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 11/18/2024

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 11/13/2024, Surveyor conducted an abbreviated survey and complaint investigation at Sunset. Data collection continued through 11/18/2024. The complaint was substantiated. Three deficiencies were identified. Census: 3	M 000		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure smoke detectors were tested monthly. Findings include: The provider is licensed to care for up to 4 residents within the following client groups: physically disabled, irreversible dementia/Alzheimer's disease, developmentally disabled, and emotionally disturbed/mental illness.	M 336		

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
	0015313	A. BUILDING: _____ B. WING _____	C 11/18/2024

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 336	Continued From page 1 On 11/13/2024, at approximately 12:30 PM, Surveyor reviewed the provider's smoke detector maintenance log from 2024, which indicated the provider had not tested or maintained the smoke detectors since May 2024. At approximately 12:35 AM, Surveyor interviewed Office Manager (OM) A. When asked about the blank areas on the smoke detector log, OM A stated House Manager (HM) B was responsible for completing the smoke detector checks and would be receiving counseling for not completing them. OM A stated s/he knew HM B did not complete them as required. OM A stated maintenance might have done the checks but s/he did not have documentation to reflect that.	M 336		
M 466	88.07(3)(e)1 MEDICATION- RECORD KEEPING The licensee shall keep a record of all prescription medications controlled, dispensed or administered by the licensee which show the name of the resident, the name of the particular medication, the date and time the resident took the medication and errors and omissions. The medication controlled by the licensee shall be kept in a locked place. This Rule is not met as evidenced by: Based on record review and interview, the provider did not keep a record of all prescription medications controlled, dispensed, or administered, for Resident 1. Resident 1's October 2024 contained 33 blank	M 466		

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 11/18/2024

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 466	Continued From page 2 entries. Findings include: On 10/07/2024, the department received a complaint alleging the provider made numerous medication errors and kept inaccurate medication administration records. On 11/13/2024, at approximately 12:10 PM, Surveyor interviewed Office Manager (OM) A. When asked about any recent medication issues, OM A stated Resident 1 recently missed a dose of his/her Insulin and a staff member had marked it as administered in the MAR. OM A stated when s/he became aware of the situation, s/he went in and corrected the MAR to reflect the Insulin was not given. OM A stated Caregiver D signed the Insulin as administered when it was not. OM A stated Caregiver D needed to slow down and s/he checked medications off too fast. OM A stated Caregiver D received counseling to address the situation. When asked why the Insulin was not available, OM A stated staff had delayed re-ordering it and when it was re-ordered, there were two conflicting orders. OM A stated the pharmacy had to follow up with the prescribing provider and that caused further delay. OM A stated it was not as much of a medication error issue but a documentation issue. At 12:58 PM, OM A emailed Surveyor records for Resident 1. Resident 1 was admitted to the provider on 06/23/2014 with multiple diagnoses including Type 2 diabetes mellitus with diabetic polyneuropathy, Type 2 diabetes mellitus with other diabetic neurological complication, Type 2 diabetes mellitus with hyperglycemia, Unspecified	M 466		

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 11/18/2024

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 466	Continued From page 3 dementia without behavioral disturbance, Hyperlipidemia and Essential hypertension. Resident 1's Individual Service Plan (ISP), dated 11/13/2024, indicated Resident 1 received medication assistance from staff. It stated staff would appropriately administer all scheduled and as needed medications for Resident 1. It stated staff would ensure Resident 1 took the correct amount of Insulin by checking the dial on the end of the pen. Surveyor reviewed Resident 1's October 2024 MAR and observed the following 33 blank entries for his/her prescribed medications: Metformin Tab 1000 MG 10/18/2024 8:00 PM Atorvastatin Tab 40 MG 10/18/2024 8:00 PM Vitamin D3 2000 IU 50 MCG Tab 10/15/2024 8:00 AM Tamsulosin Cap .4 MG 10/15/2024 8:00 AM Divalproex Tab 500 MG DR 10/18/2024 8:00 PM Oxcarbazepin Tab 150 MG 10/18/2024 8:00 PM Freestyle Libre CGM Blood Sugar 10/05/2024 8:00 AM 10/11/2024 5:00 PM 10/15/2024 12:00 PM 10/15/2024 5:00 PM 10/18/2024 12:00 PM	M 466		

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 11/18/2024

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 466	Continued From page 4 10/18/2024 5:00 PM 10/18/2024 8:00 PM 10/24/2024 12:00 PM 10/25/2024 5:00 PM Melatonin Tab 5 MG 10/18/2024 8:00 PM Mirtazapine Tab 15 MG 10/18/2024 8:00 PM Admelog Solo INJ 100U/ML 10/11/2024 5:00 PM 10/15/2024 12:00 PM 10/15/2024 5:00 PM 10/18/2024 12:00 PM 10/18/2024 5:00 PM 10/24/2024 12:00 PM 10/25/2024 5:00 PM Basaglar Kwikpen 100-U/ML 10/18/2024 8:00 PM BD Pen Needl Mis 31GX5MM 10/11/2024 Supper 10/15/2024 Lunch 10/15/2024 Supper 10/18/2024 Lunch 10/18/2024 Supper 10/18/2024 8:00 PM 10/24/2024 Lunch 10/25/2024 Supper At 3:11 PM, OM A emailed Surveyor a document titled "Staff Counseling" with Caregiver D identified. Under a section titled, "Behavior or Incident that has resulted in counseling," it stated there was a documentation error on 09/24/2024. It stated Resident 1's Admelon Insulin was charted as given but it was not given.	M 466		

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 11/18/2024

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 466	Continued From page 5 On 11/14/2024, Surveyor requested additional records for Resident 1 via email from OM A. Surveyor requested any staff notations for September 2024 and October 2024 MARs. At 2:39 PM, OM A responded via email and stated, "I have mandatory staff meetings scheduled for tomorrow with [Licensee C] in attendance to address the missing documentation. All staff involved will have counseling forms that are signed by 5pm tomorrow. All staff will comply with counseling or face further disciplinary action leading up to termination." Surveyor did not observe any staff notations that correlated with the blank entries on the MAR. On 11/18/2024, at 11:00 AM, Surveyor interviewed OM A and Licensee C via a virtual meeting. When asked about the missing documentation referenced in OM A's email, OM A stated s/he was referring to the blank areas on Resident 1's MAR. OM A stated the provider noticed the blank areas on the MAR and met with staff who were working on the days when the documentation was missing. OM A stated the provider stressed the importance of completing the documentation and would continue to work with staff to ensure it was getting done.	M 466		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who	M 570		

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 11/18/2024

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 570	Continued From page 6	M 570		

cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure a safe physical environment for 3 of 3 residents. The provider's clothes dryer had a flexible vent material, causing a possible fire hazard.

Findings include:

The provider is licensed to care for up to 4 residents within the following client groups: physically disabled, irreversible dementia/Alzheimer's disease, developmentally disabled and emotionally disturbed/mental illness.

On 11/13/2024 at approximately 11:30 AM, Surveyor observed the dryer vent. The venting was made of flexible material.

At approximately 1:25 PM, Surveyor interviewed Office Manager (OM) A. Surveyor shared concerns about the flexible venting material currently attached to the dryer. OM A stated s/he recalled a previous surveyor asking questions about the venting but did not know if it met the standards.

On 11/14/2024, at 10:33 AM, Surveyor emailed OM A and informed him/her of the above findings and asked if s/he had evidence that the venting used met the UL 2158A standard, or evidence the

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 11/18/2024

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 570	Continued From page 7 venting used was approved for use by the dryer manufacturer. At 1:54 PM, OM A responded via email and stated, "Maintenance is as we speak working on purchasing the correct dryer vent ...as soon as [s/he] installs the vent I can send a picture of the label and the vent itself affixed to the dryer ..." At 4:52 PM, Surveyor received an email from OM A with a photo attached of a dryer vent made of rigid metal material.	M 570		