STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020659	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN VALLEY CLINTONVILLE	76 W GREEN TREE ROAD CLINTONVILLE, WI 54929

(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 A complaint investigation was conducted at Sun Valley Clintonville on 08/04/2025 with information gathered through 08/05/2025. As a result of this investigation, 1 deficiency was identified, and the complaint was substantiated. Census: 16	N 000		
N 644	83.59(2)(f) Staff in charge can open all locks The staff member in charge on each work shift shall have a means of opening all locks or security devices on all doors in the CBRF. This Rule is not met as evidenced by: Based on observation, staff and resident interviews, and record review, the provider did not ensure that a staff member in charge on each work shift had the means of opening 1 of 4 resident locked doors. Resident 1's door key had been inadvertently taken home by staff after their shift change. Resident 1's door was not able to be opened when s/he fell in his/her room. Findings include: On 08/04/2025, Surveyor reviewed the provider's policies and procedures for being able to open locked resident doors in response to a concern about the inability to access all resident rooms. On 05/02/2025 at approximately 2:37 a.m., Resident 1 attempted to toilet self and fell in his/her room. Staff were unable to open the door to assist Resident 1 as there was no key available and Resident 1 had locked his/her room door before going to bed. Resident 1's record showed admission to the facility on 12/24/2024 with diagnoses of	N 644		

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

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N 644	Continued From page 1	N 644		

Parkinson's, failure to thrive, hypertension, osteoporosis, and compound fracture of L3 lumbar vertebra. Resident 1 was his/her own person and made own decisions. Resident 1's 30 day assessment dated 01/17/2025 indicated Resident 1 was continent and required standby assist when transferring. Resident 1 had a room key and had been in the habit of locking his/her room door at bedtime.

The facility submitted a self-report dated 05/03/2025 and the CPDO - (Clintonville Police Department Officers) submitted a police report dated 05/06/2025. These reports confirmed that Resident 1 had fallen at approximately 2:37 a.m. on 05/02/2025, couldn't reach his/her call button but had a phone and called FMBR (Family Member/Son) - E . Resident 1 reported to police that FMBR - E didn't answer the phone call until about 3:45 a.m. and then called the facility to let them know Resident 1 had fallen while trying to toilet self. CG (Caregiver) - A was unable to open Resident 1's door because there was no spare key. CG - A called CPD for assistance.

The police report indicated CPDO - C and D arrived at the facility about 3:46 a.m. on 05/02/2025. CPDO - D crawled through the window to unlock Resident 1's door. Resident 1 was unharmed. FMBR - E also was on scene with Resident 1. EMT's had been called and checked Resident 1 over. There was no harm to Resident 1 from the fall and s/he and FMBR - E decided against transport to the emergency room. The police report indicated no neglect but will notify State Agency to check on safety policies for door locks.

On 08/04/2025 at approximately 10:00 a.m. Surveyor asked CG (Caregiver) - G what

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N 644	Continued From page 2	N 644		

residents typically use keys for their rooms. CG - G said Residents 1, 2, 3, and 4 use keys at times and that a spare is always available in the medication room. CG - G said they are individual keys and not a Master key that opens any lock. Then CG - H showed Surveyor that the spare keys opened each of the 4 residents room doors.

During an interview with Surveyor on 08/04/2025 at 10:30 a.m. Resident 1 said s/he was not harmed during the 05/02/2025 incident and had fallen when trying to toilet self. Resident 1 confirmed s/he had not called staff before for help and had not called the facility after this fall. Resident 1 said s/he only called FMBR - E who didn't answer for about an hour. Resident 1 said FMBR - E called the facility and the police came to unlock his/her door.

In an interview with Surveyor on 08/05/2025 at 7:15 a.m., CG - A said that s/he found there was not a spare key when doing bed checks at midnight. CG - A said the previous NOC (Night of Care) staff , CG - F, had accidentally taken the key in his/her scrubs pocket from last nights bed checks and forgot to put it back. CG - A said s/he had attempted to contact CG - F to bring the key back but CG - F did not answer. CG - A said s/he was able to see Resident 1 through his/her window who was in bed sleeping on the last bed check at 2 a.m.. CG - A said that was the only way to check on Resident 1 because the room door was locked from the inside and the spare key was gone. CG - A said s/he was in the kitchen preparing food for the next day which is part of night duty and did not hear anyone calling for help. CG - A said every resident has an extra room key in the med room but Resident 1's was missing. CG - A confirmed the police arrived and were able to get in through Resident 1's window.

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N 644	Continued From page 3 CG - A confirmed FMBR - E and the ambulance came but Resident 1 did not wish to go to the emergency room and had no injury. At the time of this incident on 05/02/2025 the provider did not have a system in place to ensure staff on duty had the ability to open all resident locked doors on each shift.	N 644		