

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 110532	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/17/2025
NAME OF PROVIDER OR SUPPLIER DAYBREAK INC HORICON		STREET ADDRESS, CITY, STATE, ZIP CODE 822 E WALNUT ST HORICON, WI 53032		
(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 02/11/2025, with information obtained through 02/17/2025, the Bureau of Assisted Living, Southern Regional Office, conducted a complaint investigation at Daybreak Inc Horicon, a community-based residential facility (CBRF) located in Horicon, WI. As a result of the survey, 1 deficiency was identified. The complaint was substantiated. Census: 7	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 1 received prompt and adequate treatment appropriate to his/her needs when staff were directed to take him/her to the emergency department for further evaluation in response to his/her change of condition but did not. Findings include: On 02/11/2025, Surveyor conducted a complaint investigation into concerns of the provider's handling of resident changes of condition.	N 353		

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

TITLE

(X6) DATE

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N 353	Continued From page 1 On 02/11/2025, Surveyor interviewed Program Manager B regarding Resident 1, who was documented as having passed away on 01/09/2025. Program Manager B reported that Resident 1 used supplemental oxygen in the recent history prior to his/her passing with the most recent directives being for him/her to have no supplemental oxygen at seated rest or laying down but to have 1-2 liters [per minute] with activity. Program Manager B reported that it was typical for staff to schedule and coordinate Resident 1's medical appointments and that prior to Resident 1's passing s/he had begun having medical management through a pulmonology medical provider. On 02/11/2025, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider on 12/19/2013, where s/he resided until his/her passing on 01/09/2025 (Though initial diagnosis information did not include any specific pulmonary-related diagnoses, Surveyor's later review of offsite records, documented below, contained evidence that Resident 1 had more recently been diagnosed with chronic obstructive pulmonary disease (COPD), congestive heart failure, and obesity-related hypoventilation syndrome.) Resident 1's "Resident Case Notes," which was confirmed by Program Manager B to be where staff documented day-to-day changes with residents, documented the following: - 01/09/2025 (entry made by unidentified staff): "...We went to the bathroom and [s/he] had a [bowel movement] so we both cleaned [him/her] up and after about 10 minutes of being in the bathroom without [his/her] oxygen [s/he] was very winded and exhausted. I told [him/her] that I would come back to check on [him/her] again before lunch."	N 353		

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N 353	Continued From page 2 - 01/09/2025 (entry made by Caregiver C): " ...Writer walked [Resident 1] downstairs to take [his/her] [morning] meds. [Resident 1] did take them and [s/he] ate breakfast. Writer walked with [Resident 1] back to [his/her] room. Writer helped [Resident 1] lay down and put [his/her] feet up and put [oxygen (O2)] on [him/her]. [Resident 1] came to dining room and ate lunch. I went into office to work on menu. [Resident 1]'s roommate came down and told other staff that [Resident 1] slipped out of bed. Staff went to [Resident 1]'s room, a few seconds later I heard staff yell my name "[Caregiver C]." I ran out of office and went to [Resident 1]'s room. [Resident 1] was sitting on floor with back against [his/her] bed. I was yelling [Resident 1, Resident 1] talk to me and [s/he] did not respond. I had other staff called [sic] to inform director [Resident 1] was unresponsive and I was calling 911. While staff was calling 911 and writer with others staff help laid [Resident 1] flat and writer started chest compressions + the police showed up. The officer and I switched doing chest compressions and [emergency medical services (EMS)] arrived. After EMS showed up and worked on [him/her] awhile they pronounced [Resident 1] deceased." - Third entry under the "01/09/2025" section, made by Caregiver C: "Writer called [Resident 1's medical provider's office] and talked with [Nurse D] [his/her] nurse. The nurse told writer that [Resident 1] should be seen @ Emergency room to be evaluated more thoroughly [sic]. Writer called management and management stated to writer that Director [Licensee A] said they would just wait and take [him/her] in @ 3:30pm which is when [his/her] appt was scheduled." On 02/13/2025, at approximately 1:05 p.m.,	N 353		

