STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016721	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENOSHA PLACE	5048 GREEN BAY RD KENOSHA, WI 53144

(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 02/26/2026, Surveyor completed a verification visit and complaint investigation at Kenosha Place. As a result, 4 of the previous deficiencies were corrected, 2 deficiencies were recited, and 1 new deficiency was identified. The complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 22	{N 000}		
{N 220}	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before	{N 220}		

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
	0016721	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENOSHA PLACE	5048 GREEN BAY RD KENOSHA, WI 53144

(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 220}	Continued From page 1 the start of employment for 1 of 1 caregiver reviewed (Caregiver K). Caregiver K was screened for TB and communicable diseases 35 days after the start of employment. This is a repeat deficiency. See Statement of Deficiency (SOD) JIQ111, dated 04/03/2025. Findings include: On 02/26/2026, at 11:45 AM, Surveyor reviewed Caregiver K's record. Caregiver K was hired on 12/10/2025. Caregiver's record contained a TB test dated 01/14/2026, which was read on 01/16/2026. Caregiver K's record contained a communicable disease screening dated 01/14/2026. Caregiver K's TB and communicable disease screening were completed 35 days after her/his start of employment. On 02/26/2026, at 2:00 PM, Surveyor interviewed Administrator A and Clinical Nurse H. Administrator A reported Director of Wellness (DOW) N was responsible for completing the TB and communicable disease screening. Administrator A reported staff would bring in screenings from prior employment to use and Caregiver K may have been one of those staff. Administrator A reported s/he was unsure of the exact circumstance with Caregiver K, but it may have been found Caregiver K was missing her/his TB and communicable disease screening during an audit.	{N 220}		
{N 239}	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or	{N 239}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016721	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENOSHA PLACE	5048 GREEN BAY RD KENOSHA, WI 53144

(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 239}	Continued From page 2 other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 employees obtained all department approved training as required. Caregiver L and Caregiver M did not have training in standard precautions, fire safety and first aid and choking within 90 days after starting employment. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) P70Y11, dated 04/07/2023 and SOD JIQ111, dated 04/03/2025.	{N 239}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016721	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENOSHA PLACE	5048 GREEN BAY RD KENOSHA, WI 53144

(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 239}	Continued From page 3 Findings include: On 12/29/2025, the Department received a complaint alleging concerns regarding staff training. On 02/26/2026, at 11:45 AM, Surveyor reviewed staff records and identified the following: Caregiver L was hired on 10/22/2025. Caregiver L's record did not contain evidence of training or evidence of meeting an exemption for standard precautions, fire safety and first aid and choking. On 02/26/2026, Surveyor verified Caregiver L was not on the Community-Based Care and Treatment training registry for standard precautions, fire safety and first aid and choking. Caregiver M was hired on 11/26/2025. Caregiver M's record did not contain evidence of training or evidence of meeting an exemption for standard precautions, fire safety and first aid and choking. On 02/26/2026, Surveyor verified Caregiver M was not on the Community-Based Care and Treatment training registry for standard precautions, fire safety and first aid and choking. On 02/26/2026, at 2:00 PM, Surveyor interviewed Administrator A and Clinical Nurse H. Administrator A confirmed the code requirement. Administrator A reported s/he needed to contact the registry to find out why Caregiver L and Caregiver M were not listed on the registry.	{N 239}		
N 383	83.35(1)(c) Listed areas for assessments. Assessment. Areas of assessment. The	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016721	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENOSHA PLACE	5048 GREEN BAY RD KENOSHA, WI 53144

(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 383	Continued From page 4 assessment, at a minimum, shall include all of the following areas applicable to the resident: 1. Physical health, including identification of chronic, short-term and recurring illnesses, oral health, physical disabilities, mobility status and the need for any restorative or rehabilitative care. 2. Medications the resident takes and the resident ' s ability to control and self-administer medications. 3. Presence and intensity of pain. 4. Nursing procedures the resident needs and the number of hours per week of nursing care the resident needs. 5. Mental and emotional health, including the resident ' s self-concept, motivation and attitudes, symptoms of mental illness and participation in treatment and programming. 6. Behavior patterns that are or may be harmful to the resident or other persons, including destruction of property. 7. Risks, including, choking, falling, and elopement. 8. Capacity for self-care, including the need for any personal care services, adaptive equipment or training. 9. Capacity for self-direction, including the ability to make decisions, to act independently and to make wants or needs known. 10. Social participation, including interpersonal relationships, communication skills, leisure time activities, family and community contacts and vocational needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident (Resident 4) was assessed in physical health, which included identification of chronic, short-term, and recurring illnesses.	N 383		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016721	A. BUILDING: _____ B. WING _____	R-C 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENOSHA PLACE	5048 GREEN BAY RD KENOSHA, WI 53144

(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 383	Continued From page 5 Findings include: On 02/26/2026, at 1:00 PM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 10/15/2025 with diagnoses including dementia, congestive heart failure, and osteoarthritis. Resident 4's record contained an After Visit Summary (AVS), dated 11/16/2025 which indicated s/he was admitted to the hospital with Clostridioides difficile (C. diff) from her/his gallbladder surgery on 11/06/2025. Resident 4's record did not contain any physical health assessment, including identification of chronic, short-term, and recurring illnesses. On 02/26/2026, at 1:40 PM, Surveyor interviewed Clinical Nurse H. Clinical Nurse H reported s/he thought the assessment included all required information. Clinical Nurse H reported they would need to review their assessments to ensure code requirements.	N 383		