STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 12/03/2025 with additional information gathered through 12/09/2025, Surveyor conducted an abbreviated survey at Kimberly Place. As a result, 2 deficiencies were identified. Census: 8	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 record review and interview, the provider did not ensure Individual Service Plans (ISPs) were updated to reflect the needs of Resident 1. Resident 1's ISP was not updated to reflect his/her needs related to cleaning assistance. Findings include: On 12/03/2025, Surveyor conducted an abbreviated survey at the facility.	N 389		

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
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 1 At 11:50 AM, during a tour of the facility accompanied by Program Manager (PM) B and Regional Manager (RM) C, Surveyor observed the second level of the home which consisted of 2 apartment-type settings. PM B confirmed Resident 1 and Resident 2 resided in 1 of the apartments and each had their own bedroom, and shared the common areas to include a kitchenette, living room and bathroom. PM B stated Resident 1 mainly occupies the shared areas and Resident 2 uses the common areas downstairs due to Resident 1's behaviors and uncleanliness. Surveyor observed a shared bathroom, a living room and a kitchenette mainly used by Resident 1. The overall appearance of these areas was dirty and appeared to not have been cleaned for an unknown amount of time. The following concerns were identified: The area in and around the sink in the bathroom was cluttered, unclean and covered in hair. The area around the toilet was littered with garbage and long strands of hair. The base of the toilet had a dried yellow substance resembling urine and other debris/particles. The top of the toilet and toilet seat was dirty and had dried fecal matter. The shower was coated in a pink/brown film resembling soap scum and had mounds of hair throughout. The living room was cluttered with boxes and miscellaneous items. There was a large area rug that was dirty with stains and there were pieces of straw and other particles throughout the room. The kitchenette had a stove, cabinets, a sink and a refrigerator. The overall appearance of the	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 2	N 389		

kitchenette was unclean. There was a white substance splattered on the floor and the cabinets were dirty and had dried food splatter.

On 12/03/2025 at 11:55 AM, Surveyor interviewed PM B and RM C who acknowledged Surveyor's concerns. PM B stated it is the responsibility of both residents and staff to clean. PM B confirmed the boxes and miscellaneous items in the living room and all of the concerns and products in the bathroom belonged to Resident 1. PM B reported Resident 1 has behaviors and when staff clean, s/he gets upset and destroys property and gets physically and verbally aggressive with staff and residents. PM B stated, "If we leave [him/her] be, [s/he's] fine." RM C stated, "Staff feel like they are walking on eggshells around [Resident 1]. We have been working with [his/her] care team to address the concerns."

On 12/03/2025 at 12:00 PM, Surveyor attempted to interview Resident 1 who was in his/her room with the door closed. Resident 1 refused to allow Surveyor and PM B to enter his/her room.

On 12/03/2025 and 12/08/2025, Surveyor requested and reviewed parts of Resident 1's record and the following was identified:

Resident 1 admitted to the facility on 07/07/2022, was his/her own person and had a managed care organization (MCO). Resident 1's diagnoses included but was not limited to, alcohol use disorder, depression, borderline personality disorder, post-traumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD) and gastrointestinal cancer. Resident 1 was able to communicate his/her wants and needs, make decisions and was independent with activities of daily living (ADLs). Resident 1 required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 3	N 389		

assistance with medication management.

Resident 1's most recent annual assessment completed on 06/16/2025 identified Resident 1 required staff assistance in "toileting and elimination" and "cleaning." Additionally, it reflected Resident 1 exhibited behaviors to include verbal aggression, property destruction, elopement, self-injury, suicidal thoughts, suicidal attempts, depression, anxiety and alcohol and drug abuse (AODA). Verbal aggression and property destruction were identified as "weekly" occurrences, and the severity was "low" and required "regular staff intervention."

Resident 1's ISP, dated 09/04/2025 reflected:

- "ADL's ... independent with [his/her] ADL's (showering, brushing teeth, laundry) and does not need prompts to complete these ... I will do my laundry once a week ... I will keep my bedroom safe and clean ... [Resident 1] will continue to be independent with [his/her] personal care ..."

- "IADL's ... completely independent with all of [his/her] IADLs ... does not like prompts to complete [his/her] IADLs as they are not needed ... [Resident 1] will ensure all of [his/her] IADLs are completed as needed ..."

- "Behavioral Health ... If [Resident 1] is engaging in an outburst staff will stay calm, if [s/he] goes upstairs, [s/he] has requested that staff do not approach [him/her]. If [Resident 1] leaves the house, allow [him/her] to go ... [Resident 1] has requested that we do not contact the police until a minimum of 24 hours have passed without any contact with [Resident 1] ... Listen ... Ask questions ...When [Resident 1] is feeling upset. When [Resident 1] is showing signs or symptoms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 4	N 389		

of frustration, anger, AODA, loud music or anxiety ... able to recognize when [s/he] is upset ... will utilize [his/her] coping skills (such as deep breathing, grounding techniques or listening to music) when feeling overwhelmed or anxious to calm down ... talk to a trusted staff member when [s/he] feels ready ..."

