STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410266	A. BUILDING: _____ B. WING _____	C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AQUA VIEW	W9449 GIVENS RD BOX 400 HORTONVILLE, WI 54944

(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 10/28/2025, with information gathered through 10/30/2025, Surveyors conducted a standard survey, 1 self report review and 1 complaint investigation at Aqua View in Hortonville. One (1) of 1 complaint was unsubstantiated. As a result of the survey, 3 deficiencies were issued. Census: 7	N 000		
N 426	83.38(1)(b) Supervision. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Supervision. The CBRF shall provide supervision appropriate to the resident's needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide supervision appropriate to the resident's needs for 1 of 1 (Resident 1) resident reviewed. Resident 1 had eloped from the facility on 06/20/2025 and ended up in Illinois by family. Resident 1 returned to the facility on 07/01/2025. Resident 1 eloped again on 10/09/2025 and on 10/10/2025 was found in a local hospital.	N 426		

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

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N 426	Continued From page 1 Resident 1 returned to the facility on 10/10/2025. Resident 1 eloped again on 10/26/2025 and was found at a local gas station. The provider did not provide appropriate supervision of Resident 1 to ensure Resident 1's safety. Findings Include: On 06/26/2025, the provider self reported an elopement involving Resident 1. The self report stated, "During the afternoon of June 20th, 2025, at approximately 4:30pm [Resident 1] asked staff if [s/he] was able to walk to the gas station, but the staff discouraged [him/her] from this due to extreme heat conditions. At this time [Resident 1] expressed [his/her] frustration and left the area. Around supper time, around 5:00pm, the staff member working on the floor went to look for [Resident 1] around the property and within the house but was unsuccessful in locating [him/her]. The staff member knocked on [Resident 1's] bedroom door and did not receive an answer. Wanting to ensure [Resident 1's] safety after not getting a verbal response, the staff member opened [Resident 1's] bedroom and discovered that [his/her] window was propped open. Brotoloc North back-up, Aqua View Brotoloc North Assistant Program Manager (APM) was notified of the incident via phone and assisted with looking for [Resident 1] on the property and in Hortonville. The assistant program manager was not able to locate [Resident 1] Law enforcement was contacted and put out a nationwide missing person alert. On June 23rd, 2025, Aqua View's Program Manager received a phone call from [Resident 1's] family. [His/her] family informed the program manager that [Resident 1] was safe, with [his/her] [family members] in Illinois. [Resident 1's] case manager, guardian, and Brotoloc North Management were notified of the	N 426		

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N 426	Continued From page 2 incident..." On 10/15/2025, the provider self reported an elopement involving Resident 1. The self report stated, "Around the noon hour on October 9, 2025, staff attempted to prompt [Resident 1] for lunch and discovered that [s/he] was not in [his/her] bedroom. The Assistant Program Manager (APM) and Shift Supervisor (SS) at Aqua View conducted a search but were unsuccessful in locating [Resident 1] within the facility. After [Resident 1] was not located within the facility, the search was expanded via vehicle to the local areas within Hortonville. The Program Manager (PM), Shift Supervisor (SS), and Maintenance Staff from Aqua View conducted a thorough search of local businesses, parks, and streets, but were unsuccessful in locating [Resident 1]. The search was then expanded via vehicle to the local areas within Hortonville by the Program Manager (PM), SS, and Maintenance Staff. Despite checking local businesses, parks, and streets, [Resident 1] was not found. At approximately 12:30 PM, law enforcement was notified, and a missing person report was filed in accordance with [Resident 1's] protocol. Officers departed the facility before 1:00 PM. On the afternoon of October 10, 2025, [Resident 1's] guardian emailed the PM, reporting that [Resident 1] was at St. Elizabeth Hospital under a voluntary hold for suicidal ideation. The guardian indicated [Resident 1] was ready for discharge and to return to Aqua View. Upon [his/her] return, [Resident 1] was placed on 15-minute safety checks, as directed by the PM, to ensure [his/her] well-being. These checks continued until it was deemed appropriate to discontinue them. [Resident 1's] case manager, guardian, and Brotoloc North Management were notified of the incident."	N 426		

