STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	110539	A. BUILDING: _____ B. WING _____	C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAYBREAK INC WAUPUN	631 S MADISON ST WAUPUN, WI 53963

(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 06/06/2023, Surveyor conducted a complaint investigation at Daybreak Inc Waupun. Complaint was substantiated. 3 deficiencies were identified. 1 deficiency is a recite. Census 7	N 000		
N 164	83.12(4)(b) Reporting when law enforcement is called. A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time law enforcement personnel are called to the CBRF as a result of an incident that jeopardizes the health, safety, or welfare of residents or employees. The CBRF ' s report to the department shall provide a description of the circumstances requiring the law enforcement intervention. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies. This Rule is not met as evidenced by: Based on interview and record review the provider did not send a written report to the Department within 3 working days after law enforcement personnel were called to the facility for an incident that threated the welfare of 7 of 7 residents and Caregiver E. This is a recite from SOD # N55G11 dated 06/02/2022 and SOD # HY8411 dated 12/17/2020. Findings include:	N 164		

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

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N 164	Continued From page 1 On 06/06/2023 at approximately 3:34 PM, Surveyor interviewed Caregiver C who stated there was an incident at the facility involving law enforcement when Caregiver E called the crisis line because s/he was going to hurt him/herself about two months prior. On 06/06/2023 at approximately 3:45 PM, Surveyor interviewed Administrator A who confirmed the incident involving Caregiver E had happened resulting in law enforcement being summoned to the facility. Surveyor asked for the self-report regarding law enforcement at the facility. Administrator A stated there was not a self-report created, s/he didn't report the incident, and s/he did not plan on reporting the incident to the Department. On 06/20/2023, Surveyor reviewed police department records: On 12/05/2022, the Police Department was called to the facility regarding Resident 3, who was locked in his/her room and was stating s/he was suicidal. When the police officer was able to enter into the room Resident 3 had a charging cord in his/her hands and was putting the cord around his/her neck. The police officer grabbed the cord so it couldn't be tightened around Resident 3's neck. Surveyor verified department records and was unable to find a self-report pertaining to police being summoned. On 01/31/2023, the Police Department responded to the facility regarding a subject with a weapon. Resident 3 was wielding a large knife attempting to self-harm. Staff indicated the other residents were safe and away from the office where Resident 3 was wielding the knife. Surveyor	N 164		

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N 164	Continued From page 2 verified department records and was unable to find a self-report pertaining to police being summoned. On 03/25/2023, the Police Department were summoned for a welfare check regarding Caregiver E who had made comments that s/he was having suicidal thoughts but did not want to give a location and had talked about taking pills, using chemicals, or driving his/her car 100 miles per hour into traffic to end things. Caregiver E indicated s/he was the only employee working at the facility and that s/he had called the non-emergency number because s/he wanted to talk to someone. Surveyor verified department records and was unable to find a self-report pertaining to police being summoned. On 06/21/2023, Surveyor reviewed the facility file for self-reports regarding the above incidents. No self-reports were filed regarding the above incidents as of 06/21/2023.	N 164		
N 355	83.32(3)(k) Rights of Residents: Self-determination In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Self-determination. Make decisions relating to care, activities, daily routines and other aspects of life which enhance the resident ' s self reliance and support the resident ' s autonomy and decision making. This Rule is not met as evidenced by: Based on observation, interview and record review the provider did not ensure 7 of 7 residents were able to make decisions relating to	N 355		

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N 355	Continued From page 3	N 355		

care, activities, daily routines, and other aspects of life which enhance the residents' self-reliance and support the residents' autonomy and decision making.

Findings include:

Daybreak Inc Waupun is an 8-bed community based residential facility that can accept the following client groups: developmentally disabled, emotionally disturbed/mental illness, correctional clients, and alcohol/drug dependent.

On 06/06/2023 at 12:05 PM, Surveyor observed Residents cleaning the kitchen and washing dishes, cleaning bathrooms, and noticed a garden in the back of the facility.

On 06/06/2023 at approximately 12:21 PM, Surveyor interviewed Resident 1. Resident 1 stated Administrator A scares him/her. Resident 1 stated residents have to earn things at the facility like a vape. Resident 1 stated Administrator A is very strict and there was an incident when s/he had went and retrieved his/her vape, Administrator A had tried getting the vape back from him/her and s/he ended up falling because of the incident. Resident 1 stated s/he is scared of Administrator A. Resident 1 states that some staff will deny him/her the ability to use his/her vape if s/he doesn't do his/her chores. Resident 1 stated they are forced to work in the garden, wash dishes, clean bathrooms and other things around the house. Resident 1 stated they have to do their chores to earn things like vaping, coffee and other things. Resident 1 stated there was another incident with Manager B when s/he was yelled at for changing clothes because s/he was in shorts and it started raining so s/he went to his/her room and changed into pants and was

