STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009082	A. BUILDING: _____ B. WING _____	R-C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC. (UNDERWOOD	3146 E UNDERWOOD AVE CUDAHY, WI 53110

(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 09/08/2023, Surveyor completed 4 complaint investigations and a verification visit at Broadstep-Wisconsin, Inc. (Underwood). Five deficiencies were identified. Five of the 5 were repeat violations (see SOD 2T10112, dated 09/02/2022). Four of 4 complaints were unsubstantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 6	{N 000}		
{N 404}	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address. This Rule is not met as evidenced by:	{N 404}		

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

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{N 404}	Continued From page 1 Based on record review and interview, the provider did not ensure a physician, pharmacist, or registered nurse conducted an on-site review of the medication administration and medication storage systems for 1 of 1 year (2022). This is a repeat deficiency. See Statement of Deficiency 2T1012, dated 09/02/2022. Findings include: On 08/31/2023 at approximately 1:00 p.m., Surveyor reviewed facility safety records. There were no on-site reviews of the medication administration and storage system. Surveyor requested the annual reviews from Manager K for 2022 to present. Manager K stated s/he would send the documents. As of 09/06/2023, nothing had been received. On 09/06/2022 at 3:00 p.m., Surveyor interviewed Administrator L. Administrator L was hired in March 2023. Administrator L verified Manager K informed Administrator L about the annual reviews of the medication administration and medication storage systems requested by the Surveyor. Administrator L informed Surveyor there was a change in management in March 2023 and most of the previous management team were no longer employed. Administrator L was aware of the previous Statement of Deficiency which identified the missing medication administration and storage system reviews were not completed, and was still looking for any documentation of the annual reviews of the medication administration and medication storage system for the year 2022 to the present day. Administrator L stated a process was being developed involving the nurses and contracted pharmacy to ensure the annual on site	{N 404}		

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{N 404}	Continued From page 2 medication administration and storage system was completed in the future. On 09/08/2023 at 9:40 a.m., Surveyor received via email a form titled, "Medication Monitoring Checklist" completed by Registered Nurse (RN) I on 07/07/2023. The form indicated the medication storage system was checked; however, observation of medication administration by staff was not completed.	{N 404}		
{N 446}	83.41(1)(b) Equipment. Equipment. The CBRF shall store equipment and utensils in a clean manner and shall maintain all utensils and equipment in good repair. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure kitchen equipment was maintained in a clean manner. The oven was heavily soiled. This is a repeat deficiency. See Statement of Deficiency 2T1012, dated 09/02/2022. Findings include: On 08/31/2022 at approximately 11:00 a.m., Surveyor toured the kitchen and observed the following: Oven: Caregiver J was cooking hamburger patties in the	{N 446}		

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{N 446}	Continued From page 3 oven for lunch. Caregiver J and Manager K were present when Surveyor opened the oven door. The back and bottom inside of the oven were heavily soiled. The bottom of the oven was covered with a sheet of aluminum foil containing charred, black areas and several areas of gold colored grease-like areas. Manager K attempted to remove the sheet of aluminum foil; however, there were areas where it was stuck to the bottom of the oven and was removed in pieces. Three of 3 oven walls contained multiple areas of dried brown streaks and spatters. The oven door window was heavily covered with brown splatters and gold streaks running down the glass. Four of 4 sides around the glass window had brown splatters and streaks. Caregiver J answered 3rd shift was responsible for cleaning the stove and oven. On 09/06/2022 at approximately 3:00 p.m., Surveyor informed Administrator L this was a repeat violation. Administrator L stated a new stove had been purchased and should be delivered by next week.	{N 446}		
{N 493}	83.45(1)(b) Building integrity. Building integrity. The CBRF shall be structurally sound without visible evidence of structural failure or deterioration and shall be maintained in good repair. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 3 exits was maintained in good repair. The outer door and outside exit stairs from the 2nd floor had visible evidence of deterioration. The door was unable to be closed resulting in a	{N 493}		

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{N 493}	Continued From page 4	{N 493}		

half inch gap on 2 sides of the door and insect debris on the bottom door sill.
The exit landing had a loose board that wobbled. When walking on the stairs, the entire staircase wobbled.
Three of 7 wooden spindles on the landing were detached exposing rusty nails.
A bee's nest was observed above the door.
This had the potential to affect 6 of 6 residents should they need to evacuate using the exit.

This is a repeat deficiency See Statement of Deficiency 2T1012, dated 09/02/2022.

Findings include:

On 08/31/2023, at approximately 1:00 p.m., Surveyor toured the 2nd floor of the facility with Manager K and observed the following:

There were 2 bedrooms on the 2nd floor used by 2 of the 6 residents. There was an exit door in the common area leading outside to a wooden landing and wooden stairs to the ground.
The outer door had a gap of approximately a half inch at the top and left side. Surveyor was unable to close the door as the latching hardware did not line up with the hardware on the doorframe.
There was a heavy layer of insect debris observed on the bottom door sill.
There was a landing of wooden boards as you exited the door. Surveyor stepped on the first board, and it wobbled causing Surveyor to slightly lose balance. Manager K witnessed this.
The landing was constructed of wood and had 2 sides. Each side was connected by a vertical wooden post on each end and a top and bottom horizontal rail connected to the posts.
To the right of the landing were 7 vertical wooden spindles connected to the top and bottom rails.