- "Social Participation ... prefers to keep to [him/herself] ... does not enjoy interacting with [his/her] peers ... values [his/her] own space and time ... has social contacts outside of Kimberly Place ... will engage in healthy relationships outside of Kimberly Place ..."

Resident 1's Incident Response Plan (IRP), dated 07/01/2025 identified triggers and symptoms related to behaviors associated with AODA, suicidal ideations, elopement and verbal aggression. Triggers included "discussions related to AODA, situations not going [his/her] way, difficulty understanding certain circumstances or feeling a lack of control over [his/her] own care." Symptoms included isolation, loud music, verbal aggression, emotional dysregulation, frustration or confusion, low sense of control and seeking preferred staff. Under "Verbal Aggression" it reflected, "[Resident 1] can at times become upset and have outbursts. These can include yelling, throwing things, calling names, and blaring music ... In 2023, [Resident 1] started refusing staff assistance and rejected any staff interaction ... started working with a therapist and has been able to identify some of the things that were happening and has begun working with staff again." For staff approaches, the plan noted, "Staff will work to build a relationship with [Resident 1] using the LEAP approach ... If unable to be redirected after 30 minutes of attempting to utilize [his/her] coping

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 5	N 389		

skills of talking with staff, playing video games, going for a walk, or staff using the LEAP approach, staff are to call PLS Crisis to report ... Crisis will assess the situation and determine further action ... will respond if [Resident 1] is struggling with their mental health symptoms and the approaches in the ISP are not effective."

On 12/08/2025 at 1:15 PM, Surveyor interviewed Case Manager (CM) D who stated "[Resident 1] is very particular, prefers to be alone and doesn't want help from staff. [S/he] has behaviors and can get verbally aggressive, will throw things and charge at staff." CM D reported, "If the upstairs is messy and staff go up to clean [s/he] gets very verbally aggressive with them. They need to remind [him/her] [s/he] needs to be cleaning [his/her] things and area." S/he stated, "If staff clean without [his/her] knowledge, it will cause [him/her] to have behaviors. If the communication is there a head of time, [s/he] is more receptive." CM D stated Resident 1 is "fairly" independent with ADL's and requires reminders from staff for bathing and laundry/chores. S/he stated Resident 1 also needs assistance with refilling his/her medications. CM D discussed Resident 1 wants his/her own apartment and they are working towards that.

On 12/09/2025 at 1:00 PM, Surveyor interviewed PM B who acknowledged Resident 1's ISP was not updated to reflect his/her needs with cleaning assistance. When discussing the annual assessment completed on 06/16/2025, PM B reported Resident 1 is independent with toileting and stated, "It's just the cleaning up after. [S/he] will put feces in the garbage can." S/he stated, "I've been sending staff up there daily to clean since [Surveyor's] visit and [Resident 1] has put sticky stuff in the sink, incontinence in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 6 garbage can and on the floor, taken hair out of [his/her] hairbrush and has spread it all over the floor. [S/he] doesn't like staff in [his/her] space. [S/he] blares [his/her] music and stomps around." PM B discussed they have tried interventions with Resident 1 to include reminders, putting up signs and approaching him/her ahead of time, but they not effective and the behaviors increase. PM B reported, "If [Resident 1] is happy with staff, [s/he] doesn't need assistance. If [s/he] is unhappy or upset and staff need to step in, [s/he] makes a bigger mess." PM B stated Resident 1 does not like Resident 2 in their shared spaces. S/he reported, "[Resident 1] knows if [s/he] makes it messy [Resident 2] will not go in there as [Resident 2] like [his/her] space clean and organized." When discussing the Incident Response Plan, PM B explained it is utilized by staff and their internal crisis team when Resident 1 is having behaviors and his/her ISP is used to help prevent behaviors from happening. Cross Reference: N0481 DHS 83.43(1) Environment Safe, Clean and Comfortable	N 389		
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	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 481	Continued From page 7 did not ensure a living environment that was safe, clean and homelike. Findings include: The provider is licensed to provide care for up to 8 residents who are developmentally disabled, emotionally disturbed/mentally ill and/or have a traumatic brain injury. On 12/03/2025 at 11:35 AM during a tour of the facility accompanied by Caregiver A, Program Manager (PM) B and Regional Manager (RM) C, Surveyor observed the following: A shared bathroom on the second level of the facility commonly used by Resident 1 and Resident 2: -There was a dried brown-like substance/stain splattered in the bottom of the sink. The area in and around the sink was cluttered, unclean and covered in hair. -The area surrounding the toilet was dirty and was littered with garbage and balls of hair. The base of the toilet was unclean and had a dried yellow substance resembling urine and other debris/particles. The top of the toilet and toilet seat was dirty and had dried fecal matter. -The shower was unclean, coated in soap scum that was brown/red in color and had several mounds of hair strewn throughout. -The floor was dirty with lint and hair. A shared living room area on the second level of the facility commonly used by Resident 1 and Resident 2: -The room was cluttered with boxes and miscellaneous items. There was a large area rug	N 481		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 481	Continued From page 8	N 481		

that was dirty with brown/black stains and there were pieces of straw strewn throughout the room.
A shared kitchenette on the second level of the facility commonly used by Resident 1 and Resident 2:
-There was a white substance splattered on the floor.
-The cabinets were dirty and had dried food splatter.