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N 426	Continued From page 3 On 10/28/2025, Surveyors conducted an onsite visit to the facility. Surveyors reviewed Resident 1's resident record. Resident 1 was admitted to the facility on 05/29/2024 with diagnoses to include adjustment disorder, auditory hallucinations, bipolar 1 disorder, depression, cannabis use and schizophrenia. Resident 1 is under guardianship (dated 09/23/2021) and protective placement (dated 09/17/2025). Resident 1's record indicated Resident 1 is to "live in the least restrictive environment with 24/7 [hours/days] staffing due [sic] supervision needs related to cognition." In addition, Resident 1's record indicated Resident 1's family members have either asked Resident 1 for money or took money from Resident 1 in the past. Lastly, Resident 1 has difficulty making decisions due to cognitive impairments and vulnerability, Resident 1 "often has difficulty making good decisions." Resident 1's ISP (Individual Support Plan) dated 06/30/2025 indicated Resident 1 is independent with all ADLs (activities of daily living). Additionally, the ISP indicated Resident 1 will "refrain from elopment [sic], while residing at Aqua View" in addition, Resident 1 will "remain in line of sight, when in the community." Resident 1 has a court appointed guardian. Resident 1's ISP stated, "Behavioral: [Resident 1] will refrain from purchasing or consuming drugs and/or alcohol while residing at Aqua View. [Resident 1] will have zero incidents of elopement or verbal aggression towards staff and/or peers. [Resident 1] will have appropriate interactions with staff and peers. [Resident 1] will using coping skills when [s/he] is upset or frustrated. [Resident 1] will not elope from the property, if/when [s/he] is upset." The ISP indicates the following "measurable steps": Staff will follow the Elopement/Missing person	N 426		

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protocol, if [Resident 1] has an incident in which [s/he] leaves Aqua View without informing staff. [Resident 1] is not able to take independent walks into the community, at this time, due to cognition an decision making skills. 1. Staff will contact Brotoloc North back-up and management, and local law enforcement if at any point they are not able to follow [Resident 1], [s/he] wanders away and is out of their sight, or they are not able to follow within close enough distance to ensure [his/her] safety. 2. If unable to locate - local law enforcement will be contacted ASAP [as soon as possible], but within at least 30 minutes of [Resident 1] being discovered to be missing. 3. Staff will call local law enforcement immediately if there are any concerns regarding [Resident 1's] health/safety. 4. The police will be asked to stay engaged in the situation until it is resolved, or they are compelled to take alternative action. 5. Staff will notify [Resident 1's] guardian, and CCI [Community Care, Inc.] CM/RN [case manager/registered nurse] of situation.
6/20/2025, staff was not able to find [Resident 1] [s/he] had searched for [him/her] to notify [him/her] that dinner was almost done. Writer had then called backup whom was also Aqua View's APM [assistant program manager] and non-emergency Outagamie County Sheriff's Office to notify of them. APM had arrived to Aqua View and had searched throughout Hortonville for [Resident 1], as well as the Police on patrol. General Event Report (GER) was completed for a missing person while the writer had filed a GER for Elopement. [Resident 1] returned on 7/1/25 from [his/her] [family member's] home. 9/2025, [Resident 1] was put on Chapter 55 statures, per Outagamie Co. and care team is looking to seek placement closer to [his/her] family."

Surveyor reviewed Resident 1's daily notes. The

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N 426	Continued From page 5 following was noted: -06/16/2025 3p-11p shift: "Writer had found out [s/he] had disappeared and eloped when dinner was done at 5:30 pm. Back up and non-emergency was notified and police patrolled around Hortonville looking for [him/her]. Around 6:30 pm [Resident 1] was found in the rec center [on the property]." -06/20/2025 note: "I received a call from Aqua View this afternoon that [Resident 1] had eloped again. After [Resident 1] was given enough time to return to the house and did not return, staff was informed to call non emergency. The police were unable to locate [Resident 1] and when writer arrived to Hortonville and checked places they were unable to locate [Resident 1] also. [Resident 1's] guardian stated that [s/he] wanted an alert put in place since [Resident 1] has family in Chicago and Grand Rapids. An officer came to the house to get a picture and [Resident 1's] medication list. [S/he] contacted [him/her] supervisor and told writer that the [sic] are labeling [Resident 1] as a missing person and putting a missing person alert nationwide." -06/20/2025 3p-11p shift: "[Resident 1] tonight took [his/her] 4pm meds and afterwards, had come to writer, asking writer if [s/he] could walk into town to buy stuff. Writer had been concerned about the weather and was unsure about [Resident 1's] status on [his/her] permission to walk into town to buy things. Writer decided to now allow [Resident 1] to walk into town. [Resident 1] had begun to get angry saying to the writer. "[swear word] this man, this is [swear word], I'm a grown [swear word] [wo/man], I don't need somebody telling me [swear word]." Writer had chose to walk away from [Resident 1] when [s/he] was angry. Around 4:30 pm, it dawned on the writer that [s/he] had possibly eloped, Writer had seen [s/he] was not at Aqua View and [s/he]	N 426		

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had left a window wide open with a broom in the window to keep it ajar. Writer had been searching for [him/her] to notify [him/her] that dinner was almost done. Writer had then called backup whom was also Aqua View's APM and non-emergency Outagamie County Sheriff's Office to notify of them. APM had arrived to Aqua View and had searched throughout Hortonville for [Resident 1], as well as the Police on patrol. the APM had filed a GER for a missing person while the writer had filed a GER for Elopement."
-07/22/2025 3p-11pm shift: "[Resident 1] tonight was med compliant and ate dinner. [Resident 1] had walked off the premises today without writer knowing and [Resident 1] never notified the writer, [Resident 1] had been picked up by the backup manager today on the road."
-07/23/2025 note: "Currently, [Resident 1] is under emergency protective placement due to [his/her] elopement in late June 2025. Staff must know where [s/he] is at all times, as it is your job to keep [him/her] safe and know [his/her] whereabouts. [S/He] has a court date on 7/31 regarding this, as well for this to become an official change in legal status for [Resident 1]."
-07/22/2025 (LATE ENTRY on 07/24/2025) 7:15p-7:25p shift: "While at Aqua view on Tuesday evening. Writer left for 10 min's to pick up medications at Sylvan view and come back. When arriving back, [Resident 1] could be seen walking away from the house. [S/He] was not far away at the time, but was past the property. Writer told the staff who was working at the time. [S/He] asked that I send [him/her] back, as I was leaving. When writer pulled up to [Resident 1], he was on the road, in front of the corner of the property. It sounded as though [Resident 1] wanted to go to a "friends." [S/He] had pointed towards the trailer park. [Resident 1] talked about having a hard time due to waiting on his spending

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card. [S/He] stated that [s/he] was told that [s/he] would get it and [s/he] would get back pay. Writer stated that if someone who is part of [his/her] team told [him/her] that, they should know. Writer urged [him/her] to smoke [his/her] cigarettes"
-08/24/2025 7a-3pm shift: "[Resident 1] was med compliant. [S/He] took a peers phone to call [his/her] guardian today and peer told writer about this. [S/He] had writer talk to [his/her] guardian because [s/he] wanted to go to the gas station to get a vape and smokes, [his/her] guardian said "As long as it's okay with the APM I don't care, [s/he] isn't supposed to call me on weekends unless it's an emergency" Writer said "Okay and sorry [s/he] called you" So writer called APM via phone and the APM said "No I'm not comfortable with this happening since the last time [s/he] went to Illinois but [s/he] can tomorrow" Writer told [Resident 1] this and [s/he] got upset and while walking away says "Fine I just won't talk" then " I can wait til tomorrow but I don't want too" Then [s/he] found out a peer was going to the gas station for smokes, [s/he's] trying to get peer to buy [him/her] some, writer stepping in saying "[Resident 1] you're going tomorrow you need to wait instead of having others do it for you and they're not allowed too" Writer then walked away but could hear [Resident 1] still telling same peer some information but couldn't make out what it was exactly for. After all of this [s/he] hasn't talked to writer sense. [S/He] ate the prepared meal for lunch. He spent the shift playing basketball or in [his/her] room. [S/He] is currently talking to peer at time of report."
-09/03/2025 3p-11pm shift: "[Resident 1] tonight was med compliant and ate dinner. Early on in the shift, [Resident 1] had gone out to the gas station to buy things. [Resident 1] had taken quite some time so writer called backup and backup had gone to look for [him/her] after almost 2

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hours of being gone, however as Backup was about to drive, they had seen [Resident 1] on [his/her] way back..."
-09/10/2025 7a-11pm shift: "[Resident 1] came to the med room on [his/her] own. [Resident 1] was med compliant. [Resident 1] ate planned lunch, but saved supper for later. [Resident 1] helped with kitchen clean up after lunch. [Resident 1] played basketball outside. [Resident 1] asked to walk to the BP gas station. [Resident 1] returned within [his/her] time limit..."
-09/16/2025 7a-3pm shift: "...[Resident 1] walked to the gas station and back within the appropriate time. [Resident 1] listened to music in rec center with peer. [Resident 1] played basketball and spent time in [his/her] room.
-09/24/2025 3-11pm shift: "Resident 1] left to go into town to the gas station at 3:45 pm. Writer had asked [him/her] to wait until other staff arrived so [s/he] could be taken to the gas station, writer also asked [him/her] to wait so [s/he] could have [his/her] 4pm meds on time. [S/He] said no and stated [s/he] was in a rush, [s/he] then walked out of the house. Writer told [him/her to be back by 5pm at the latest. Writer received a phone call from an unknown number at around 5pm, it was [Resident 1] asking for the house address and stated [s/he] would be back by 5:30pm. APM called to check if [s/he] was back at 5pm, which [s/he] was not back at that time. APM looked around Hortonville at around 5:30, APM could not find [him/her]. APM came to Aqua View at around 6:00pm helping look for [Resident 1] around the premises. [S/He] showed up to Aqua View at 6:30pm with a police escort. Writer and APM later found out that that number [s/he] called from, was at a Walgreens in Grand Chute WI. APM also told writer that [Resident 1] told APM when [s/he] returned that [s/he] was trying to go to the Western Union Bank in Appleton WI. While

