STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012968	A. BUILDING: _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE EAST	207 W PARRY ST DODGEVILLE, WI 53533

(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 09/20/2024, the bureau of assisted living southern regional office conducted a standard survey at Sunnyside East a CBRF located in Dodgeville, WI. As a result of this survey, 2 violations of DHS Chapter 83 were issued. Census: 8	N 000		
N 358	83.32(3)(n) Rights of Residents: Safe environment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Safe environment. Live in a safe environment. The CBRF shall safeguard residents from environmental hazards to which it is likely the residents will be exposed, including both conditions that are hazardous to anyone and conditions that are hazardous to the resident because of the residents ' conditions or disabilities. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the CBRF safeguarded residents from environmental hazards to which it is likely the residents would be exposed, including conditions which are hazardous to anyone and conditions that are hazardous to the resident because of the residents' conditions or disabilities. FINDINGS INCLUDE: On 09/20/2024, Surveyor arrived at facility for standard survey.	N 358		

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
	0012968	A. BUILDING: _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE EAST	207 W PARRY ST DODGEVILLE, WI 53533

(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 358	Continued From page 1 On 09/20/2024, Surveyor reviewed Department facility facesheet. Facility is licensed as a non-ambulatory CBRF. Facility is licensed to provide care to the following client groups: emotionally disturbed, mental illness, traumatic brain injury and physically disabled. On 09/20/2024 at 8:30 AM, Surveyor toured the facility. Surveyor tested the door handle on the laundry room door. Surveyor opened the laundry room door without a key. Surveyor entered the laundry room and observed the following: 1.) On the counter to the left of the dryer there was a 1-gallon container of concentrated bleach (Picture 1). Surveyor picked up the bottle, shook its contents, and felt the container to be approximately 50% full. 2.) On the counter to the left of the dryer there was a 1-gallon container of, "Fabuloso: Multi-Purpose Cleaner," (Picture 2). Surveyor observed the container was approximately 25% full of a purple liquid. 3.) On top of open space between the dryer and counter was a 2.43-gallon container of, "XTRA," laundry detergent (Picture 3). Surveyor picked up the bottle, shook its contents, and felt the container to be approximately 25% full. 4.) Surveyor looked behind the laundry room dryer. Surveyor observed a silver-metallic colored accordion style vent connected to the dryer. On 09/20/2024 at 8:45 AM, Surveyor asked Lead B to follow them to the laundry room. Surveyor observed Lead B open the laundry room door without a key. Lead B stated the door was in working order and was normally kept locked.	N 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012968	A. BUILDING: _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE EAST	207 W PARRY ST DODGEVILLE, WI 53533

(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 358	Continued From page 2 Lead B acknowledged the laundry room was unlocked. Lead B acknowledged the gallon of concentrated bleach, laundry detergent and multi-cleaner solution were unsecured. Lead B acknowledged the accordion style dryer vent. Lead B stated the dryer had been repaired the day before. Lead B stated the accordion style dryer vent could be replaced by the afternoon and a photo of the replacement could be e-mailed to Surveyor by the end of the following business day (09/23/2024). On 09/20/2024 at 10:12 AM. Surveyor went to use the resident bathroom located across the hallway from the facility kitchen. When Surveyor went to wash their hands. Surveyor found the automated hand soap dispenser and automated hand towel dispenser to be empty. Surveyor utilized personal hand-sanitizer for hand hygiene. While in the bathroom Surveyor observed the following: 1.) A board propped up below the bathroom countertop, appeared to have been broken off from the bottom of the countertop. A moderate amount of paint/laminate had been peeled off the front of the countertop (Picture 4). 2.) An approximately 12-inch (in) x 2 in section of damaged drywall behind the toilet tank cover (Picture 5). 3.) Masking tape used to cover an electrical switch (Picture 6). 4.) An approximately 12 in x 3 in section of damaged drywall above the floor trim on the convex corner between the toilet paper holder and bathroom counter (Picture 7).	N 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012968	A. BUILDING: _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE EAST	207 W PARRY ST DODGEVILLE, WI 53533

(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 358	Continued From page 3 On 09/20/2024 at 10:25 AM, Surveyor asked Administrator A to follow them to the resident bathroom. Administrator A attempted to use the automated hand soap dispenser and automated paper towel dispenser. Administrator A acknowledged both the hand soap dispenser and paper towel dispenser were empty. Administrator A acknowledged residents did not have a means to complete hand hygiene in the bathroom at that time. Administrator A stated there is a resident who had a habit of emptying the paper towel dispenser. Administrator A asked Caregiver C to refill the automated hand soap dispenser and hand towel dispenser. Administrator A acknowledged the damage to drywall, damage to bathroom counter and the masking tape over the light switch. On 09/20/2024 at 11:00 AM. Surveyor discussed the accordion style dryer vent in the laundry room with Administrator A. Administrator A verified the dryer was repaired earlier in the week. Administrator A stated maintenance could replace the accordion style vent with a ridged vent and a photo emailed to Surveyor by the end of the day on 09/23/2024. On 09/24/2024 at 6:00 AM, Surveyor reviewed e-mail account. No, emails from facility had been sent to Surveyor. On 09/24/2024 at 4:11 PM, Surveyor spoke with Administrator A on the phone. Administrator A acknowledged documentation of the accordion style dryer vent being replaced by a ridged vent had not been sent to Surveyor. CROSS REFERENCE N0504 DHS Chapter 83.46(1)(c) Heating System Maintenance	N 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012968	A. BUILDING: _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE EAST	207 W PARRY ST DODGEVILLE, WI 53533

(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 504	Continued From page 4	N 504		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure the buildings gas furnace was serviced a least once every 3 years. FINDINGS INCLUDE: On 09/20/2024, Surveyor arrived at facility for a standard survey. On 09/20/2024 at 10:50 AM, Administrator A gave Surveyor a tour of the facility. Surveyor observed a gas furnace was the primary heating system for the building. On 09/24/2024, Surveyor reviewed the receipt for the most recent gas furnace services. The receipt was dated 06/01/2021. On 09/24/2024 at 4:14 PM, Surveyor spoke with	N 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012968	A. BUILDING: _____ B. WING _____	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE EAST	207 W PARRY ST DODGEVILLE, WI 53533

(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 504	Continued From page 5 Administrator A over the phone. Surveyor discussed the above concern with Administrator A. Administrator A acknowledged the gas furnace had not been serviced within the last 3 years. Administrator A stated s/he would make an appointment as soon as possible for the gas furnace to be serviced. CROSS REFERENCE N0358 DHS Chapter 83.32(3)(n) Rights of Residents: Safe Environment	N 504		