A shared bathroom on the second level of the facility commonly used by Resident 3 and Resident 4:

-The shower was unclean, coated in soap scum that was brown/red in color and had a black-like substance resembling mold in the grout (both inside and outside).
-The floor was dirty with lint and hair.
-The base of the toilet was unclean and had a dried yellow substance resembling urine. There was dried urine and fecal matter on the toilet and seat.
-The area surrounding the sink was unclean. There was a brown-like substance around the faucet and dirt/grime in the grout along the side of the sink.
-A large heating vent on the wall located near the shower was covered in a layer of dust and grime.
-A small heating vent on the wall above the toilet was covered in a layer of dust.

A shared living room area on the second level of the facility commonly used by Resident 3 and Resident 4:

-There was dust and particles throughout the entire floor. There was a line of dirt/grime along the baseboards in the hallway. There was a rug in the hallway that was unclean and littered with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 481	Continued From page 9	N 481		

debris and lint particles.
-Resident 4's room had a strong odor of uncleanliness.

A shared kitchenette on the second level of the facility commonly used by Resident 3 and Resident 4:

-The floor was unclean and had dried liquid splatter, crumbs and dirt particles.
-The cabinets were dirty with grime and dried food/liquid splatter.

Basement (where laundry room is located):

-There were thick cobwebs on the ceiling throughout the basement.

On 12/03/2025 at 11:55 AM, Surveyor interviewed PM B and RM C who acknowledged Surveyor's concerns. PM B stated Resident 1, Resident 2, Resident 3 and Resident 4 live in an apartment-type setting where each apartment has 2 bedrooms, a kitchenette, a living room and bathroom. PM B stated all residents have access to laundry services in the basement. PM B reported there are 2 residents in each apartment and they share the common areas to include the kitchenette, bathroom and living room. S/he indicated they are mostly independent and the goal is to work towards transitioning them into their own apartment. PM B acknowledged the strong odor in Resident 4's room. PM B discussed staff need to provide a lot of prompts for Resident 4 to shower and clean his/her room. S/he stated, "There is a lot of reinforcement and encouragement. We've tried different incentives with [him/her]. It works for a little while and then [s/he] loses motivation." PM B and RM C discussed that Resident 1 is behavioral and tends

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 481	Continued From page 10	N 481		

to get upset and will act out when staff clean. RM C acknowledged how unclean Resident 1 and Resident 2's shared bathroom was and stated, "It's not fair to [Resident 2] to have to live like that."

On 12/03/2025 at 1:45 PM, while speaking with PM B and RM C, Surveyor observed a document titled "House Cleaning Checklist" hanging on the wall in the staff office. PM B reported s/he recently created the cleaning checklist "in hopes staff would use it." Surveyor reviewed the checklist which included specific tasks in the following areas, "general cleaning, kitchen cleaning, bathroom cleaning and other cleaning tasks." Surveyor reviewed the tasks listed under "bathroom cleaning" and the following was noted, "clean and sanitize toilets, sinks and showers/bathtubs; clean mirrors, windows and any other surfaces; stock toilet paper, paper towel and soap; and empty and clean the trash can as needed." Additionally, under "general cleaning" there was a task stating, "sweep and mop or vacuum all floors and rugs." PM B reported staff should be cleaning on every shift and this would include the apartments upstairs. S/he stated, "I've done a lot to push staff to get them to clean."

On 12/04/2025 at 9:37 AM, Surveyor received an email from PM B stating, "I have implemented a formal cleaning plan and communicated expectations to all staff. A detailed end-of-shift cleaning checklist has been created, which staff are required to complete and submit to me before the end of their shift."

On 12/09/2025 at 1:00 PM, Surveyor interviewed PM B who acknowledged the cleanliness concerns during Surveyor's onsite visit and stated it was "unacceptable." S/he stated, "You coming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010891	A. BUILDING: _____ B. WING _____	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIMBERLY PLACE	314 W KIMBERLY AVE KIMBERLY, WI 54136

(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 481	Continued From page 11 was a big eye opener. I had a staff meeting yesterday and I expressed how shocked and disappointed I was to see how it looked upstairs." PM B expressed s/he has a plan in place to ensure cleanliness going forward. The provider did not ensure a living environment that was safe, clean, comfortable and homelike for all residents.The provider did not ensure a living environment that was safe, clean, comfortable and homelike for all residents. Cross Reference: N0389 DHS 83.35(3)(d) Service Plans Updated Annually or on Changes	N 481		