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{N 000}	Initial Comments On 01/16/2024, with information gathered through 01/18/2024, Surveyor conducted a standard licensure survey and a verification visit at Daybreak Inc Waupun. Fifteen deficiencies were identified. Four of the 15 deficiencies were repeat violations (see Statement of Deficiency (SOD) 6VPK11, SOD 6VPK12, SOD N55G11, and SOD FO5L11.) Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
N 239	83.20(2)(a)-(d) Department-approved training courses. Standard Precautions. All employees who may be occupationally exposed to blood, body fluids or other moist body substances, including mucous membranes, non-intact skin, secretions, and excretions except sweat, whether or not they contain visible blood shall successfully complete training in standard precautions before the employee assumes any responsibilities that may expose the employee to such material. Fire safety. Within 90 days after starting employment, all employees shall successfully complete training in fire safety. First aid and choking. Within 90 days after starting employment, all employees shall successfully complete training in first aid and procedures to alleviate choking. Medication administration and management. Any employee who manages, administers or assists residents with prescribed or over-the-counter medications shall complete training in medication administration and management prior to assuming these job duties.	N 239		

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

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N 239	Continued From page 1	N 239		

This Rule is not met as evidenced by:
Based on record review and interview the provider did not ensure 1 of 2 employees reviewed obtained standard precautions training for staff who were likely exposed to bodily fluids and other moist body substances including mucous membranes, non-intact skin, secretions, and excretions except sweat.

Caregiver E, who had responsibilities that would create exposure to blood, body fluids or other moist body substances, did not have training in standard precautions prior to assuming these duties.

Findings include:

On 01/16/2024, Surveyor conducted a review Resident E's facility file to verify compliance with department approved training requirements. Surveyor requested training records from Manager B for Caregiver E.

Standard Precautions

The record for Caregiver E, hired 10/24/2022, did not contain evidence of training or evidence of meeting an exemption for standard precautions. On 01/16/2024, at approximately 11:31 AM, Surveyor interviewed Manager B. Manager B confirmed Caregiver E performs job tasks that may expose the employee to blood or other bodily fluids. Manager B confirmed the provider did not have evidence Caregiver E completed or met an exemption for standard precaution training prior

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N 239	Continued From page 2 to assuming these job duties. On 01/18/2024, Surveyor verified Caregiver E was not on the Community-Based Care and Treatment training registry for standard precautions.	N 239		
N 243	83.21(1)-(3) All employee training. The CBRF shall provide, obtain or otherwise ensure adequate training for all employees in all of the following: Resident rights. Training shall include general rights of residents including rights as specified under s. DHS 83.32(3). Training shall be provided as applicable under ss. 50.09 and 51.61 and chs. 54, 55, and 304, Stats., and ch. DHS 94, depending on the legal status of the resident or service the resident is receiving. Specific training topics shall include house rules, coercion, retaliation, confidentiality, restraints, self-determination, and the CBRF ' s complaint and grievance procedures. Residents ' rights training shall be completed within 90 days after starting employment. Client Group. Training shall be specific to the client group served and shall include the physical, social and mental health needs of the client group. Specific training topics shall include, as applicable: characteristics of the client group served, activities, safety risks, environmental considerations, disease processes, communication skills, nutritional needs, and vocational abilities. Client group specific training shall be completed within 90 days after starting employment. Client Group. In a CBRF serving more than one client group, employees shall receive training for each client group.	N 243		

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N 243	Continued From page 3 Recognizing, preventing, managing, and responding to challenging behaviors. Specific training topics shall include, as applicable: elopement, aggressive behaviors, destruction of property, suicide prevention, self-injurious behavior, resident supervision, and changes in condition. Challenging behaviors training shall be completed within 90 days after starting employment. This Rule is not met as evidenced by: Based on source record review and interview the provider did not ensure Caregiver E, obtained all training as required within 90 days after starting employment. Caregiver E did not have training in resident rights within 90 days after starting employment. Caregiver E did not have training in recognizing, preventing, managing and responding to challenging behaviors within 90 days after starting employment. Caregiver E did not have training in required client groups within 90 days after starting employment. Findings include: On 01/16/2024, Surveyor conducted a review of Caregiver E's facility file to verify compliance with all employee training requirements. Surveyor requested training records from Manager B for Caregiver E.	N 243		

