STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017857	A. BUILDING: _____ B. WING _____	C 08/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE PARTNERS CLINTONVILLE II	61 INDUSTRIAL AVE CLINTONVILLE, WI 54929

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N 000	Initial Comments On 08/11/2026, Surveyor conducted a complaint investigation at Care Partners Clintonville II. The complaint was substantiated, and 2 deficient practices were identified. Census: 25	N 000		
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. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 1's Individual Service Plan (ISP) addressed all his/her care needs. The provider was aware Resident 1 was in need of foot/nail care and that Resident 1 was not able to perform his/her own foot /nail care. No assessment or interventions for foot/ nail care were documented within the resident's ISP. Findings include: The provider is licensed to serve up to 26	N 389		

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

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N 389	Continued From page 1 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/ or terminally ill. On 07/31/2026, the Department received a complaint alleging resident's care needs were not being met. On 08/11/2026, Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 04/14/2021 with diagnoses including heart disease. Resident 1 had an activated Power of Attorney for healthcare (POA) C. Resident 1's ISP, dated 04/14/2026, under Capacity For Self Care, Resident 1 was noted as "Needs some assistance." The ISP addressed Resident 1 needed assistance with "Grooming" "Bathing" and "Skin Assessment" including hair care and showers but did not specify if Resident 1 was to received assistance with foot or nail care. The ISP noted staff were to complete a "body audit" on shower days and "routine skin assessments" as well as to don and doff Resident 1's compression stockings daily. On 08/11/2026 at 2:00 PM, Surveyor interviewed Administrator A and AA B. Administrator A stated Resident 1 was signed up for podiatry oversight of his/her foot care in previous years but was taken off of the list (unable to confirm date) by podiatry as s/he began to refuse cares. Administrator A stated since coming off of podiatry services Resident 1 was still hesitant to allow staff to perform nail care. Administrator A stated Resident 1's family was aware of Resident 1's pattern of refusals of care and the family had been maintaining his/her foot care as they were the only ones Resident 1 would usually allow. Administrator A stated it was known that the	N 389		

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N 389	Continued From page 2	N 389		

family would perform nails cares monthly during their visits, similar to how they provided for Resident 1 to receive haircuts. Administrator A stated although the provider was aware the resident required assistance for foot/ nail care, s/he did not have as assessment of Resident 1's foot/ nail care needs or a documented intervention within the ISP noting the family would be providing the nail care.

AA B stated Resident 1 would only allow him/her to provide nails care when his/her family was present otherwise the family would usually do nail care monthly when they came to visit. (Surveyor reviewed e-mail correspondence from Family Member F on 07/30/2026 that corroborated Family Member G trimmed Resident 1's toenails in May of 2026.) AA B was aware Resident 1 was in need of nail care AA B stated s/he was happy when s/he saw Resident 1's family at the facility on 07/28/2026 as s/he could usually get Resident 1 to agree to cares, such as nail trimming, if family was present. AA B stated, "I saw they were here and thought "oh good! Maybe now [Resident 1] will let me clip those nails!"

Administrator A and AA B observed a picture of Resident 1's right foot (taken on 07/28/2026,) where the Resident's nails were overgrown with discoloration and sloughing skin. (Photo 1) AA B confirmed the photo was taken just prior to him/her clipping Resident 1's nails on 07/28/2026, before Resident 1 went to the doctor. Administrator A and AA B confirmed staff would have seen the state of the resident's foot and nails when they applied compression stockings and assisted with bathing. Administrator A and AA B both confirmed, to a reasonable and prudent caregiver or passerby, the foot and nails appeared in need of care and that the care had

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N 389	Continued From page 3 not been regularly performed as the overgrowth of the nails indicated they were not trimmed recently or regularly. The provider was aware Resident 1 needed assistance to maintain his/her nails, that the task was not being completed by the provider (as Resident 1 refused) or regularly by his/her family (as indicated by the overgrowth of the nails) and did not seek intervention or updated the ISP to include nail care. Cross Reference Y3244 DHS 50.09(1)(L) Care	N 389		
Y3244	50.09(1)(L) Care (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to (l) Receive adequate and appropriate care within the capacity of the facility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received	Y3244		

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Y3244	Continued From page 4	Y3244		

adequate assessment and care for a skin tear. The provider did not ensure the resident received a medical assessment after sustaining a skin tear that progressed to an infected open wound and cellulitis.

