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 _____	C 03/02/2026

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 03/02/2026, Surveyor conducted 3 complaint investigations at Kindred Living of Kenosha III LLC. As a result, 4 deficiencies were identified and 3 complaints were substantiated. Census: 8	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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the Department within 7 days when an allegation of abuse for 1 of 1 resident (Resident 1) occurred. There was an allegation of abuse between Resident 1 and Caregiver C.	N 158		

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

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N 158	Continued From page 1 Findings include: On 1/22/2026, the Department received a complaint alleging concerns of abuse to a resident. Record Review On 03/02/2026, at 11:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 07/24/2025 with diagnosis including orthostatic hypotension, syncope and collapse, and epilepsy. Resident 1's file indicated s/he was her/his own person. Surveyor reviewed Resident 1's progress notes and incident reports. An incident report, dated 12/02/2025, indicated the following: "[Resident 1] told me on 12/02/2025 that s/he was trying to leave the house on 11/30/2025 because staff [Caregiver C] was screaming and s/he grabbed her/him and pulled her/him back in the house hitting her/his left shoulder and leg on the door. At the time staff had called me I could hear [Resident 1] screaming. I told staff to call an ambulance. I heard [Resident 1] shout "you hit my shoulder". I then heard staff say, "that's it I am calling." I kept calling [Caregiver C] name and then I hung up". A second incident report, dated 12/02/2025, written by Caregiver D indicated the following: "[Kenosha Police Department] (KPD) arrived at 11:00 PM with a call of caregiver mishandling resident. KPD asked resident what happened. Due to resident refusing treatment there was no further action to be taken. Resident stated [Caregiver C] pulled her/him by her/his right arm injuring her/his left shoulder on door frame."	N 158		

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N 158	Continued From page 2 On 03/02/2026, at approximately 11:45 AM, Surveyor reviewed Caregiver C's file. Caregiver C was hired on 03/04/2025. Surveyors did not review any disciplinary actions or incident reports in Caregiver C's file. Caregiver C was terminated on 11/30/2025 after the incident involving Resident 1. On 03/02/2026, at approximately 12:30 PM, Surveyor reviewed Department files. Surveyors did not review any evidence of a self-report filed within 7 days of Resident 1's allegation of caregiver abuse/misconduct. On 03/02/2026, at 2:00 PM, Surveyor interviewed Owner A and LPN B. LPN B confirmed the code requirement. Surveyor inquired if a self-report was filed with the Department within 7 days of the allegation. LPN B reported she was informed by the prior administrator the resident's managed care organization (MCO) and Adult Protective Services (APS) was notified of the incident but was unsure it the Department was notified. LPN B reported Caregiver C was terminated by the prior administrator the day the allegation occurred. LPN B acknowledged a report should have been submitted to the Department.	N 158		
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.	N 165		

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N 165	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview, the provider did not report an incident to the Department within 3 working days of a serious injury in 1 of 1 resident (Resident 1). Resident 1 required multiple sutures after a fall. Findings include: On 12/30/2025, the Department received a complaint of a resident with multiple bruises and injuries. On 03/02/2026, at 11:30 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted on 07/24/2025 with diagnosis including orthostatic hypotension, syncope and collapse, and epilepsy. Resident 1's file indicated s/he was her/his own person. Surveyor reviewed Resident 1's progress notes and incident reports. An incident report, dated 11/28/2025, indicated Resident 1 had a fall on 11/28/2025 at approximately 3:30 AM. The reported stated Resident 1 tripped over her/his oxygen cord which resulted in injuries to her/his right eye, right cheek, and a "gash" on her/his right arm. Resident 1 was sent to the emergency department and required sutures for the wound on her forehead, cheek, and right forearm. On 03/02/2026, at 12:30 PM, Surveyor reviewed Department files. Surveyors did not locate any evidence of a self-report filed within three days of Resident 1's fall with injury resulting in hospitalization and treatment. On 03/02/2026, at approximately 11:00 AM, Surveyor interviewed Licensed Practical Nurse (LPN) B. LPN B reported Resident 1 had a history of falls while residing at the facility. LPN B	N 165		

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N 165	Continued From page 4 reported Resident 1's falls were documented in her/his file. LPN B reported Resident 1 was discharged from the facility on 12/15/2025. On 03/02/2026, at 2:00 PM, Surveyor interviewed Owner A and LPN B. LPN B confirmed the code requirement. LPN B acknowledged a report should have been submitted to the Department. LPN B reported s/he informed the prior administrator to file a self-report but was unsure if a report was filed.	N 165		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a living environment that was clean, comfortable, and homelike for 8 of 8 residents. Kitchen cabinets were sticky to the touch. The kitchen ceiling contained stains and chipped paint. Window fixtures on the first-floor common area and living room were broken. Findings include: The facility is a class AA ambulatory community based residential facility licensed to serve up to 8 residents in the areas of traumatic brain injury, advanced age, irreversible dementia/ Alzheimer's, developmentally disabled, terminally ill, pregnant	N 481		

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N 481	Continued From page 5 women/counseling, alcohol/drug dependent, emotionally disturbed/ mental illness, and physically disabled. On 03/02/2026, at approximately 9:45 AM, Surveyor toured the facility and observed the following: Kitchen: - Exterior doors of cupboards and the microwave above the stove were sticky to touch and contained food residue and a substance similar to dust. - The paint on the ceiling above the stove was peeling off. - The pain on the south wall of the kitchen was chipped and peeling off. - The kitchen window was missing a screen. First Floor Common Areas: - 4 windows in the common area contained broken blinds. - The baseboards were torn off the wall in two locations - The thermostat was handing out of the wall by electrical cords Second Floor Resident Bathrooms: - The base of the shower contained a dark substance around the edge consistent with mold/mildew On 03/02/2026, at 2:00 PM, Surveyor interviewed Owner A and LPN B. Owner A reported a new staff was hired last week. Owner A reported maintenance staff would make repairs needed in the facility.	N 481		

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N 617	Continued From page 6	N 617		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the temperature of water at fixtures used by residents did not exceed 115 degrees Fahrenheit (F) in 2 of 2 bathrooms. Bathroom water temperatures measured between 128 degrees F and 130 degrees F. Findings include: The facility is a class AA ambulatory community based residential facility licensed to serve up to 8 residents in the areas of traumatic brain injury, advanced age, irreversible dementia/ Alzheimer's, developmentally disabled, terminally ill, pregnant women/counseling, alcohol/drug dependent, emotionally disturbed/ mental illness, and physically disabled. On 02/09/2026 the Department received a complaint alleging water temperatures were to high. On 03/02/2026, at approximately 9:45 AM, Surveyor toured the facility and observed the following:	N 617		

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N 617	Continued From page 7 First floor resident bathroom water temperature was 128.7 degrees F. Second floor resident bathroom water temperature was 130.8 degrees F. Exposure to hot water is a potential environmental danger for residents. Elderly residents and residents with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA Publication-01942, Hot Water Temperatures in Adult Family Homes, August 2017.) On 03/02/2026, at 2:00 PM, Surveyor interviewed Owner A and LPN B. Owner A reported a new staff was hired last week. Owner A reported s/he believed the water heater required a second regulator. Owner A reported s/he would have the water temperature adjusted by maintenance staff.	N 617		