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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 06/16/2026, Surveyors conducted a verification visit and 6 complaint investigations at Care Partners Assisted Living Altoona I. Data collection continued through 06/23/2026. Four of 6 complaints were substantiated. Four deficiencies were identified. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 20	{N 000}		
N 158	83.12(2)(a) Caregiver: Investigating abuse & neglect Investigating and reporting abuse, neglect, or misappropriation of property. Caregiver. 1. When a CBRF receives a report of an allegation of abuse or neglect of a resident, or misappropriation of property, the CBRF shall take immediate steps to ensure the safety of all residents. 2. The CBRF shall investigate and document any allegation of abuse or neglect of a resident, or misappropriation of property by a caregiver. If the CBRF ' s investigation concludes that the alleged abuse, or neglect of a resident or misappropriation of property meets the definition of abuse or neglect of a resident, or of misappropriation of property, the CBRF shall report the incident to the department on a form provided by the department, within 7 calendar days from the date the CBRF knew or should have known about the abuse, neglect, or misappropriation of property. The CBRF shall maintain documentation of any investigation.	N 158		

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
	0016157	A. BUILDING: _____ B. WING _____	R-C 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 158	Continued From page 1	N 158		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not retain documentation of their investigation into an allegation of verbal abuse by a caregiver for 1 of 1 (Resident 1) residents reviewed.

On 05/18/2026, the provider discovered an allegation of physical abuse by Caregiver B involving Resident 1 taking place on 05/06/2026. The allegation was unsubstantiated in writing.

On 05/27/2026, the provider discovered an allegation of verbal abuse by Caregiver B involving Resident 1. The provider did not investigate and document the allegations of verbal abuse.

On 05/28/2026, the provider submitted a misconduct incident report (MIR) to the Office of Caregiver Quality (OCQ) that only included information related to the physical abuse allegations.

On 06/16/2026, the provider acknowledged both physical and verbal abuse allegations were substantiated.

Findings include:

On 05/13/2026 and 5/18/2026, the department received complaints alleging caregiver misconduct.

On 06/16/2026, at approximately 9:15 AM, Surveyors interviewed Administrator A. When asked about recent caregiver misconduct allegations, Administrator A stated there was an allegation of physical aggression towards Resident 1. Administrator A stated the allegations

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 158	Continued From page 2	N 158		

were substantiated and Caregiver B was terminated. Administrator A stated they identified concerns with Caregiver B's physical and verbal interactions toward Resident 1.

At 11:22 AM, Surveyors requested documentation from Administrator A including Resident 1's records and staff misconduct investigations.

Resident 1 was admitted on 06/28/2019 and had a guardian.

A document titled, "Interview with [Caregiver C] on 05/27/2026 - [Caregiver C] was gone on vacation during the initial investigation" read, in part, "Have you ever witnessed someone being verbally rude/mean or aggressive to residents? While talking to [Caregiver C] [s/he] noted that [s/he] had heard on multiple accounts a caregiver, [Caregiver B], be verbally mean to residents ...[Caregiver C] responded that [s/he] talked in a degrading tone to residents and that [s/he] had spoken to [Caregiver B] on adjusting the behavior but it was not received by [Caregiver B]. I had asked if this was ever reported to someone in leadership, [Caregiver C] noted no as [s/he] was afraid to say anything but [s/he] had discussed it with other staff ...Have you ever witnessed someone being physically aggressive towards a resident? [Caregiver C] identified that [s/he] has witnessed [Caregiver B] 'pull [Resident 1] out of bed' on a few occasions ..."

On 05/28/2026, at 4:44 PM, a MIR was submitted to OCQ. The MIR identified an incident taking place on 05/06/2026 at 10:05 AM. The date discovered was 05/18/2026. The MIR alleged Caregiver B was physically aggressive with Resident 1. An investigation took place and there