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N 353	Continued From page 3 Surveyor interviewed Nurse D from Resident 1's primary care provider clinic, who was a registered nurse (RN). Nurse D reported that on 01/09/2025 at 9:32 a.m. a clinic receptionist, Receptionist E, took a message from Caregiver C of reports that Resident 1 was experiencing low oxygen saturation levels, diarrhea, and was uncomfortable. Caregiver C had reported that Resident 1 had an appointment with the clinic later that day at 3:30 p.m. but was wondering if Resident 1 should be taken to the emergency department. Nurse D reported that because of the medical concerns noted, the call was triaged to him/her from Receptionist E right away instead of calling Caregiver C back later. Nurse D reported that when s/he took the call from Caregiver C, Caregiver C reported to him/her that [Resident 1]'s oxygen saturation was at 87% while s/he was in bed. Caregiver C also reported that s/he provided supplemental oxygen to Resident 1 at 1 liter [per minute], which raised his/her oxygen saturation to 90%. Caregiver C reported to Nurse D that Resident 1 also had severe diarrhea with incontinence and had previously recently been seen on an emergent basis due to cellulitis and edema concerns for which s/he was prescribed antibiotics. Nurse D reported that given this background information provided by Caregiver C, s/he told Caregiver C to send Resident 1 to the emergency department. Nurse D reported that this recommendation was made and documented at 9:43 a.m. from his/her notes. Nurse D reported that the call ended quickly after this and that s/he assumed Resident 1 was going to be taken to the emergency department. Nurse D denied having received any indication by Caregiver C that Resident 1 wouldn't be subsequently taken to the emergency department. Nurse D reported that Resident 1's follow-up outpatient medical appointment, which	N 353		

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N 353	Continued From page 4 was scheduled that day for 3:30 p.m. was cancelled as part of routine procedure since patients would not be seen on an outpatient basis after having gone to the emergency department on the same day. Nurse D reported the next call s/he received was at 1:54 p.m. from Caregiver C in which Caregiver C notified the clinic that Resident 1 had passed away. As part of the same interview, Nurse D further explained the significance of Resident 1's low oxygen saturation levels. Nurse D reported that anytime a patient's oxygen saturation levels were below 92% that s/he typically recommended for patients to be sent to the emergency department. Nurse D reported that standard oxygen saturation levels should be above 92% and if they fell below this there could be concerns for the patient's blood perfusion and wanting to further evaluate for the underlying cause of low levels. Nurse D reported that particularly for Resident 1 there was concern of these low levels in the context of his/her other respiratory diagnoses of COPD and sleep apnea. On 02/14/2025, at approximately 12:48 p.m., Surveyor interviewed Caregiver C. Caregiver C reported that approximately 3 days prior to Resident 1's passing s/he began having concerns about Resident 1 because Resident 1 was experiencing confusion regarding his/her oxygen use and didn't seem like him/herself based on how s/he was talking or the questions s/he was asking Caregiver C. Caregiver C reported that the instructions for Resident 1's oxygen use were for him/her to have no supplemental oxygen while sedentary and have 1 liter [per minute] while moving. Caregiver C reported that during this episode s/he had tested Resident 1's oxygen saturation levels, which were about 84%, causing	N 353		

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N 353	Continued From page 5 Caregiver C to wonder if this was related to Resident 1's onset of confusion. Caregiver C reported s/he had Resident 1 lay in bed with his/her supplemental oxygen and discussed this concern with Office Manager F who reported s/he would talk with Licensee A. Caregiver C reported that the next time s/he saw Licensee A again s/he discussed this incident with him/her, to which s/he replied, "Okay" and then left. As part of this same interview, Caregiver C reported that the day after this Resident 1 still had seemed kind of confused and so s/he called Resident 1's managed care organization for further guidance. Caregiver C reported that the case management staff told him/her to keep supplemental oxygen on Resident 1 and continue with his/her regularly scheduled outpatient appointment the next day (01/09/2025). Caregiver C reported that the next day (01/09/2025) s/he called Resident 1's primary care provider's clinic to ask if Resident 1 should be taken to the emergency department or if staff should wait and take Resident 1 to his/her appointment later that day. Caregiver C reported that the clinic nurse s/he spoke with said that Resident 1 should probably be seen in the emergency department. Caregiver C reported that within approximately 15 minutes of this phone call s/he then called Office Manager F and relayed the information that the clinic nurse had recommended Resident 1 be taken to the emergency department. Caregiver C reported that Office Manager F told him/her that s/he would pass the message onto Licensee A and discuss it with him/her. Caregiver C reported that within approximately 30 minutes s/he received a call back from Office Manager F, in which Office Manager F reported that Licensee A was going to wait to take Resident 1 to his/her scheduled outpatient appointment later that day.	N 353		

