

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016767	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/04/2026
NAME OF PROVIDER OR SUPPLIER CARE PARTNERS ASSISTED LIVING HORTONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 112 HARRIS WAY HORTONVILLE, WI 54944		
(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 08/04/2026, Surveyor investigated 1 complaint and conducted a standard survey at Care Partners Assisted Living Hortonville. The complaint was unsubstantiated. As a result of the survey, no new deficiencies were identified. Census 46	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE