Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018352	A. BUILDING: _____ B. WING _____	R-C 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR EAST	4221 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 03/17/2026, Surveyor conducted a verification visit and 3 complaint investigations at Country Side Manor East. As a result of the survey previous deficiencies were corrected, 1 of 3 complaints was substantiated resulting in 1 deficiency. Under statutory provision of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 14	{N 000}		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents reviewed had their needs, abilities and physical and mental conditions assessed. Resident 1 was not assessed following a fall with injury.	N 381		

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
	0018352	A. BUILDING: _____ B. WING _____	R-C 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR EAST	4221 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 381	Continued From page 1 Resident 2's was not assessed for decline in health, ambulation and change in diet. The findings include: On 01/28/2026 and 02/10/2026, the department received complaints alleging residents with multiple falls and change in condition. The provider is licensed as a class CNA (non-ambulatory) CBRF able to serve up to 16 residents within the client groups of advanced age, physically disabled, terminally ill and/or irreversible dementia/Alzheimer's. On 03/17/2026, Surveyor requested Resident 1 and Resident 2's record from Administrator L and Associate Administrator (AA) B. Resident 1 was admitted to the facility October 2022 with diagnoses to include Alzheimer's disease, depressive disorder and hyperlipidemia. Resident 1's record reflected Resident 1 had a fall on 12/04/2025 in his/her room. Resident 1 was sent to the emergency room. Resident 1 returned 12/05/2025 to the facility with a C6 fracture and a neck brace. Resident 1's notes: 12/04/2025, 9:45 PM - "Resident was in [his/her] room when [s/he] around 445pm. [S/he] said [s/he] had lost [his/her] balance and fell to the floor. [S/he] reported that [s/he] hit head and [his/her] hip when [s/he] fell." 12/05/2025, 3:45 AM - "Resident came back from hospital about 10:30pm on 12/4/25. [S/he] has a C6 fracture." "Resident was very restless and kept climbing out of bed." 12/06/2025, 5:45 PM - "Resident has been refusing to keep [his/her] neck brace on that [s/he] is wearing due to [his/her] broken neck." 01/22/2026, 10:30 AM - "OK to remove C-Collar	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018352	A. BUILDING: _____ B. WING _____	R-C 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR EAST	4221 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 381	Continued From page 2 due to patient regularly attempting to remove it." Resident 2 was admitted to the facility 09/03/2024 with diagnoses to include dementia, depressive disorder, anxiety and Alzheimer's disease. Resident 2's record reflected s/he had several falls, s/he had difficulty swallowing his/her food. Resident 2's individual service plan (ISP) reflected s/he was on a mechanical soft diet, and s/he was independent with all mobility and walks around the facility. Resident 2's notes: 02/02/2026 1:30 PM - "resident was not swallowing [his/her] food today, both meals staff attempted to assist [him/her] with eating, res [sic] kept holding it in [his/her] mouth or it was just sliding right out." February 2026 - Several notes reflect that resident was restless, not sleeping, not eating. 03/13/2026 12:15 PM - "½ of puree fish for lunch." On 03/17/2026 at 10:28 AM, Surveyor interviewed AA B. AA B stated Resident 2 had taken a big decline and was bed bound most of the time. AA B stated s/he believed the decline started approximately 3 months ago. AA B confirmed Resident 2 was not independent with mobility. Surveyor requested assessments completed for Resident 2. AA B acknowledged Resident 1 was no longer at the facility. AA B confirmed Resident 1 returned from the hospital on 12/05/2026 with a neck brace. AA B stated Resident 1 did not like wearing the neck brace and would continuously remove the brace. AA B stated they received a d/c order for the neck brace on 01/20/2026. Surveyor requested assessment completed for Resident 1 regarding the neck brace. On 03/17/2026 at 11:10 AM, Surveyors	N 381		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018352	A. BUILDING: _____ B. WING _____	R-C 03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY SIDE MANOR EAST	4221 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 381	Continued From page 3 interviewed Administrator L. Administrator L confirmed Resident 2 was a pureed diet. Administrator L stated Resident 2 tucked his/her chin and wasn't able to lift his/her head and had recently had a decline. Surveyor requested assessment completed for Resident 2. Administrator L confirmed Resident 1 returned from the hospital with a neck brace. Surveyor requested the assessment completed for Resident 1. On 03/17/2026 at approximately 2:30 PM, Surveyor interviewed AA B and Administrator L. Administrator L and AA B acknowledged they did not have an assessment on Resident 2 with his/her decline, or an assessment for Resident 1 as they believed his/her wearing the neck brace was short term. The provider did not ensure residents had their needs, abilities and physical and mental conditions assessed.	N 381		