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 _____	R-C 12/03/2025

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 12/02/2025, with information gathered through 12/03/2025, Surveyor conducted a verification visit at Daybreak Inc Waupun. Two deficiencies identified. Two of the 2 deficiencies were repeat violations (see Statement of Deficiency (SOD) HY8411, SOD M9VX13, SOD M9VX14 and SOD M9VX15). Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 5	{N 000}		
{N 408}	83.37(1)(i) PRN psychotropic medication. As needed (PRN) psychotropic medication. When a psychotropic medication is prescribed on an as needed basis for a resident, the CBRF shall do all of the following: 1. The resident ' s individual service plan shall include the rationale for use and a detailed description of the behaviors which indicate the need for administration of PRN psychotropic medication. 2. The administrator or qualified designee shall monitor at least monthly for the inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use. 3. Documentation in the resident ' s record shall include the rationale for use, description of behaviors requiring the PRN psychotropic medication, the effectiveness of the medication, the presence of any side effects, and monitoring for inappropriate use for each PRN psychotropic medication given.	{N 408}		

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

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{N 408}	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 1 of 1 resident's record included the rationale for use of the medication. This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) M9VX13, dated 08/26/2024, SOD M9VX14, dated 03/11/2025, and SOD M9VX15, dated 08/29/2025. Resident 11 was prescribed Hydroxyzine HCL (hydrochloride) and his/her record did not indicate the rationale for the administration of the medication. Findings include: On 12/02/2025, Surveyor and Manager B observed Resident 11's blister card of Hydroxyzine in the med closet. The blister card, which was dispensed on 08/18/2025, stated, "Take 1 tablet by mouth every 6 hours as needed for anxiety." There were 23 of 30 tablets remaining. On 12/02/2025, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the facility, 02/12/2024, with diagnoses including schizophrenia, generalized anxiety and borderline personality disorder. Resident 11 is his/her own person. Resident 11's Medication Administration Records (MARs), dated 11/09/2025 through 12/02/2025, documented:	{N 408}		

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{N 408}	Continued From page 2 "Hydroxyzine HCL (hydrochloride) Tab (tablet) 50 MG (milligram) - Take 1 tablet by mouth every 6 hours as needed for anxiety." Documented as administered: 11/11/2025 - Anxious 11/29/2025 - Anxiety Resident 11's daily notes documented on 11/11/2025 and 11/29/2025 that Resident 11 had requested the PRN Hydroxyzine, but specific behaviors were not identified. Resident 11's "Individual Service Plan (ISP)," dated 04/07/2025, documented: "Psychiatric med management by [doctor name]. Controlled, supervised self-administration medication regimen." The ISP did not identify the rationale for the PRN Hydroxyzine. Resident 11's "Self-Administration of Medication Assessment," dated 02/14/2024, documented: "To comprehend what was read on the medication bottle - No" "To correctly count the medication from the bottle for accurate administration - No" "To record in some fashion the dose administration - No" "Resident has adequate cognitive ability to understand and follow through with self-administration of medication - [Resident 11] suffers from scattered thoughts and some auditory stimuli. Writer believes this may be disruptive." On 12/02/2025, at approximately 2:00 PM, Surveyor interviewed Manager B. Surveyor reviewed Resident 11's ISP with Manager B and explained that a rationale for the administration of Resident 11's Hydroxyzine was not listed on the	{N 408}		

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{N 408}	Continued From page 3 ISP. Surveyor asked Manager B what behaviors would Resident 11 display when s/he was administered a PRN Hydroxyzine. Manager B stated, "Honestly, I am not sure there is a specific behavior. Usually, Resident 11 will request the medication, and we follow [his/her] request. Staff will try to redirect by suggesting non-pharmaceutical interventions such as deep breaths, going for a walk, quiet time, etc. but [s/he] has the right to [his/her] medication." Surveyor asked for clarification on how Manager B completed his/her monthly review of the PRN Hydroxyzine if s/he did not have a baseline to work from to ensure Resident 11 was not misusing his/her medication. Manager B stated s/he understood why having a baseline documented would be beneficial in the monitoring of PRN psychotropics. Surveyor and Manager B discussed how to develop that baseline by including Resident 11 in the discussion.	{N 408}		
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 observation, record review and	N 426		

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N 426	Continued From page 4	N 426		

interview, the provider did not provide or arrange supervision for residents of the facility who experienced behavioral needs.

