

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0012225</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/03/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SUNNYSIDE WEST</b> |                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>209 W PARRY ST<br/>DODGEVILLE, WI 53533</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| {N 000}                                                   | <p>Initial Comments</p> <p>On 07/03/2025, the bureau of assisted living southern regional office conducted a verification visit at Sunnyside West a CBRF located in Dodgeville, WI.</p> <p>As a result of this survey, 0 violations of DHS Chapter 83 were issued.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 8</p> | {N 000}                                                                                 |                                                                                                                          |                                                                |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE