] felt find [sic] and was acting [his/her] normal [sic]." The provider noted	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014663	A. BUILDING: _____ B. WING _____	R-C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ANTIGO II	1415 10TH AVENUE ANTIGO, WI 54409

(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 432}	Continued From page 4 the following medications were given in error to Resident 1 on 05/12/2025: Levothyroxine 50 mg, Allopurinol 100 mm (two tablets 200 mg), Aspirin 81 mg, Bumetanide 2 mg (two tablets 4 mg), Dilt-Xr 240 mg, Metoprolol 100 mg, Once daily [men/women] 50+, Spironolacton 25 mg, Metoclopramide 5 mg, Potassium 20 Meq, Oxybutynin 5 mg, Primidone 50 mg. On 05/29/2025 at 8:38 AM, Surveyor asked Director A via e-mail about medication administration for Resident 1. On 05/29/2025 at 10:58 AM, Director A stated via e-mail, "Yes there has been a med error for [Resident 1] on the day [s/he] moved out (5-12-25) [sic] Caregiver B had given [him/her] another resident's medications on [sic] accident. Lakeland Care, guardian, and primary doctor were notified." On 05/29/2025 at 11:55 AM, Surveyor asked Director A via e-mail, "What medication was given to [Resident 1]? Was there an adverse reaction? Was staff re-trained on medications? On 05/29/2025 at 12:14 PM, Director a reported via e-mail that Resident 1 received the following medications in error on 05/12/2025: Levothyroxine 50mg Allopurinol 100mg (2 tablets) Aspirin 81mg Bumetanide 2mg (2 tablets) Dilt-Xr 240mg Metoprolol 100mg Once daily women's vitamin Spironolactone 25mg Metoclopramide 5mg Potassium 20Meq	{N 432}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0014663	A. BUILDING: _____ B. WING _____	R-C 05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ANTIGO II	1415 10TH AVENUE ANTIGO, WI 54409

(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 432}	Continued From page 5 Oxybutynin 5mg Primidone 50mg Director A noted via e-mail, "[S/He] did not have any reaction. [S/He] stated [s/he] felt fine. Then later on that day is when [s/he] moved to the other facility. Lakeland Care updated the new facility of [sic] mediation error before [his/her] arrival. Yes staff re-education was done." On 05/29/2025 at approximately 2:07 PM, Surveyor interviewed Director A via telephone. Surveyor asked Director A about Resident 1's medication error on 05/12/2025. Director A reported that Caregiver B "punched out someone else's medications, got distracted and was not paying attention, put the medications in a cup and set them on the table in front of [Resident 1] and [s/he] took them." The provider did not ensure medication administration appropriate to Resident 1's needs.	{N 432}		