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N 243	Continued From page 4 Resident Rights The record for Caregiver E, hired 10/24/2022, did not contain evidence of training or evidence of meeting an exemption for resident rights. On 01/16/2024, at approximately 11:31 AM, Surveyor interviewed Manager B. Manager B confirmed the provider did not have evidence Caregiver E completed or met an exemption for resident rights training. Recognizing, Preventing, Managing and Responding to Challenging Behaviors The record for Caregiver E, hired 10/24/2022, did not contain evidence of training or evidence of meeting an exemption for challenging behaviors training. On 01/16/2024, at approximately 11:31 AM, Surveyor interviewed Manager B. Manager B confirmed the provider did not have evidence Caregiver E completed or met an exemption for challenging behaviors training. Client Group The facility was licensed to provide care and services to residents within the client groups of emotionally disturbed/mental illness, alcohol/drug dependent, developmentally disabled, and correctional clients. The record for Caregiver E, hired 10/24/2022, did not contain evidence of training or evidence of meeting an exemption for client group training. On 01/16/2024, at approximately 11:31 AM, Surveyor interviewed Manager B. Manager B confirmed the provider did not have evidence	N 243		

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N 243	Continued From page 5 Caregiver E completed or met an exemption for client group training specific to insert client group(s) emotionally disturbed/mental illness, alcohol/drug dependent, developmentally disabled, and correctional clients.	N 243		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Caregiver E received at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Caregiver E did not have continuing education for standard precautions, client group, medications, resident rights, prevention and reporting of abuse, neglect, and misappropriation, and fire safety and emergency procedures including first aid. Findings include: On 01/16/2024, Surveyor reviewed Caregiver E's	N 277		

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N 277	Continued From page 6 facility file. Caregiver E did not have documentation in his/her file that s/he received 15 hours of continuing education for 2023. Caregiver E was hired on 10/24/2022. On 01/16/2024 at approximately 11:31 AM, Surveyor shared findings with Manager B. Manager B stated s/he did not know where the documentation was for Caregiver E's training. Manager B stated that s/he did orientation training with Caregiver E. Manager B stated trainings would be located in Caregiver E's facility file.	N 277		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Resident 6 was screened for communicable disease including tuberculosis. The provider did not have documentation in	N 302		

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N 302	Continued From page 7 Resident 6's record for communicable disease screen or tuberculosis screen. Findings include: On 01/16/2024 at approximately 10:25 AM, Surveyor reviewed Resident 6's facility file. The following was reviewed: Resident 6 did not have documentation in the facility record of a communicable disease screen including for tuberculosis. On 01/16/2024 at approximately 10:30 AM, Surveyor shared findings with Manager B. Manager B stated s/he could not find the communicable disease screen in Resident 6's file. Manager B stated it is usually included in the admissions paperwork and could not find documentation for the communicable disease screen or tuberculosis test.	N 302		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not administer medications in the intervals prescribed by a practitioner for 1 of 1 resident. Resident 1 was administered as needed (PRN) milk of	N 352		

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N 352	Continued From page 8 magnesium when the medication had expired. Findings include: On 01/16/2024, at approximately 10:45 AM, Surveyor toured the med room and observed the providers over-the-counter house medications Milk of Magnesia with an expiration date of 09/2023. On 01/16/2024, Surveyor reviewed Resident 1's record. Resident 1's December 2023 and January 2024 Medication Administration Records (MAR) which documented Polyethylene glycol for constipation was administered on 12/01/2023, 12/15/2023, 12/24/2023, and 01/01/2024. Resident 1's "PRN Orders," dated 09/12/2022, documented: "Milk of magnesia - one ounce every 4 hours PRN - laxative." Polyethylene glycol was not listed on the PRN order. On 01/16/2024, at approximately 11:00 AM, Surveyor interviewed Manager B. Manager B stated Resident 1 received the 'house' over-the-counter milk of magnesia when it was documented on his/her MAR as receiving polyethylene glycol. Manager B stated s/he was not aware that the milk of magnesia had expired and would replace it immediately. Surveyor noted the 'house' antacid had expired in 03/2023 and the peroxide had expired in 2019.	N 352		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan	N 386		

