STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0011199	A. BUILDING: _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC. (KIEHNAU)	10133 10135 W KIEHNAU AVE MILWAUKEE, WI 53224

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N 000	Initial Comments On 06/18/2025, Surveyor completed a complaint investigation and standard survey at Broadstep-Wisconsin Kiehnau. As a result, 8 deficiencies were identified. The complaint was unsubstantiated. Census: 4	N 000		
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 2 of 2 residents (Resident 3 and Resident 4) individual service plans (ISP) were updated annually. Resident 3's and Resident 4's ISPs were due to be updated in 2023 and 2024. Findings include: On 06/13/2025, at 12:15 PM, Surveyor reviewed resident records and identified the following:	N 389		

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

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N 389	Continued From page 1 Resident 3 was admitted to the facility on 06/11/2010 with diagnoses including severe intellectual disabilities, attention deficit hyperactivity disorder, impulse disorder, mood disorder and autism. Resident 3's ISP was dated 09/01/2022. Resident 3's record did not contain evidence of an ISP review in 2023 and 2024. Resident 4 was admitted to the facility on 12/05/2012, with diagnoses including moderate intellectual disabilities and impulse disorder. Resident 4's ISP was dated 09/01/2022. Resident 3's record did not contain evidence of an ISP review in 2023 and 2024. On 06/13/2025, at 1:20 PM, Surveyor interviewed Program Manager A. Program Manager A confirmed the requirement. Program Manager A reported Case Manager C was assigned to the facility and was responsible for ensuring the annual reviews of the ISPs. Program Manager A was unsure why the ISPs were not reviewed in 2023 and 2024.	N 389		
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	N 404		

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N 404	Continued From page 2 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: Based on record review and interview, the provider did not ensure the Community-Based Residential Facility (CBRF) medication administration and storage system were reviewed by a physician, pharmacist, or registered nurse at least annually for 2 of 2 years (2023 and 2024). Findings include: On 06/13/2025, at 10:30 AM, Surveyor requested the review of the provider's medication administration and storage system for 2023 and 2024. On 06/13/2025, at 11:25 AM, Surveyor interviewed Program Manager A. Program Manager A confirmed the code requirement. Program Manager A reported s/he would contact pharmacy and send information by Monday, June 16th at 10:00 AM. As of 06/18/2025, at 2:00 PM, no documentation was sent to Surveyor.	N 404		

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N 406	Continued From page 3	N 406		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation and interview, the provider did not establish an effective procedure for proper destruction and disposal of expired medications. Expired medications were observed store with resident's non-expired medications in 1 of 1 medication storage cabinet. Findings include: On 06/13/2025, at 12:55 PM, Surveyor observed the medication filing cabinet. Surveyor observed	N 406		

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N 406	Continued From page 4 the following expired medications: -Resident 1 APAP (acetaminophen) 325 mg with a discard date of 12/24/2024 APAP 325 mg with a discard date of 01/20/2025 -Resident 2 Triple Antibiotic Ointment with a discard date of 05/22/2025 Hydrocortisone cream 2.5% with a discard date of 05/22/2025 Hydrocortisone cream 2.5% with a discard date of 05/30/2025 Triamcinolone 0.1% with a discard date of 05/22/2025 On 06/13/2025, at 1:15 PM, Surveyor interviewed Program Manager A. Program Manager A confirmed the code requirement. Program Manager A reported the nurse was responsible for review of the medications to ensure expired medication were disposed of.	N 406		
N 407	83.37(1)(h) Scheduled psychotropic medications. Scheduled psychotropic medications. When a psychotropic medication is prescribed for a resident, the CBRF shall do all of the following: 1. Ensure the resident is reassessed by a pharmacist, practitioner or registered nurse, as needed, but at least quarterly for the desired responses and possible side effects of the medication. The results of the assessments shall be documented in the resident ' s record as required under s. HFS 83.42(1)(q). 2. Ensure all resident care staff understands the potential benefits and side effects of the medication.	N 407		

