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
	0018350	A. BUILDING: ______ B. WING ______	R-C **04/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSIDE MANOR	**6300 67TH STREET** **KENOSHA, WI 53142**

(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 04/28/2026, Surveyor completed a verification visit and 2 complaint investigations at Parkside Manor. As a result, all deficiencies from Statement of Deficiency (SOD) UJZS12 were corrected, and one deficiency was identified. One complaint was substantiated, and one complaint was unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 52	{N 000}		
N 156	83.12(1)(b) Death reporting related to accident or injury Resident death related to an accident or injury. When a resident dies as a result of an incident or accident not related to the use of a physical restraint, psychotropic medication, or suicide, the CBRF shall send a report to the department within 3 working days of the resident ' s death. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not send a report to the Department within 3 working days when Resident 27 died from an incident or accident not related to physical restraint, psychotropic medication, or suicide. Findings include: On 01/07/2026, the Department received a complaint alleging concerns related to a resident death. On 04/27/2026, at approximately 2:00 PM, Surveyor reviewed Resident 27's record.	N 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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N 156	Continued From page 1 Resident 27 was admitted on 12/07/2024. Resident 27's file contained an incident report dated 01/02/2026 at 10:00, which indicated the following: "...Briefly describe what occurred: Caregiver as [sic] walking in the hallway and could hear the resident yelling. The resident was lying on the floor. Two Caregivers [sic] had just left the resident's room a few minutes before the resident fell. Caregivers assisted the resident up off the floor. Resident hadd [sic] on slippers, and the call light was near the resident..." Resident 27's file contained a progress note, dated 01/02/2026 at 12:45 PM, which annotated the fall and indicated Resident 27 was sent to the hospital further treatment. A progress note, dated 01/05/2026 at 8:06 AM, indicated Resident 27 was discharged from the system and contained a note which stated, "[Resident 27] passed in the hospital." On 04/28/2026, at approximately 11:45 AM, Surveyor interviewed Family Member CC. Family Member CC reported s/he was informed Resident 27 "had a brain bleed" after imaging was conducted in the emergency room on 01/02/2026. On 04/28/2026, at approximately 11:45 AM, Surveyor interviewed Executive Director (ED) AA. ED AA reported s/he did not report the fall/death because s/he was not aware it was a reportable event. ED AA reported s/he was unaware Resident 27 suffered from a brain bleed. ED AA stated s/he would review self-reporting guidelines.	N 156		