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N 386	Continued From page 9 Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure one 2 of 2 residents (Resident 5 and Resident 6) had a comprehensive individual service plan (ISP) within 30 days after admission. Findings include: The provider is licensed to care for up to 8 residents in the client groups: alcohol/drug dependent, correctional clients, emotionally disturbed/mental illness and developmentally disabled. On 01/16/2024, Surveyors reviewed Resident 5's and Resident 6's record. Example 1: Resident 5 Resident 5's progress notes documented: "10/05/2023 - At 3:33 writer received a call from	N 386		

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[Resident 5's] case manager regarding [his/her] mental state. 10 minutes later [his/her] case manager called back informing writer that [Resident 5] just tried to wrap [his/her] headphone cord around [his/her] neck in an attempt to end [his/her] life."
"10/17/2023 - [Resident 5] was put on a safety watch per discussion with first shift & [county]."
"10/30/2023 - [Resident 5] said it doesn't matter if [s/he's] here on [his/her] birthday [s/he] is going to end [his/her] life."
"11/16/2023 - [Resident 5] stated [s/he] doesn't like it here. Writer asked [him/her] if it was better than the hospital to which [s/he] said that it was but [s/he] doesn't hear the voices anymore and [s/he] misses them."

Resident 5's county human services department assessment, dated 02/21/2023, documented: "[Resident 5] reports this [his/her] main concern is overcoming cravings/withdrawals from substances. [S/he] reports that [s/he] experiences cravings every day, but some days it is more intense than others. [S/he] reports that when experiencing a high intensity of cravings, this triggers [his/her] anxiety and thoughts of self-harm. ... Recently [Resident 5] had made a suicide attempt while at home ..."
The assessment did not provide guidance for staff on how to care for Resident 5's needs.

Resident 5 was admitted to the facility on 08/02/2023 and his/her record did not include an individual service plan.

Example 2: Resident 6

Resident 6's progress notes documented:
"11/08/2023 - Made attempt to skip lunch ...
[S/he] also stated that [his/her] room lights still

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talk to [him/her] & that [his/her] body is possessed by an alien entity that was sent to [him/her] across space & time. [S/he] also stated that [s/he] has voices talking to [him/her]. ... [Resident 6] believes that [s/he] is under constant surveillance via [his/her] phone, the lights that talk to [him/her], the windows & those around [him/her]."
"11/09/2023 - [Resident 6] came to writer stating who my 'real' boss is and that [s/he] needs to kill my 'boss. ...'
"When it was time for meds at 8p there was no response from [Resident 6's] room. Once everyone had their meds writer tried to get [him/her] to come down and after no response writer entered the room at 8:20p when [Resident 6] couldn't be found anywhere else in the house. Writer called [Administrator A], [Manager B] and non-emergency services."

Resident 6 was admitted to the facility on 10/09/2023 and his/her record did not include an individual service plan.

On 01/16/2024 at approximately 10:30 AM, Surveyor shared findings with Manager B. Manager B stated Resident 5 and Resident 6's individual service plan is probably on Administrator A's computer and s/he did not have access to the computer. Manager B stated s/he would try to contact Administrator A to obtain copies of the current individual service plans.

On 01/16/2024 at approximately 4:07 PM, Surveyors received an email from Manager B. Manager B stated Administrator A was out of the office for the day and the other documents that were requested were processed out of his/her office. The email also stated no further information would be provided by 4:00 PM.

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N 386	Continued From page 12 On 01/18/2024 at approximately 3:30 PM, Surveyors still had not received any requested documentation. On 01/18/2024, Surveyor reviewed the Department self-reports from the provider which documented that Resident 6 had eloped from the facility on 11/09/2023 and 11/20/2023. Surveyor was unable to determine what supervision Resident 6 required.	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 or Resident 7's Individual Service Plans (ISP) were updated annually. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) 6VPK11,	N 389		