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 158	Continued From page 3 were no substantiated findings of physical abuse. Caregiver B "did receive a corrective action and is mandated to complete additional training on working with residents with Dementia [sic] prior to working the floor again at Care Partners." The MIR did not include reference to any verbal abuse allegations or investigations. At approximately 12:30 PM, Surveyors interviewed Administrator A. When asked about the misconduct report involving Resident 1, Administrator A stated s/he was made aware of the allegations on 05/16/2026. Administrator A stated Corporate Registered Nurse (CRN) D was responsible for submitting the MIRs. Administrator A stated CRN D used Administrator A's statement. Administrator A stated they had multiple staff gone, so the initial investigation did not feel like they had enough to substantiate the allegations. One day after the provider unsubstantiated the initial allegations, Administrator A stated multiple staff reported they had witnessed physical and verbal abuse by Caregiver B. Administrator A stated s/he called Caregiver B back within 48 hours and Caregiver B was terminated. Administrator A stated s/he substantiated physical and verbal abuse after the additional staff statements came in. Administrator A stated s/he informed CRN D via email of the additional statements on 05/27/2026. The provider submitted a MIR informing OCQ of unsubstantiated findings of physical abuse despite stating they had substantiated physical and verbal abuse and terminated Caregiver B due to the findings. The provider did not retain documentation of their investigation into the verbal abuse allegations or report their substantiated findings to OCQ.	N 158		

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 158	Continued From page 4 Cross Reference N0170 DHS 83.12(5)(b) Notification: Abuse and Neglect Allegations	N 158		
N 170	83.12(5)(b) Notification: abuse and neglect allegations. The CBRF shall immediately notify the resident ' s legal representative when there is an allegation of physical, sexual or mental abuse, or neglect of a resident. The CBRF shall notify the resident ' s legal representative within 72 hours when there is an allegation of misappropriation of property. This Rule is not met as evidenced by: Based on record review and interview, the provider did not immediately notify Resident 1's legal representative, Guardian E, when they received allegations of physical and verbal abuse. Findings include: On 5/13/2026 and 5/18/2026, the department received complaints alleging caregiver misconduct. On 06/16/2026, at approximately 9:15 AM, Surveyors interviewed Administrator A. When asked about recent caregiver misconduct allegations, Administrator A stated there was an allegation of physical aggression towards Resident 1. Administrator A stated the allegations were substantiated and Caregiver B was terminated. Administrator A stated they identified concerns with Caregiver B's physical and verbal interactions toward Resident 1. At 11:22 AM, Surveyors requested documentation from Administrator A including	N 170		

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 170	Continued From page 5 Resident 1's record and all documents related to staff misconduct investigations and allegations. Surveyor reviewed the documentation provided by Administrator A. Documentation did not include evidence Guardian E was notified. Resident 1 was admitted on 06/28/2019 and had a guardian. On 05/28/2026, the provider submitted a misconduct incident report (MIR) to the Office of Caregiver Quality (OCQ) indicating physical abuse allegations were made and were unsubstantiated. The MIR included Guardian E's contact information. On 06/23/2026, at 11:40 AM, Surveyor interviewed Guardian E via phone. Guardian E confirmed s/he was assigned as Resident 1's guardian in February. When asked if Guardian E was informed by the provider of any abuse allegations made involving Resident 1, Guardian E stated s/he was not. Guardian E stated the provider told him/her Resident 1 sustained injuries from running into walls. Guardian E stated they were moving Resident 1 because of the incidents, and felt it was not a safe placement for Resident 1. Cross Reference N0158 DHS 83.12(a) Caregiver: Investigating Abuse & Neglect	N 170		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall	N 326		

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 326	Continued From page 6	N 326		

explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not give Resident 2 or his/her legal representative a 30-day written advance notice of discharge for 1 of 1 resident discharge reviewed.

Findings include:

The provider is licensed to care for 20 residents in the client groups physically disabled, irreversible dementia/Alzheimer's disease, terminally ill, and advanced aged.

On 06/10/2026, the Department received a complaint regarding an improper discharge of a resident.

On 06/16/2026 at approximately 12:30 PM, Surveyor interviewed Administrator A about Resident 2's discharge. Administrator A stated Resident 2 was admitted to the hospital as a result of a UTI (urinary tract infection) prior to Administrator A's date of hire. Administrator A stated Resident 2 had security called on him/her at the hospital for behaviors, and refusals. Administrator A stated s/he did not document his/her assessment of Resident 2 in the hospital and did not issue a 30-day written notice for

