

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010891	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/17/2026
NAME OF PROVIDER OR SUPPLIER KIMBERLY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 04/14/2026 with additional information gathered through 04/17/2026, Surveyor conducted a verification visit at Kimberly Place. As a result, 2 of 2 previous deficiencies were corrected and no new deficiencies were identified. Under statutory provisions of WI Stat. Ch. 50 a \$200 revisit fee is being assessed. Census: 6	{N 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE