STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018351	A. BUILDING: _____ B. WING _____	R-C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR WEST	4228 KADLEC DRIVE SHEBOYGAN, WI 53083

(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 11/03/2025, Surveyors conducted one (1) verification visit and investigated two (2) complaints. Additional information was gathered through 11/06/2025. As a result, 2 complaints were unsubstantiated, 1 deficiency was verified as corrected and 2 deficiencies were identified. Two of 3 deficiencies are repeat violations. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 42	{N 000}		
{N 386}	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on interview and record review, the provider did not develop a comprehensive Individual Service Plan (ISP) for 1 of 1 resident (Resident 6) reviewed.	{N 386}		

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
	0018351	A. BUILDING: _____ B. WING _____	R-C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR WEST	4228 KADLEC DRIVE SHEBOYGAN, WI 53083

(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 386}	Continued From page 1 Resident 6 did not have a comprehensive ISP within 30 days after admission. This is a repeat deficiency. See Statement of Deficiency (SOD) 2EY011, dated 06/07/2025. Finding include: On 11/03/2025, Surveyors reviewed Resident 6's record. Resident 6 was admitted to the facility on 09/23/2025. Resident 6's ISP, unsigned by resident/resident representative, was dated 10/30/2025. On 11/03/2025 at 4:05 PM, Surveyor interviewed Regional Wellness Director (RWD) G who stated an initial ISP is completed prior to admission and then another is done at 30 days in the facility. RWD G stated the ISP is reviewed with and signed by resident and family/Power of Attorney (POA). Surveyor asked if Resident 6's comprehensive assessment was completed within 30 days after admission. RWD G stated, "No, it was done on 10/30/2025 and was late." RWD G confirmed that the ISP was not currently signed by resident/resident representative, but would be signed at the time of the next family visit.	{N 386}		
{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	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018351	A. BUILDING: _____ B. WING _____	R-C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR WEST	4228 KADLEC DRIVE SHEBOYGAN, WI 53083

(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 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 interview and record review, the provider did not update the Individual Service Plan (ISP) when 3 of 3 residents (Resident 3, Resident 4, and Resident 5) had a change in plan of care / change in condition. Resident 3 has restrictions on visitors that are not listed on the ISP. Resident 4 uses an assistive device for ambulation and his/her transfer status and use of assistive device are not listed on the ISP. Resident 5 had a change in condition; was using supplemental oxygen and was receiving hospice services. These changes were not listed on the ISP. This is a repeat deficiency. See Statement of Deficiency (SOD) 2EY011, dated 06/07/2025. Findings include: Example 1 On 11/03/2025 at approximately 9:30 AM, Associate Administrator E told Surveyors that the facility did not allow Resident 3's family member to visit at the facility due to a pending police investigation concerning an allegation of abuse.	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018351	A. BUILDING: _____ B. WING _____	R-C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR WEST	4228 KADLEC DRIVE SHEBOYGAN, WI 53083

(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 Surveyors requested and reviewed Resident 3's ISP. Resident 3's ISP had a report date of 06/16/2025. Important to note: Resident 3's ISP does not mention visitor restrictions. Example 2 Resident 4's Emergency Department After Visit Summary, dated 10/26/2025, states, in part: Instructions: ...use your walker when up and ambulating ... On 11/04/2025 at 4:31 PM, Surveyor interviewed Medication Assistant H who stated that Resident 4 used a walker for ambulation. Surveyors requested and reviewed Resident 4's ISP. Resident 4's ISP had a report date of 07/11/2025. Important to note: Resident 4's ISP does not mention his/her transfer status or use of assistive device (walker). Example 3 Resident 5's Observation note dated 10/22/2025 at 9:30 PM, states, in part: hospice came to see resident, is now on hospice ... Resident 5's Notification of Change sheet, dated 04/10/2025, states, in part: How to Turn on an Oxygen Tank ... 3. Adjust the liter flow using the dial on the regulator in accordance with your physician's prescription. For Resident 5 it is 5 L/min (liters per minute via NC (Nasal Cannula) continuously ...	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018351	A. BUILDING: _____ B. WING _____	R-C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR WEST	4228 KADLEC DRIVE SHEBOYGAN, WI 53083

(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 Resident 5's Physician Progress Note, dated 10/20/25, states, in part: ...New Concerns: On hospice since 10/22/2025 ... Surveyors requested and reviewed Resident 5's ISP. Resident 5's ISP had a report date of 03/25/2025. Important to note: Resident 5's ISP does not mention hospice services or use of supplemental oxygen. On 11/03/2025 at approximately 12:10 PM, Surveyors interviewed Associate Administrator (AA) E who stated residents need new/updated ISPs; s/he will use form to get updates to staff ASAP and staff will read and sign to acknowledge updates. The nurse was supposed to do weekly rotation to ensure updates were signed and updates made to the ISP, but s/he was not doing it. Notification of Change in ISP Forms are kept in front of the ISP binder and staff (caregivers and medication assistants) are to check daily. AA E confirmed it is a nurse delegated task to ensure updates are signed; the previous nurse was not following up on orders. The provider is working on reviewing and updating the ISPs. On 11/04/2025 at 1:32 PM, Surveyors interviewed Medication Assistant (MA) J and asked how staff became aware of changes / updates to the ISP. MA J stated through verbal communication with the previous shift or the nurse. MA J stated the ISP is locked in the nurse's office; there is access to the ISP in the computer, but it is not updated. On 11/04/2025 at 4:05 PM, Surveyor interviewed Regional Wellness Director G who stated that Resident 4 passed away on 11/01/2025 while on	{N 389}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018351	A. BUILDING: _____ B. WING _____	R-C 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR WEST	4228 KADLEC DRIVE SHEBOYGAN, WI 53083

(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 hospice services and Resident 4 had been using supplemental oxygen at time of death. The provider did not update the ISP when residents had a change in plan of care / change in condition.	{N 389}		