STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020107	A. BUILDING: _____ B. WING _____	R-C 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED LIVING OF KENOSHA III	1834 60TH ST KENOSHA, WI 53140

(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 08/06/2026, Surveyor completed a standard survey, verification visit, and 1 complaint investigation at Kindred Living of Kenosha III LLC. As a result, SOD EQM811 was corrected, 5 new deficiencies were identified, and 1 complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 8	{N 000}		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the resident or the resident's legal representative (if applicable),	N 387		

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

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N 387	Continued From page 1 Managed Care Organization (MCO) care management team, or the Licensee/ Administrator signed the individual service plan (ISP), acknowledging their involvement in, understanding of, and agreement with the ISP for 1 of 1 (Resident 5) resident reviewed. Findings include: On 08/04/2026, at approximately 11:00 AM, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 02/01/2026. Resident 5's record indicated s/he was her/his own person. Resident 5 was enrolled in an MCO care management program. Resident 5's ISP, dated 04/25/2026, was not signed by Resident 5 or her/his MCO care managers. On 08/04/2026, at approximately 2:30 PM, Surveyor interviewed Administrator E and Community Liaison B. Administrator E and Community Liaison B confirmed the code requirement. Community Liaison B reported prior Administrator F was responsible for ISP updates. Administrator E and Liaison B confirmed prior Administrator F signed all ISP's but did not have residents, guardians, or MCO case managers sign ISPs as applicable. Administrator E reported prior Administrator F and other staff members were fired, and s/he recently took the administrator position and hired a new executive director who started on 08/03/2026. Administrator E reported s/he would ensure ISPs are signed by all parties involved.	N 387		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each	N 393		

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N 393	Continued From page 2	N 393		

resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the provider did not ensure 1 of 4 resident (Resident 5) was evaluated, using the form provided by the Department, within 3 days of the resident's admission to determine whether the resident was able to evacuate the community based residential facility (CBRF) within 2 minutes.

Findings include:

On 08/04/2026, at approximately 11:00 AM, Surveyor reviewed Resident 5's record. Resident 5 was admitted on 02/01/2026. Resident 5's record contained a resident evacuation evaluation dated 04/25/2026. Resident 5's record did not contain evidence of an evacuation assessment within 3 days of the resident's admission to determine whether the resident was able to evacuate the community based residential facility (CBRF) within 2 minutes.

On 08/04/2026, at approximately 11:45 AM, Surveyor interviewed Administrator E. Administrator E confirmed the code requirement. Administrator E and Surveyor reviewed Resident

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N 393	Continued From page 3 5's physical and electronic file. Administrator E confirmed Resident 5's files did not contain evidence of a completed resident evacuation assessment within 3 days of the resident's admission to determine whether the resident was able to evacuate the CBRF within 2 minutes. Administrator E reported s/he would ensure all future residents were evaluated within the required timeframe.	N 393		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted for 3 of 4 quarters in this review period (3rd quarter of 2025 through second quarter of 2026). There were no documented fire drills conducted	N 525		

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N 525	Continued From page 4 in the 3rd and 4th quarters of 2025, and no fire drill documented in the 1st quarter of 2026. The provider did not maintain documentation of drills. Findings include: This facility was licensed on 06/25/2025 to serve up to 8 ambulatory residents in the client groups of traumatic brain injury, pregnant women/counseling, developmentally disabled, alcohol/drug dependent, advanced age, terminally ill, irreversible dementia/ Alzheimer's, and emotionally disturbed/ mental illness. On 08/04/2026, at approximately 10:45 AM, Surveyor reviewed safety records and identified the following: Surveyor was provided fire drill documentation for 2026. A fire drill was conducted on 06/16/2026. Surveyor did not review evidence of any other fire drills conducted in 2026. Surveyor requested documentation for 2025. No documentation was received. On 08/04/2026, at approximately 12:00 PM, Surveyor interviewed Community Liaison B and Consultant D. Community Liaison B and Consultant D confirmed the code requirement. Community Liaison B and Consultant D reported the drills were conducted in the third and fourth quarter of 2025 by the prior administrators and were documented and placed in a binder. Consultant D reported s/he could not locate the files after searching. Consultant D reported s/he would ensure Administrator E is aware of the code requirement and that they would be conducted quarterly.	N 525		

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N 526	Continued From page 5	N 526		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted for 1 of 2 semi-annual drills that should have been conducted from 06/25/2025 (date of license) through date of survey. No tornado, flooding, or other emergency or disaster drills were documented in 2025. The provider did not maintain documentation of drills. Findings include: This facility was licensed on 06/25/2025 to serve up to 8 ambulatory residents in the client groups of traumatic brain injury, pregnant women/counseling, developmentally disabled, alcohol/drug dependent, advanced age, terminally ill, irreversible dementia/ Alzheimer's, and emotionally disturbed/ mental illness. On 08/04/2026, at approximately 10:45 AM, Surveyor reviewed safety records and identified the following: Surveyor was provided with evacuation drill documentation for 2026. Surveyor requested documentation for 2025. No documentation was received. Surveyor did not locate or review evidence of tornado, flooding, or other emergency or disaster	N 526		

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N 526	Continued From page 6 drills conducted semi-annually in 2025 (since date of license). On 08/04/2026, at approximately 12:00 PM, Surveyor interviewed Consultant D. Consultant D reported s/he was unaware of the code requirement. Consultant D reported drills were conducted in 2025 by the prior administrators and were documented and placed in a binder. Consultant D reported s/he could not locate the files after searching. Consultant D reported s/he would ensure Administrator E is aware of the code requirement and required drills were conducted.	N 526		
N 535	83.48(1)(b) Smoke and heat detectors per NFPA 72. Smoke and heat detectors shall be installed and maintained in accordance with NFPA 72 National Fire Alarm Code and the manufacturer ' s recommendation. Smoke detectors powered by the CBRF ' s electrical system shall be tested by CBRF personnel according to manufacturer ' s recommendation, but not less than once every other month. CBRFs shall maintain documentation of tests and maintenance of the detection system. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that CBRF (community-based residential facility) personnel tested smoke detectors at least once every other month from June to December 2025. The provider did not maintain documentation of smoke detector testing.	N 535		

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N 535	Continued From page 7 Findings include: This facility was licensed on 06/25/2025 to serve up to 8 ambulatory residents in the client groups of traumatic brain injury, pregnant women/counseling, developmentally disabled, alcohol/drug dependent, advanced age, terminally ill, irreversible dementia/ Alzheimer's, and emotionally disturbed/ mental illness. On 08/04/2026 at approximately 10:45 AM, Surveyor reviewed all safety documentation provided by Administrator E and Consultant D. Surveyor did not locate documentation or evidence the facility smoke detectors were tested once every other month From June to December 2025. On 08/04/2026, at approximately 12:00 PM, Surveyor interviewed Consultant D. Consultant D reported s/he was unaware of the code requirement. Consultant D reported smoke detector checks were conducted in 2025 by the prior administrators and were documented and placed in a safety binder. Consultant D reported s/he could not locate the files after searching. Consultant D reported s/he would ensure Administrator E is aware of the code requirement and required smoke detector checks were conducted.	N 535		