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APM was checking [his/her] room to make sure [s/he] wasn't there, [s/he] had found a THC device in [his/her] room. [Resident 1] IS TO NO LONGER GO INTO TOWN BY [HIM/HERSELF]. [S/HE] IS TO BE WITH STAFF WHENEVER [S/HE] GOES INTO TOWN."
-10/02/2025 7am-3pm shift: "...[Resident 1] wanted to go shopping, but [s/he] was informed that shopping day is tomorrow. [Resident 1] got upset and walked into town to the BP and back..."
-10/09/2025 7am-3pm shift: "[Resident 1] was med compliant this morning. [S/He] eloped early this afternoon and is still OOF [out of facility] at this time."
-10/26/2025 3-11pm shift: "Around 6pm today staff heard on [sic] knock on the door. When staff went to answer it was the cops. The cop had told staff that [s/he] seen [Resident 1] at a gas station and knew [s/he] wasn't supposed to be out so [s/he] gave [him/her] a ride [him/her] [sic]. When staff asked [Resident 1] what [s/he] was doing all [sic][s/he] said was "I walked to the gas station". [Resident 1] is currently in [his/her] room sleeping and has taken all meds for the day. The rest of the evening [Resident 1] spent outside playing basketball where staff could see or in [his/her] room resting."

On 10/28/2025 at approximately 9:15 AM, Surveyors interviewed Assistant Program Manager A regarding Resident 1. Assistant Program Manager A indicated Resident 1 has a guardian. Assistant Program Manager A stated Resident 1 likes to go outside and play basketball and smoke and that Resident 1 usually stays on the property. Assistant Program Manager A indicated Resident 1 is not allowed to go in the community by self. Assistant Program Manager A verified in June that Resident 1 did elope and made it all the way to Illinois. Resident 1 also had

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another incident just this past weekend. Resident 1 wanted to get cigarettes at the gas station and staff let him/her go. The police ended up bringing Resident 1 back to the facility. Assistant Program Manager A indicated Resident 1 knows s/he should not leave the property by self, s/he usually stays on the premise. Assistant Program Manager A stated since the elopement to Illinois, guardian and case manager are working on finding a facility closer to family in Illinois.

Surveyor reviewed a "General Events Report" (GER) dated 10/26/2025 completed by the facility. The GER stated, "Police saw [Resident 1] at the gas station and know [s/he] is not to be in the community by himself." A summary of the incident stated, "On Sunday 10-26-25 around 6pm the police brought [Resident 1] back to the house after they saw [him/her] at the Hortonville BP knowing that [s/he] is not to be in the community by [him/herself]." The GER indicated corrective actions taken are to "remind [Resident 1] that [s/he] is not to leave the premises without staff." Additionally, the GER states the "Plan of Future Corrective Action: know where [Resident 1] is at all times."

On 10/28/25 at approximately 10:10 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he walks to the gas station sometimes but needs supervision. Resident 1 stated two days ago (referring to 10/26/25 elopement) Resident 1 left the facility and walked to the gas station. Once there, a police officer asked Resident 1 if s/he needed a ride home. Resident 1 said yes and the police officer told Resident 1 that s/he was not in trouble. Resident 1 was driven home by the police officer. Resident 1 shared another elopement where Resident 1 left the facility, date unknown, and needed to perform