Staff were not aware Resident 10 left the facility unsupervised, two days in a row, and law enforcement contact was made.

Findings include:

The provider was licensed to serve up to 8 residents within the client groups of alcohol/drug dependent, correctional clients, emotionally disturbed/mental illness and developmentally disabled.

On 12/02/2025, Surveyor reviewed the facility's written reports submitted to the department as s/he conducted his/her offsite for a verification visit. The reports documented:
11/16/2025 - Caregiver H realized at approximately 8:00 PM that Resident 10 was not in the facility. Law enforcement was contacted. Resident 10 returned to the facility at approximately 10:10 PM.
11/17/2025 - Caregiver H discovered that Resident 10 had left the facility between 7:40 PM and 8:00 PM. Law enforcement was contacted. Law enforcement located Resident 10 at approximately 10:00 PM.

On 12/02/2025, at approximately 12:45 PM, when Surveyor arrived at the facility, Surveyor observed that a doorbell sound went off inside the home every time the door was opened and/or closed.

On 12/02/2025, Surveyor reviewed Resident 10's record.

Resident 10 moved into the facility, 01/24/2024,

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N 426	Continued From page 5 and was represented by Guardian J. Resident 10's "Individual Service Plan," dated 11/20/2025, documented: Supervision: Needs some supervision - ADL's (activities of daily living), med management, financial management and decision making Elopement - Client will not exit facility without staff knowledge. Monitor client mood, mental status, document comments & behaviors. Resident 10's daily progress notes documented: 11/16/2025 - Writer (Caregiver H) was in office while a peer was doing after dinner clean up. Resident 10 came down and offered to take garbage out. It was while doing this that Resident 10 left the property. Writer did not know this or discover these events until 2 hours later. Writer informed director and called local police. Resident 10 returned on his/her own at 10:10 PM. 11/17/2025 - Writer (Caregiver H) checked in with him/her at 7:40 PM about possibly joining him/her again after meds. Resident 10 seemed open to it if s/he decided to stay up. Some point between that interaction and writer giving meds, Resident 10 eloped the houses again. Writer had been charting at the time. Called police, Resident 10 was found and returned at 10:05 PM. On 12/02/2025, at approximately 3:00 PM, Surveyor interviewed Manager B. Surveyor asked for clarification regarding the 11/16/2025 incident where Resident 10 did not return after taking the garbage out and staff did not realize s/he had not returned to the facility. Manager B explained that when s/he interviewed Caregiver H s/he asked him/her why s/he did not know that Resident 10 had not come back into the home after taking the garbage out, as staff were to know where the residents are. Caregiver H	N 426		

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stated s/he assumed Resident 10 was in his/her room. Manager B stated s/he tried to determine a timeframe as to how long Resident 10 had been out of the home. Manager B had asked Caregiver H if Resident 10 had participated in 7:00 PM snack. Caregiver H stated s/he had yelled up the stairs to let residents know that it was snack time, but Resident 10 did not come down, so s/he assumed Resident 10 wanted to be left alone. Caregiver H realized there was a concern when Resident 10 was not available for 8:00 PM meds. Manager B stated Caregiver H had not properly monitored Resident 10's whereabouts. Surveyor and Manager B determined Resident 10 was unaccounted for for approximately 4 hours on 11/16/2025. Surveyor then asked for clarification regarding the 11/17/2025 incident where Caregiver H had an approximate time that Resident 10 left the home, when would it be considered an elopement. Manager B explained that Resident 10 was allowed to go into the community unsupervised, but s/he had to inform staff where s/he was going, and a time allotment would be discussed. For example, Resident 10 states s/he wants to walk to the post office to mail a letter, we know approximately how long that should take and when to expect Resident 10 back. If they do not return in that time allotment, then the resident is given some additional time before law enforcement is contacted. Manager B stated the 11/16/2025 and 11/17/2025 incidents were concerning because they occurred in the evening and the weather was cool and staff did not know Resident 10's mindset when s/he left the home, was s/he dressed appropriately and will s/he be safe. Manager B stated staff should know when a resident leaves the home so that the provider can properly monitor the situation. Surveyor and Manager B determined Resident 10 had been

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N 426	Continued From page 7 unaccounted for for approximately 2.5 hours on 11/17/2025. Underground Weather (Madison) recorded the temperature for 11/16/2025 at 9:53 PM at 32 degrees Fahrenheit and 11/17/2025 at 9:53 PM at 40 degrees Fahrenheit.	N 426		