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 326	Continued From page 7 involuntary discharge. Administrator A further stated a notice was not necessary if the resident was not able to return from the hospital, based on his/her interpretation of the company policy. Surveyor requested and reviewed Resident 2's complete record received from Administrator A. Surveyor reviewed a document titled, "Resident Discharge." The form documented Resident 2's date of discharge was 04/09/2026. The reason for discharge read, "Not an appropriate readmission currently @ Mayo hospital." No additional information on the reason for discharge was documented in Resident 2's record. On 06/16/2026 at approximately 3:15 PM, Surveyor interviewed Resident 2's legal guardian and power of attorney for health care (POAHC F) via phone. POAHC F stated s/he was never notified Resident 2 may be discharged from the facility and it had not been discussed. POAHC F stated the facility was aware of Resident 2's urination concerns but had never brought up discharge. When asked why Resident 2 went to the hospital, POAHC F stated Resident 2 was initially sent out to be treated for a suspected UTI but had a hernia which was surgically removed. POAHC F stated Resident 2 required rehab (rehabilitation) at a skilled nursing facility, and when rehab was complete s/he was "ready to go back home." POAHC F further stated Resident 2 was angry and very upset s/he had to go to rehab and blamed his/her family for losing his/her home. POAHC F stated Resident 2 eventually moved to West Bend, WI as a result of the facility not taking him/her back. POAHC F informed Surveyor all of Resident 2's family resided in the Eau Claire area.	N 326		

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 326	Continued From page 8 On 06/17/2026 at approximately 11:10 AM, Surveyor interviewed Resident 2's managed care organization (MCO) regarding the discharge. Care Coach (CC) G stated Resident 2's previous CC (CC H) was no longer working there and shared the following notes verbally: -Resident 2 was hospitalized 03/19/2026 through 03/25/2026. -Resident 2 had hernia surgery on 03/23/2026 and went to short term rehab for physical therapy (PT) and occupational therapy (OT). -Resident 2 completed PT and OT and was ready to be discharged back to the facility on 04/07/2026. -CC H reached out to the facility to let them know Resident 2 was ready to return. -On 04/09/2026, Administrator A left the MCO a voicemail stating s/he had re-assessed Resident 2 and stated s/he was no longer appropriate for the facility and had discharged him/her from the facility effective 04/09/2026. -Communication concerns were noted with the facility in retrieving Resident 2's belongings. The provider did not provide Resident 2 or Resident 2's legal representative a 30-day written advance notice and did not provide assistance in relocating the resident. The provider did not allow Resident 2 to return after hernia surgery and a short-term rehab stay.	N 326		
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	N 389		

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 389	Continued From page 9 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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed (Resident 1's) legal representative signed the individual service plan (ISP) acknowledging their involvement in, understanding of, and agreement with the ISP. The provider conducted an internal investigation and found Resident 1's ISP to have forged signatures on it. This is a repeat deficiency. See Statement of Deficiency (SOD) LDKS11, dated 01/02/2025 and SOD 2R0011, dated 02/09/2021. Findings include: On 04/24/2026, the department received a complaint alleging ISP documentation had been falsified. On 04/28/2026, the department received a self-report from the provider indicating an internal investigation was conducted and it was discovered that the previous director had altered documentation. It was identified there had been forged signatures on Resident 1's ISP. The	N 389		

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	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 389	Continued From page 10 previous director was terminated. On 06/16/2026, at approximately 9:15 AM, Surveyors interviewed Administrator A. When asked about recent caregiver misconduct allegations, Administrator A stated the previous director was terminated and was found to have forged documentation. Administrator A stated Resident 1's corporate guardian indicated s/he did not sign the forms. Administrator A stated the provider's investigation did substantiate the concerns. At 11:22 AM, Surveyors requested documentation from Administrator A including Resident 1's records and staff misconduct investigations. The documentation included the following: Resident 1 was admitted on 06/28/2019 and had a guardian. A misconduct incident report (MIR) with a discovery date of 04/20/2026. The MIR indicated an internal investigation was conducted and concluded that a signature had been falsified. A supplemental document submitted with the MIR indicated, in part, "[MCO] responded that they had completed a meeting a few weeks prior and were supplied with an ISP that they found to be completed with inaccurate documentation/dates and forged signatures. These signatures were allegedly completed by Care Partners." An email sent to the provider, dated 04/21/2026. The email read, in part, "The guardian requested to move [Resident 1] due to [his/her] current ISP that was provided to us with false information and documentation ....As you can see, the review dates are incorrect, my staff did not sign it and	N 389		

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 06/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS ASSISTED LIVING ALTOON	**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 389	Continued From page 11 the staff whose signatures are present, were not employed with us and did not complete the ISP review. The guardian also stated that they did not sign this document on the dates listed. It looks to us like these signatures were transposed ..." The provider did not ensure Resident 1's legal representative signed Resident 1's ISP. Resident 1's ISP was found to have forged signatures on it.	N 389		