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N 389	Continued From page 13 dated 04/09/2019, SOD 6VPK12, dated 09/14/2020, and SOD N55G11 dated 06/02/2022. Findings include: The provider is licensed to care for up to 8 residents in the client groups: alcohol/drug dependent, correctional clients, emotionally disturbed/mental illness and developmentally disabled. On 01/16/2024, Surveyor reviewed Resident 1's and Resident 7's record. Resident 1 was admitted on 03/28/2022. Resident 1's available ISP was dated 09/11/2022. Resident 7 was admitted on 10/13/2020. Resident 7's available ISP was dated 12/22/2022. On 01/16/2024, at approximately 11:00 AM, Surveyor interviewed Manager B. Manager B stated, "[Resident 1's] current ISP was probably on Administrator A's laptop which [s/he] did not currently have access to." On 01/16/2024 at approximately 4:07 PM, Surveyors received an email from Manager B. Manager B stated Administrator A was out of the office for the day and the other documents that were requested were processed out of his/her office. The email also stated no further information would be provided by 4:00 PM. On 01/18/2024 at approximately 3:30 PM, Surveyors still had not received any requested documentation.	N 389		

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N 391	Continued From page 14	N 391		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure all employees who provide resident care and services shall had continual access to the residents' assessments and individual service plan. Findings include: On 01/16/2024 at approximately 10:25 AM, Surveyor reviewed Resident 5 and Resident 6's facility file. The following was reviewed: Resident 5 was admitted to the facility on 08/02/2023. There was no documentation in Resident 5's facility file of an individual service plan. Resident 6 was admitted to the facility on 10/09/2023. There was no documentation in Resident 6's facility file of an individual service plan. On 01/16/2024 at approximately 10:30 AM, Surveyor shared findings with Manager B. Manager B stated Resident 5 and Resident 6's individual service plan is probably on the computer. Manager B stated Administrator A had some computer issues. Manager B stated s/he would try to contact Administrator A to obtain copies of the individual service plan but did not have access to them at that time. Manager B stated that s/he did not have access to the	N 391		

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N 391	Continued From page 15 individual service plans on the computer. On 01/16/2024 at approximately 4:07 PM, Surveyors received an email from Manager B. Manager B stated Administrator A was out of the office for the day and the other documents that were requested were processed out of his/her office. The email also stated no further information would be provided by 4:00 PM. On 01/18/2024 at approximately 3:30 PM, Surveyors still had not received any requested documentation. Cross Reference N0304 83.28(5) Temporary Service Plan N0386 83.35(3)(a) Comprehensive Individualized Service Plan	N 391		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not ensure that a Resident Satisfaction Survey was completed for all residents in 2021, 2022 and 2023. Findings include: On 01/16/2024, Surveyor requested the 2021,	N 392		

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N 392	Continued From page 16 2022, and 2023 Resident Satisfaction Survey that were sent out to the residents and/or resident representatives. Manager B stated s/he was not aware of a resident satisfaction survey. As of 01/18/2024 at 3:30 PM, Surveyor did not receive any additional documentation.	N 392		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident records reviewed (Resident 1, Resident 7) were evaluated annually to determine their mental or physical capability to respond to a fire alarm. This is a repeat deficiency. See Statement of Deficiency (SOD) FO5L11, dated 05/25/2018. Findings include: The provider is licensed to care for up to 8 residents in the client groups: alcohol/drug dependent, correctional clients, emotionally disturbed/mental illness and developmentally disabled. On 07/11/2023, Surveyor reviewed Resident 1 and Resident 7's record. Resident 1 was admitted to the facility on 03/28/2022 and his/her current evacuation	N 394		

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N 394	Continued From page 17 assessment was dated 03/30/2022. Resident 7 was admitted to the facility on 10/13/2020 and his/her current evacuation assessment was dated 11/17/2021. On 01/16/2024, at approximately 11:00 AM, Surveyor interviewed Manager B. Manager B stated s/he understood the resident's evacuation assessments were to be updated annually and s/he would update the records.	N 394		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Resident 6 had a written practitioner's order in Resident 6's facility file for prescription medications, over the counter medications, or dietary supplements. Findings include: On 01/16/2024 at approximately 10:25 AM, Surveyor reviewed Resident 6's facility file and noted the following: Resident 6's medication administration record	N 400		

