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
	0015313	A. BUILDING: _____ B. WING _____	C 05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET	2121 SUNSET LANE LA CROSSE, WI 54601

(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
M 000	INITIAL COMMENTS On 05/06/2026, Surveyor conducted a complaint investigation at Sunset. Data collection continued through 05/18/2026. The complaint was substantiated. One deficiency was identified. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not send a written report to the Department within 24 hours after Resident 1 was admitted into the hospital due to an overdose. Findings include: On 02/27/2026, the department received a complaint regarding resident care. On 05/06/2026, at approximately 11:45 AM,	M 134		

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

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M 134	Continued From page 1	M 134		

Surveyor called Owner A via phone while onsite at the facility. Owner A stated Resident 1 experienced significant behavioral challenges while residing with the provider. Owner A stated Resident 1's psychiatrist made a home visit with Resident 1 to adjust his/her medications, and s/he overdosed him/her. Owner A stated they called 911 and staff were not equipped to manage that level of complexity. Owner A stated Resident 1's liver did not flush out medications and that was why the overdose happened. Owner A stated the psychiatrist came to see Resident 1 on 01/30/2026 and Resident 1 was hospitalized on 01/31/2026. Resident 1 did not return to the facility and was currently residing in a different facility.

Surveyor requested Resident 1's record from Owner A.

At 1:02 PM, Surveyor reviewed Resident 1's record.

Resident 1 was admitted on 10/13/2025 and had a guardian.

An observation note, dated 01/31/2026, read, "I [sic] got here at 8:30 am ,[sic] my co worker who was here gave me the run down on evrything [sic] as usual. Around 10am i checked on [Resident 1] [s/he] seemed tired but was breathing so i left [him/her] alone. around 11:15am i checked on [him/her] agaun [sic] and [s/he] seemed off not responding like [his/her] normal self so i called my bosses and i was instructed to call the ems immediately"

On 05/18/2026, at 2:00 PM, Surveyor interviewed Owner A via phone. When asked if the provider submitted a self-report regarding Resident 1's

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M 134	Continued From page 2 change in condition, Owner A stated s/he was looking in his/her records and did not see evidence a report was submitted to the department. The provider did not send a written report to the Department within 24 hours after Resident 1 experienced a significant change in condition after s/he experienced a medication overdose and was hospitalized.	M 134		