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{N 493}	Continued From page 5 Three of 7 spindles were detached from the lower edge of the landing exposing 3 rusty nails. The wooden landing and steps were visibly deteriorated. The wood was dry and cracked. Surveyor walked down the stairs and the entire staircase wobbled. A bee's nest was located above the door on the soffit. Surveyor observed bees flying around the nest. The loose board on the landing, the 3 detached spindles, a wobbly staircase, and a bee's nest were a safety hazard. This has the potential to affect 6 of 6 residents should they need to evacuate using this exit. On 08/31/2023, at approximately 1:00 p.m., Surveyor interviewed Manager K. Manager K reported the condition of the landing and stairs were "not good." Manager K reported the exit would be used in case of an emergency evacuation and the main entrance was obstructed. Manager K stated s/he was not aware of the condition of the landing and the stairs and stated it would be repaired as soon as possible. On 09/06/2023 at approximately 3:00 p.m., Surveyor informed Administrator L of the findings.	{N 493}		
{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 all cleaning compounds were	{N 499}		

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{N 499}	Continued From page 6	{N 499}		

stored in a secure area. Cleaning compounds were observed unsecured under the kitchen sink, and in an unsecured cabinet in the living room. This had the potential to affect 6 of 6 residents living in the home.

This is a repeat deficiency. See Statement of Deficiency 2T1012, dated 09/02/2022.

Findings include:

On 08/31/2023 at approximately 11:50 a.m., Surveyor toured the kitchen and observed the following:

Kitchen cabinet below the sink:
The cabinet was not secured.
One gallon bottle dish soap.
One gallon Murphy Wood Cleaner.
One bottle Clorox bleach.
One spray bottle (half full) with no label.
One bottle 16 ounces Fabuloso multi-purpose cleaner.
One gallon Windex glass cleaner.
One bottle Dawn dish soap.
One 32-ounce bottle NABC Disinfectant Bathroom Cleaner
One spray bottle with small amount blue liquid in with no label
Four 1-gallon size bottles of All-Purpose Vinegar cleaner.

Cabinet in living room:
The cabinet had 2 doors and had an engaged lock; however, the cabinet was not secured. The hinges on the right door were broken. When Manager K went to open the door, Manager K just pulled on the door and both doors opened. Surveyor asked Caregiver J how long the cabinet was broken. Caregiver stated s/he told Manager

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{N 499}	Continued From page 7 K it was broken a couple weeks ago. Top shelf: Lysol Disinfectant spray. One bottle Scrubbing Bubbles bathroom cleaner. Four bottles Lysol toilet cleaner. Fourteen 16-ounce bottles Fabuloso multi-purpose cleaner. Two packages Lysol disinfecting wipes. Two bottles Method bathroom cleaner. Seven 32-ounce bottles NABC Disinfectant Bathroom Cleaner. One spray bottle Consume toilet, urinal, and shower room cleaner. Bottom shelf: Two packages Lysol disinfecting wipes. One gallon Tide laundry detergent. One gallon Pine-Sol multi-surface cleanser. One spray bottle Lysol All-Purpose cleaner. Three bottles 16 ounces Fabuloso multi-purpose cleaner. On 09/06/2023, at approximately 3:00 pm, Surveyor interviewed Administrator L. Administrator L reported Manager K was responsible for ensuring the cleaning supplies were secured. Administrator L confirmed they should have been secured and they ordered a new cabinet to store the cleaning supplies in the day of the onsite observation.	{N 499}		
{N 553}	83.48(6)(d) Integrated heat detector in furnace room. CBRFs shall have at least one heat detector integrated with the smoke detection system at all of the following locations or in accordance with the heat detector manufacturer ' s specifications: Furnace room.	{N 553}		

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{N 553}	Continued From page 8	{N 553}		

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure a heat detector was installed in the enclosed basement. The basement contained a furnace and laundry area, with a clothes dryer in the same area.

This is a repeat deficiency. See Statement of Deficiency 2T1012, dated 09/02/2022.

Findings include:

On 08/31/2023 at approximately 11:30 a.m., Surveyor toured the facility basement and observed the following:

The basement contained a clothes washer and dryer and a furnace in the same area. The basement had a door that could be closed. Surveyor observed 2 smoke detectors in the basement. There was no heat detector.

On 08/31/2023, at approximately 11:50 a.m., Surveyor interviewed Manager K by telephone and asked if a heat detector had been installed in the basement. Manager K stated a heat detector was installed and s/he would provide paperwork.

On 08/31/2023, at approximately 12:40 p.m., Manager K arrived at the facility. The paperwork Manager K provided was the furnace inspection.

On 09/06/2023 at approximately 3:00 p.m., Surveyor interviewed Administrator L. Administrator L reported they were unsure if a heat detector was installed and would look for the documentation and send it to Surveyor.

On 09/08/2023 at 11:33 a.m., Administrator L

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{N 553}	Continued From page 9 emailed a smoke and heat detector inspection report completed on 08/11/2023. The report verified there were no heat detectors in the basement.	{N 553}		