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N 407	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents (Resident 3 and Resident 4) were assessed for the desired responses and possible side effects of her/his scheduled psychotropic medication by a pharmacist, practitioner, or registered nurse (RN) quarterly for the years 2023, 2024 and the 1st quarter of 2025. Resident 3's and Resident 4's records did not contain documentation indicating Resident 3 and Resident 4 were assessed for desired responses or side effects. Findings include: On 06/13/2025, at 12:15 PM, Surveyor reviewed resident records and identified the following: Resident 3 was admitted to the facility on 06/11/2010 with diagnoses including severe intellectual disabilities, attention deficit hyperactivity disorder, impulse disorder, mood disorder and autism. Resident 3's medication administration record (MAR), dated 06/12/2025, identified Resident 3 was prescribed aripiprazole 15 milligram (mg) tablet by mouth once a day, divalproex extended release (ER) (mood stabilizer) 500 mg tablet by mouth twice a day, and divalproex ER 250 mg tablet by mouth twice a day. Resident 3's face sheet, dated 03/29/2022, indicated Resident 3 had been prescribed the medications as follows; aripiprazole had a start date of 07/15/2021, and divalproex ER had a start date of 08/09/2021. Resident 3's record did not contain documentation indicating a psychotropic medication review by a pharmacist, practitioner, or RN was completed quarterly in 2023, 2024, and the 1st quarter of 2025.	N 407		

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N 407	Continued From page 6 Resident 4 was admitted to the facility on 12/05/2012, with diagnoses including moderate intellectual disabilities and impulse disorder. Resident 4's MAR, dated 06/12/2025, identified Resident 4 was prescribed aripiprazole 30 mg tablet by mouth once a day, divalproex ER (mood stabilizer) 500 mg tablet by mouth once a day, quetiapine 400 mg tablet by mouth twice a day. Resident 4's face sheet, dated 03/29/2022, indicated Resident 4 had been prescribed the medications as follows; aripiprazole had a start date of 06/17/2021, divalproex ER had a start date of 05/24/2021, and quetiapine had a start date of 07/20/2021. Resident 4's record did not contain documentation indicating a psychotropic medication review by a pharmacist, practitioner, or RN was completed quarterly in 2023, 2024, and the 1st quarter of 2025. On 06/13/2025, at 1:00 PM Surveyor interviewed Program Manager A. Program Manager A reported a new nurse was hired but just started a couple of months ago, but prior to the new nurse being hired, Nurse E was responsible for ensuring the psychotropic medication reviews were completed. Program Manager A called Nurse E, and placed Nurse E on speaker phone so Surveyor could inquire about the medication reviews. On 06/13/2025, at 1:10 PM, Surveyor interviewed Nurse E. Nurse E reported s/he did not have them. Surveyor inquired if the psychotropic medication reviews were completed, and s/he did not have access to the reviews or know if they were not completed. Nurse E reported s/he needed to "talk with my supervisor." Surveyor inquired when Nurse E would speak to her/his supervisor. Nurse E reported it would not be	N 407		

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N 407	Continued From page 7 today due to her/his child was getting married, so it would be sometime next week. Surveyor informed Nurse E s/he needed the psychotropic medication reviews today during the survey. As of 06/18/2025, at 2:00 PM, no documentation was sent to Surveyor.	N 407		
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 cleaning compounds and toxic substances were securely stored in 2 of 2 areas. Cleaning compounds and toxic substances were not securely stored under the kitchen sink and in the activity room. Findings include: The facility is license to serve up to 8 residents in client groups of developmentally disabled and emotionally disturbed/mental illness. On 06/13/2025, at 11:45 AM, Surveyor toured the facility and observed the following: Kitchen In a cabinet under the sink was a bottle of Lysol toilet bowl gel, a bottle of Pine-Sol multi-surface cleaner, a spray bottle of Pine-Sol multi-purpose cleaner and a bottle of Zep cleaner. The cabinet	N 499		