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N 355	Continued From page 4 yelled at for changing his/her clothes because s/he was cold. On 06/06/2023 at approximately 12:42 PM, Surveyor interviewed Resident 2. Resident 2 stated s/he witnessed Resident 1 being pushed down the stairs by Administrator A. Resident 2 stated Resident 1 had a bruise from the incident. Resident 2 stated that residents are forced to do chores at the facility and if they don't do the chores they get things taken away like day passes to see friends and family, they aren't able to vape or smoke. Resident 2 stated Administrator A and Manager B are the ones that enforce this and they are forced to work in the garden, wash dishes, and clean bathrooms. Resident 2 stated Administrator A is verbally abusive towards residents. Resident 2 stated Administrator A swears at residents, calls residents stupid, and doesn't respect our dignity. Resident 2 stated Administrator A told the residents if they called state they would be issued a 30 day notice and be kicked out. Resident 2 stated s/he was threatened with a 30 day notice for wanting to report. Resident 2 stated when s/he asks for something from Administrator A, s/he will flick it at them instead of handing the item to them. Resident 2 stated the facility is doing room searches when residents are leaving, and that Maintenance D will do the room searches when residents are out of the building. On 06/06/2023 at approximately 1:05 PM,. Surveyor interviewed Manager B. Manager B stated if residents do not do their chores like cleaning they do take away their vapes until the chores are done. Manager B stated they can only smoke during assigned times. Manager B stated the chores were posted on the board.	N 355		

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N 355	Continued From page 5 On 06/06/2023 at approximately 1:10 PM, Surveyor reviewed documentation that was posted on a bulletin board at the facility. A paper called "dish duties" was hanging showing residents assignments for when they are assigned to do the dishes. The next paper showed laundry days and listed residents names and days they are allowed to do laundry. The next paper hanging was called "assigned weekly tasks of 06/05/2023 to 06/11/2023". The paper indicates each resident is assigned an area for the week to keep clean. The areas include basement, porches, kitchen, bathroom, stairs and hallway, living room and dining room, stove and refrigerator, trash assignments and bathroom cleaning assignment. On 06/06/2023 at approximately 2:00 PM, Surveyor reviewed Resident 1 and Resident 2's individual service plan (ISP). The following was reviewed: Resident 1's ISP does not indicate Resident 1's chores and desired outcome. Resident 1 was admitted to the facility on 03/28/2022. Resident 1 has a diagnosis of Schizoaffective disorder. Resident 1's ISP does not indicate Resident 1 wants to do chores. Resident 1's ISP indicates Resident 1 is to do chores that are assigned by the facility. Resident 1's facility file did not indicate chores were part of a treatment plan. Resident 3's ISP does not indicate Resident 3's chores and desired outcome. Resident 3 was admitted to the facility on 02/18/2020. Resident 3 is diagnosed with borderline personality disorder. Resident 3's ISP does not indicate Resident 3 wants to do chores. Resident 3's ISP indicates Resident 3 is to do chores that are assigned by the facility. Resident 3's facility file did not indicate	N 355		

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N 355	Continued From page 6 chores were part of a treatment plan. On 06/06/2023 at approximately 2:42 PM, Surveyor interviewed Administrator A. Administrator A stated that there may have been occasions when staff would get frustrated and swear at residents but couldn't recall anything off hand. On 06/06/2023 at approximately 3:34 PM, Surveyor interviewed Caregiver C. Caregiver C stated that staff are told if residents don't do chores they are supposed to take away their vapes until they do their chores. Caregiver C stated that s/he has witnessed Administrator A become snarky with residents but has not heard Administrator A swear at residents. Caregiver C stated there was an incident that when s/he came in for his/her shift, Resident 1 had told him/her that Administrator A had pushed him/her and s/he had fallen. Caregiver C stated Resident 1 did have a bruise on his/her leg. Caregiver C also stated the facility has done room searches when the residents were not at the facility and that Maintenance C would do the room searches when residents were out of the facility. On 06/12/2023, Surveyor reviewed the providers program statement. The program statement does not indicate that residents are responsible for the cleanliness of the home, cooking dinner, or taking care of the garden.	N 355		
N 415	83.37(2)(d) Documentation of medication administration. Documentation of medication administration. As required under s. DHS 83.42(1)(o), at the time of medication administration, the person	N 415		

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N 415	Continued From page 7 administering the medication or treatment shall document in the resident record the name, dosage, date and time of medication taken or treatments performed and initial the medication administration record. Any side effects observed by the employee or symptoms reported by the resident shall be documented. The need for any PRN medication and the resident ' s response shall be documented. This Rule is not met as evidenced by: Based on observation, record review and interview the provider did not ensure at the time of medication administration, the person administering the medication documented in the resident record the name, dosage, date and time of medication taken in the medication administration record for 7 of 7 residents residing at the facility. Findings include: On 06/06/2023 at approximately 2:10 PM, Surveyor observed the medication cabinet. On 06/06/2023 at approximately 2:20 PM, Surveyor reviewed 7 of 7 resident's medication administration records. 7 of 7 residents did not have medications signed out for the pm medication pass on 06/05/2023. Surveyor reviewed medication cards and noted the 06/05/2023 medications were missing from the packaging. On 06/06/2023 at approximately 2:42 PM, Surveyor interviewed Administrator A who stated "[explicit} I am guessing that [Caregiver E] didn't sign off on the medications that were given last	N 415		

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N 415	Continued From page 8 night". Administrator A indicated on 05/23/2023, s/he wrote a note in the communication log regarding medications not being signed out at the time of administration and s/he would look into this concern.	N 415		