

Wisconsin Department of Health Services

|                                                       |                                                                                                                                                                       |                                                                             |                                                                                                                          |                          |                                                        |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0011510</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALDER HOME</b> |                                                                                                                                                                       |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8212 61ST ST<br/>KENOSHA, WI 53142</b>                                       |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                          | ID<br>PREFIX<br>TAG                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| M 000                                                 | <p><b>INITIAL COMMENTS</b></p> <p>On 09/12/2025, Surveyor conducted an abbreviated survey at Alder Home.</p> <p>No deficiencies were identified.</p> <p>Census: 4</p> | M 000                                                                       |                                                                                                                          |                          |                                                        |

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

TITLE

(X6) DATE