The provider relied on caregiver observations reported to the provider's RN (RN E.) The caregivers were not medically qualified to assess the resident, did not recognize the wound was infected, and reported the changes observed to RN E as within normal limits of healing. The RN did not conduct an assessment or advise for the resident to be sent out for a medical assessment.

Findings include:

The provider is licensed to serve up to 26 residents who may have diagnoses including advanced age, physical disability, irreversible dementia/ Alzheimer's disease, and/ or terminally ill.

On 07/31/2026, the Department received a complaint alleging resident's care needs were not being met.

On 08/11/2026, Surveyor reviewed Resident 1's record and noted s/he was admitted to the facility on 04/14/2021 with diagnoses including heart disease. Resident 1 had an activated Power of Attorney for healthcare (POA) C. Per Resident 1's Individual Service Plan (ISP,) dated 04/14/2026, Resident 1 required staff assistance to place compression stockings on bilateral lower legs daily. Surveyor reviewed Resident 1's incident report, dated 07/17/2026, written by Administrator A. The report noted on 07/17/2026 at 7:55 AM while placing compression stockings on Resident 1, Caregiver D's fingernail accidentally tore

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Y3244	Continued From page 5	Y3244		

Resident 1's skin. The report noted the wound was cleaned and bandaged, and staff spoke with Resident 1's family about the incident. Surveyor reviewed Resident 1's standing orders from his/her medical provider dated 11/20/2025 which included the order to utilize antibiotic ointment and bandage as needed. Resident 1's ISP noted an update written by Administrator A on 07/17/2026 under "Skin Assessment" instructing staff to keep the cut on Resident 1's lower leg clean and to change the bandage twice daily. Surveyor reviewed Resident 1's task administration record did not include a space for the staff to document when the bandage was being changed to follow-through with the assessed need that was implemented in the ISP. The only documented record of the wound being monitored and cared for between the date it occurred on 07/17/2026 and the date Resident 1 was seen in the emergency department on 07/28/2026 was noted within the 24-hour charting where Assistant Administrator B (AA B) documented changing the bandage during his/her PM shift on 07/19/2026, 07/21/2026, 07/22/2026,07/24/2026, and 07/27/2026.

On 08/11/2026 at 2:00 PM, Surveyor interviewed Administrator A and AA B. Administrator A stated at the time of the incident on 07/17/2026 the wound was a minor scrape and that the staff followed standing orders by cleaning, applying antibiotic ointment and covering it with a band aid. AA B stated the morning shift medication passers had to apply the compression stockings and the PM medication passers had to remove the compression stockings and it was then that the caregivers would change the dressing and monitor the wound. AA B stated there was verbal communication between the staff members who performed cares about changing the resident's

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Y3244	Continued From page 6 dressing during the time the compression stockings were placed and removed but that there was not consistent charting documenting the cares were being completed as the ISP directed. Administrator A and AA B confirmed none of the staff at the facility were qualified to make a medical assessment and RN E did not assess the resident's wound. AA B stated s/he recalled a "few days" before 07/28/2206 the wound appeared to be changing and s/he called RN E to report his/her observations (date unknown.) AA B reported it appeared to him/her the edges were red but beginning to heal. AA B stated, "It looked like when a kid falls off their bike and gets a scraped knee, you know when the edges look a bit different, like it was reddened but healing." When asked about the reddened areas, in regard to AA B stating the wound appeared to be changing, AA B stated, "[Resident 1's] legs needed [compression] stockings, they were always warm and a bit reddened/discolored." Administrator A and AA B acknowledged, because the redness and warmth could be due to various reasons (including infection,) because warmth and redness were common for Resident 1's lower legs, and because the staff were not licensed to assess the resident, an assessment of the wound should have been conducted by a licensed person when it was noticed the wound was changing. AA B stated on 07/28/2026 Resident 1's family was present and when the dressing was removed, it had adhered to the wound and pulled some of the scabbing off during the dressing change. AA B stated the family believed the wound and surrounding skin was infected and decided to take Resident 1 to the emergency department.	Y3244		

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Y3244	Continued From page 7 Surveyor reviewed the emergency department discharge record which noted Resident 1 was seen on 07/28/2026 and was diagnosed with cellulitis of the right lower extremity, wound of the right lower extremity, and skin infection. Resident 1 was placed on oral antibiotics for 7 days and a topical prescription antibiotic ointment for the wound. Cross Reference N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	Y3244		