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(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 426	Continued From page 11 a money transfer. The first store Resident 1 went to could not perform that transaction. A man approached Resident 1 and asked if Resident 1 needed help. Resident 1 replied yes and asked for a ride to a named drug store. Resident 1 stated the man drove Resident 1 to Appleton (approximately ten miles away.) The man then gave Resident 1 twenty dollars. Resident 1 stated from there, the police brought Resident 1 back to the facility. Resident 1 stated that is when s/he was placed on restrictions and needed to have supervision. Resident 1 stated his/her guardian is trying to find a home in Illinois so Resident 1 can be closer to family. On 10/28/25 at approximately 11:30 PM, Surveyor interviewed Guardian C over the course of two phone calls. Guardian C confirmed s/he was the guardian for Resident 1. Guardian C described Resident 1 as impulsive and fast as Resident 1 had multiple incidents where Resident 1 left the facility without staff knowing. Guardian C stated Resident 1 was recently found at the local gas station a couple of nights prior (referring to the 10/26/25 elopement) and the police brought Resident 1 back to the facility. Guardian C stated s/he is aware Resident 1's elopements are hard on the facility and police resources. Guardian C stated Resident 1 will verbalize understanding that Resident 1 is not to walk away from the facility but does not have the capacity to follow-through with that understanding. Guardian C stated the facility does bring Resident 1 on outings if Resident 1 asks. The facility would provide a ride but may have to wait. Guardian C shared when Resident 1 eloped to Illinois, Resident 1 was without scheduled prescription medications and was living on the streets. Resident 1 flagged a police officer down and stated he/she was suicidal.	N 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410266	A. BUILDING: _____ B. WING _____	C 10/30/2025

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AQUA VIEW	W9449 GIVENS RD BOX 400 HORTONVILLE, WI 54944

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N 426	Continued From page 12 On 10/28/2025 at approximately 1:15 PM, Surveyors interviewed Assistant Program Manager A and Program Manager B. Program Manager B reviewed the elopement incidents on 06/20/2025 and 10/09/2025 with Surveyors. Program Manager B stated after the 10/09/2025, facility staff did conduct 15 minute checks on Resident 1, but those have since discontinued. Program Manager B had indicated the facility was attempting to allow Resident 1 the right to leave the facility when s/he would like to. Program Manager B stated they have been discussing the new HCBS (Home and Community Based Services) rules and want to ensure they are doing everything to protect Resident 1's rights. Program Manager B did verify Resident 1 is under guardianship and protective placement and with that the facility needs to be providing an environment that is safe for Resident 1. Program Manager B stated with the most recent elopement (10/26/2025), Resident 1 will not be able to leave the facility without a staff member. In addition, the facility will implement 15 or 30 minute checks on Resident 1 to be able to better monitor him/her. Lastly, Program Manager B stated s/he will contact Resident 1's managed care organization case manager and nurse to set up a meeting to have a discussion about Resident 1's rights but also providing a safe environment.	N 426		
N 542	83.48(4)(b) Smoke detector at hallway side of stairways Pursuant to s. 50.035(2)(b), Stats., all facilities shall have at least one smoke detector located at each of the following locations: On the hallway side of every enclosed stairway on each floor level.	N 542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410266	A. BUILDING: _____ B. WING _____	C 10/30/2025

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N 542	Continued From page 13 This Rule is not met as evidenced by: Based on observation and interview, the provider did not have at least one smoke detector on the hallway side of an enclosed stairway leading to the basement of the facility. Findings Include: On 10/28/2025 at approximately 12:30 PM, Surveyor conducted a tour of the home with Assistant Program Manager A. During the tour, Surveyor observed there was no smoke detector located on the hallway side of the enclosed stairway leading to the basement of the facility. While on tour, Assistant Program Manager A verified there was no smoke detector on the hallway side of the enclosed staircase and stated, "I will let [maintenance person] know [s/he] needs to add a smoke detector. [S/he] is here today."	N 542		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not ensure all exit passageways and stairways were clearly identified with emergency egress lighting with a stand-by power source. Four (4) of 4 exits identified on the fire evacuation map were not clearly identified at the door with emergency egress lighting with a stand-by power source.	N 666		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	410266	A. BUILDING: _____ B. WING _____	C 10/30/2025

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N 666	Continued From page 14 Findings Include: On 10/28/2025 at approximately 12:30 PM, Surveyor conducted a tour of the home with Assistant Program Manager A. During the tour, Surveyor observed the fire evacuation map on the wall. Surveyor identified 4 exit passageways (foyer, family room, exit near office and exit near phone rorom) on the map. Throughout the tour, Surveyor observed the 4 exit passageways did not have emergency egress lighting above or near the door indicating they were exit doors. Surveyor did not observe any other exit passageways throughout the home. At approximately 12:45 PM, Surveyor interviewed Assistant Program Manager A regarding the exit passageway signage. Assistant Program Manager A indicated they are aware exit signs need to be placed above the doors based on sister facility's survey last week. Assistant Program Manager A stated they are in the process of ordering and putting up the exit signs up.	N 666		