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N 400	Continued From page 18 indicated Resident 6 was administered the following scheduled medications: Levothyroxine, hydroxyzine, fluoxetine, lithium carbonate, invga sustenna, and prazosin. Resident 6's medication administration record also indicated Resident 6 had received acetaminophen on 11/29/2023 and on 01/03/2024 and antacid on 12/10/2023 and 01/12/2024. Resident 6's facility file did not contain written practitioner's orders for prescription medications or over the counter medications taken during 12/2023 and 01/2024. On 01/16/2024 at approximately 10:30 AM, Surveyor shared findings with Manager B. Manager B stated s/he could not locate Resident 6's practitioner's orders.	N 400		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure that cleaning compounds and toxic substances were stored in a secure area. Findings include: The provider is licensed to care for up to 8 residents in the client groups: alcohol/drug dependent, correctional clients, emotionally disturbed/mental illness and developmentally disabled.	N 499		

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N 499	Continued From page 19 On 01/16/2024, at approximately 10:50 AM, Surveyor toured facility and observed a commercial style dishwasher. Surveyor opened up the kitchen sink cabinet and observed opened gallons of machine dishwash detergent and rinse that contained tubing that fed into the bottles and traveled towards the dishwasher. On 01/16/2024, at approximately 11:15 AM, Surveyors interviewed Manager B. Manager B stated that s/he did not know that dishwashing chemicals were to be securely stored. Manager B stated s/he would inform Administrator A.	N 499		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by:	N 525		

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N 525	Continued From page 20 Based on record review and interview the provider did not ensure fire drills were conducted quarterly in 2022 and 2023. The provider did not ensure at least one fire evacuation drill was simulated for the conditions during usual sleeping hours. This is a repeat deficiency. See Statement of Deficiency (SOD) N55G11, dated 06/02/2022. Findings include: On 01/16/2024 at approximately 10:15 AM, Surveyor reviewed the facilities binder named "fire book". The record indicated there was three fire drills conducted in 2022, 01/06/2022 at 10:20 AM, 06/30/2022 at 2:00 PM, and 07/05/2022 during pm hours. There was no indication that there was a noc simulated drill for 2022, and there was no documentation of a fourth fire evacuation drill. The record indicated there was one fire drill conducted in 2023 on 01/17/2023. There was no record of 3 other drills including a noc simulated drill. On 01/16/2024 at approximately 10:45 AM, Surveyor interviewed Manager B. Manager B stated the fire book has all of the fire drills going back the facility conducted.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually.	N 526		

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N 526	Continued From page 21 This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure semi-annual tornado, flooding, or other emergency or disaster evacuation drills in 2023. This is a repeat deficiency. See Statement of Deficiency (SOD) N55G11, dated 06/02/2022, and SOD 6VPK12, dated 09/14/2020. Findings include: On 01/16/2024 at approximately 10:15 AM, Surveyor reviewed the facility binder for fire drills and evacuation drills. The record did not indicate there was other evacuation drills conducted during 2023. On 01/16/2024 at approximately 10:45 AM, Surveyor interviewed Manager B. Manager B stated all of the drills conducted were in the fire book.	N 526		
N 636	83.59(1)(f) Exit passageways, stairways: width maintained All habitable floors shall have at least 2 exits providing unobstructed travel to the outside. Small class AA CBRFs licensed on or before the effective date of this section with no more than 2 habitable floors may have one exit from the second floor. Exit passageways and stairways to outside exits shall be at least 36 inches in width and maintained clear and unobstructed at all times. Exit passageways and stairways to outside exits shall be at least 32 inches in width in facilities licensed on or before the effective date of this section. In existing large facilities, the minimum corridor width shall be at least 4 feet.	N 636		

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N 636	Continued From page 22 This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure the upstairs exit was maintained and clear. Findings include: On 01/16/2024 at approximately 9:50 AM, Surveyors toured the facility. On tour of the facility it was observed the upstairs emergency exit door was blocked by snow and not easily opened. The stairs leading down to the ground level were covered in 8-10 inches of snow. It did not appear an attempt was made to remove the snow from the emergency exit. On 01/16/2024 at approximately 10:05 AM, Surveyor shared findings with Manager B. Manager B stated s/he saw the door was hard to open and that the exit was snow covered. On 01/16/2024, Surveyor reviewed the National Weather Service website that indicates the last snow fall in Waupun was on 01/13/2024 with an accumulation of 1 inch. Prior to that on 01/12/2024, it was recorded 6.6 inches.	N 636		