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N 353	Continued From page 6 Caregiver C denied having been given any further directives for how to monitor or assess Resident 1. Caregiver C reported s/he was not provided any explanation for why Resident 1 was not going to be taken to the emergency department. Caregiver C reported having been concerned for Resident 1's medical condition and stated, "[Congestive heart failure (CHF)] scares me, especially with [his/her] edema." Caregiver C reported s/he had limited knowledge of assisting Resident 1 with the management of these conditions and so s/he was concerned for Resident 1's condition. As part of the same interview, Caregiver C reported that Resident 1 was upstairs in his/her room that morning but came down for lunch prior to returning to his/her room. Caregiver C reported that s/he was in the office when Resident 1's roommate called out that Resident 1 slid off his/her bed and couldn't get up. Caregiver C reported that the other staff member who was on duty that day, Caregiver G, went upstairs to address the situation and shortly after called out to Caregiver C for help. Caregiver C reported that upon entering the room s/he observed Resident 1 stuck between his/her bed and the wall, unconscious and unresponsive. Caregiver C reported that EMS was contacted and that staff started chest compressions on Resident 1 after they were able to lay him/her flat. On 02/14/2024, Surveyor again reviewed Resident 1's "Resident Case Notes" and observed an entry made on 01/08/2025 that generally correlated with Caregiver C's report. The entry documented that around 10:00 a.m. that day Caregiver C checked Resident 1's oxygen saturation levels which were at 84%, improved with supplemental oxygen to 90-91%.	N 353		

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N 353	Continued From page 7 The entry also documented that, "[Resident 1's managed care organization] said to keep [Resident 1] on O2 while in bed ..." After lunch, "[Resident 1] allowed writer to check [his/her] O2 again and it was @ 89%. Writer turned O2 up to 2 liters. [Resident 1]'s O2 was @ 93%." On 02/14/2025, Surveyor reviewed a report received from the local medical examiner's office regarding Resident 1's passing. The report, authored by Deputy Medical Examiner H documented the following: " ...[Caregiver C] informed me of the following details. [Caregiver C] called [Resident 1's primary care provider] Office at the [clinic location] and spoke with [Nurse D]. [Caregiver C] stated to [Nurse D] that [Resident 1]'s oxygen had dropped to 87 percent on room air, [s/he] put [his/her] oxygen on and [his/her] O2 saturation came up to 90 percent. [S/he] was still having difficulty breathing and with [his/her] complex medical history [Nurse D] recommended they take [Resident 1] to the hospital and not wait until [his/her] 3:00 PM appointment. So, they canceled the appointment. [Caregiver C] then called [his/her] bosses [Licensee A] and [Office Manager F] and informed them of the phone call with the nurse and they told [him/her] to wait until [Resident 1]'s afternoon appointment, which unknown to them was cancelled because [s/he] was to go directly to the [emergency room] to be evaluated with such low oxygen levels ..." The report documented that Resident 1 was pronounced deceased at 2:30 p.m. on 01/09/2025. On 02/17/2025, Surveyor reviewed outside medical reports obtained for Resident 1, which	N 353		

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N 353	Continued From page 8 documented the following communication notes: - 01/09/2025 (9:29 a.m.) from Receptionist E: "Patient having low oxygen uncontrollable diarrhea appointment today 3:30 here should they just go to [emergency room]" - 01/09/2025 (9:33 a.m.) from Nurse D: "[Caregiver C] called from Daybreak. [Patient's] O2 Sat[uration] is low at 87% while in bed. They did put 1 [liter] of O2 on [him/her] and [his/her] O2 Sat did go up to 90%. [Patient] is having severe diarrhea with incont[inence]. [S/he] was recently seen at [nearby emergency room] on 12/27/2024; [diagnosis]: Edema and Cellulitis of great toe of right foot ...I instructed [him/her] to take/send [him/her] to the [emergency room] for further evaluation." - 01/10/2025 (9:04 a.m.) from Medical Provider I: "I spoke on the phone with ...about [Resident 1]'s sudden death. I shared [his/her] recent history of COPD, CHF, and obesity related hypoventilation syndrome ...The RN shared earlier yesterday what was going on with [him/her] and the recommendation for the patient to be sent to the [emergency room], which I was in agreement with. It is unclear to me why the patient was not sent promptly to the [emergency room], nor can we predict if it would have been a life saving event, although that is where [s/he] would have received the most appropriate care at that time." On 02/14/2025, at approximately 9:10 a.m., Surveyor interviewed Licensee A. Licensee A reported that it was a misstatement that Resident 1 needed to be taken to the emergency department. Licensee A reported that his/her understanding of the situation was that it wasn't said to Office Manager F that Resident 1 should	N 353			

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N 353	Continued From page 9 go the emergency department, but that Caregiver C had presented a couple of options including bringing Resident 1 to urgent care or attending his/her appointment later that day in regards to his/her medical concerns. Upon reviewing Resident 1's case notes, including the entry about the recommendation for Resident 1 to be taken to the emergency department, with Licensee A, s/he reported that Caregiver C had charted something after the coroner was on site and s/he didn't think the information charted was accurate. Licensee A reiterated that the situation regarding Resident 1 was presented to him/her as that staff could take Resident 1 to the emergency department but not that they needed to.	N 353			