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N 499	Continued From page 8 did not contain a locking mechanism. Activity Room On the southeastern wall of the activity room, was a wall of cabinets. A lower cabinet, labeled "Kiehnau Cleaning Supplies" contained a hasp. There was no locking mechanism on the hasp. Inside the cabinet was a bottle of Glass Plus glass cleaner, 2 cans of Easy Off heavy duty oven cleaner, 2 cans of Zep disinfectant & sanitizer spray, a bottle of Pine-Sol, a bottle of Fabuloso, a bottle of Spartan Xcelente multi-surface cleaner and a bottle of bleach. Surveyor observed residents ambulating throughout the facility. On 06/13/2025, at 1:20 PM, Surveyor interviewed Program Manager A and House Manager B. Program Manager A, and House Manager B confirmed the code requirement. Program Manager A reported s/he thought there was a locking mechanism on the kitchen cabinet, as all programs were to have a locking cabinet under the kitchen sink. House Manager B reported s/he found a lock for the activity closet and would ensure the cabinet was locked.	N 499		
N 507	83.46(1)(f) Combustibles. Combustible materials shall not be placed within 3 feet of any furnace, boiler, water heater, fireplace or other similar equipment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure combustible materials were not placed within 3 feet of 1 of 2 furnaces and 1 of 2	N 507		

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N 507	Continued From page 9 water heaters. Findings include: On 06/13/2025, at 11:50 AM, Surveyor toured the basement with House Manager B. Surveyor observed a canvas picture leaned up against the furnace, 2 plastic totes next to the canvas picture which contained 4 furnace filters, a cardboard box piled on top of the totes. Behind the plastic totes was a closet door, a window screen frame with window screen, and a stack of plywood. The furnace filters were 10.5 inches away from the furnace, the cardboard box was 16 inches way from the furnace and the closet door and stack of plywood was 23 inches way. The stack of plywood was 13 inches way from the water heater. On 03/26/2025, at 1:30 PM, Surveyor interviewed House Manager B. House Manager B reported s/he was not aware the code requirement included the water heater. House Manager B reported s/he was in the process of cleaning out the basement and would ensure the items were moved away from the furnace and water heater.	N 507		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure tornado, flooding, or other emergency or disaster drills were conducted	N 526		

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N 526	Continued From page 10 semi-annually for 2 of 2 years. There were no other emergency or disaster drills conducted in 2023, 2024, or to date in 2025. Findings include: On 06/13/2025, at 10:38 AM, Surveyor reviewed the facility safety files with House Manager B. The safety files did not contain evidence of other emergency or disaster drills for 2023, 2024 or to date in 2025. On 06/13/2025 at 1:20 PM, Surveyor interviewed Program Manager A. Program Manager A confirmed the code requirement. Program Manager A reported operation managers were responsible for ensuring drills were completed. Program Manager A reported s/he was unsure why the drills were not completed.	N 526		
N 530	83.47(3) Fire inspection. Fire inspection. The CBRF shall arrange for an annual inspection by the local fire authority or certified fire inspector and shall retain fire inspection reports for 2 years. This Rule is not met as evidenced by: Based on record review and interview, the provider did not arrange for an annual fire inspection for 2 of 2 years reviewed (2023, 2024, and to date in 2025). Findings include: On 06/13/2025, at 10:38 AM, Surveyor requested to review safety files. The documentation	N 530		

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N 530	Continued From page 11 indicated a fire inspection was conducted on 11/01/2022. Surveyor did not review evidence of a fire inspection conducted in 2023 and 2024. On 06/13/2025, at 1:20 PM, Surveyor interviewed Program Manager A. Surveyor inquired if Program Manager A knew where the documentation for the fire inspections was located. Program Manager A reported s/he was unaware of where the documentation was located but would speak with Administrator D and send the inspections to Surveyor by Monday, June 16th at 10:00 AM. As of 06/18/2025, at 2:00 PM, no documentation was sent to Surveyor.	N 530		