STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009000	A. BUILDING: _____ B. WING _____	R-C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC. (KINNICKINNIC	2858 S 68TH ST MILWAUKEE, WI 53219

(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 01/07/2025 with information gathered through 01/08/2025, Surveyors conducted a standard survey, verification visit and 1 complaint investigation. Ten deficiencies were identified. Two of 10 deficiencies are repeat deficiencies. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee will be assessed. Census: 4	{N 000}		
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 documentation was	N 302		

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

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N 302	Continued From page 1 obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 3 of 4 residents (Residents 1, Resident 3 and Resident 5) were screened for clinically apparent communicable disease, including tuberculosis within 90 days before or 7 days after admission. Findings include: On 01/08/2026 at approximately 11:30 AM, Surveyor reviewed resident records and identified the following: -Resident 1 was admitted on 11/27/2023. Resident 1's record had no documentation showing they had been screened for clinically apparent communicable disease, including tuberculosis by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission. -Resident 3 was admitted on 10/27/2023. Resident 3's record had no documentation showing they had been screened for clinically apparent communicable disease, including tuberculosis by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission. -Resident 5 was admitted on 10/27/2023. Resident 5's record had no documentation showing they had been screened for clinically apparent communicable disease, including tuberculosis by a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse within 90 days before or 7 days after admission.	N 302		

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N 302	Continued From page 2 On 01/08/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager H and Administrator N. Administrator N reported they did not locate these documents but would ensure they were reviewed and updated immediately.	N 302		
N 305	83.28(6) Resident rights, grievance procedure, rules Resident rights, grievance procedure, and house rules. Before or at the time of admission, the CBRF shall provide and explain resident rights, the house rules of the CBRF as required under s. DHS 83.32 (2), and the grievance procedure, including written information regarding the names, addresses and telephone numbers of all resident advocacy groups serving the client groups in the facility, including the long term care ombudsman program and the protection and advocacy services of Disability Rights Wisconsin, Inc. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide resident rights, grievance procedures and house rules before or upon admission for 3 of 4 resident reviewed (Resident 1, Resident 5, and Resident 6). Findings include: On 01/07/2025, at approximately 1:24 PM, Surveyor requested Resident 1's, Resident 5's and Resident 6's records from Program Manager H.	N 305		

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N 305	Continued From page 3 On 01/08/2025, at approximately 9 AM, Surveyor received resident records via-email. Surveyor reviewed resident records and identified the following: -Resident 1 was admitted on 11/27/2023 their record did not contain evidence of being provided with resident rights, grievance procedures and house rules before or upon admission. -Resident 5 was admitted on 10/31/2023 their record did not contain evidence of being provided with resident rights, grievance procedures and house rules before or upon admission. -Resident 6 was admitted on 10/27/2023 their record did not contain evidence of being provided with resident rights, grievance procedures and house rules before or upon admission. On 01/08/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager H and Administrator N. Administrator N reported they did not locate these documents but would ensure they were reviewed and updated immediately.	N 305		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the	N 326		

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N 326	Continued From page 4 resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident was served a 30-day written advance notice of discharge. Resident 2 began verbally harassing another resident and was verbally given a 30-day notice of discharge but was not provided a written notice which explained to the resident the need for and possible alternatives to the discharge. Findings include: On 09/12/2025, the Department received a complaint alleging a resident was discharged and moved to another facility within the company without being provided a written notice of discharge. On 01/07/2026, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 11/14/2019. Resident 2 did not have a legal guardian or activated power or attorney for healthcare document. Resident 2 was discharged on 08/01/2025 to another facility within the company. Resident 2's record did not contain a written 30-day notice of discharge. On 01/08/2026 at approximately 2:00 PM, Surveyor Program Manager H and Administrator L. Program Manager H reported Resident 2 began verbally harassing other residents. In addition, Resident 2 often brought outside garbage into the facility, which caused environmental concern. Program Manager H	N 326		

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N 326	Continued From page 5 reported having a verbal conversation with Resident 2 about the need to move to another facility due to Resident 2's continued behaviors. Program Manager H confirmed Resident 2 was their own decision maker. Program Manager H confirmed not providing Resident 2 with a written notice of discharge.	N 326		
{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 each resident received updated Individual Service Plans (ISPs) annually for 2 of 4 residents reviewed (Resident 1, and Resident 3. Resident 1 and Resident 3 had ISPs updated in 2025, but did not have required signatures. This requirement is being cited for a 3rd time. See statements of deficiency (SOD) HVB512 dated 04/06/2023, and SOD HVB513 dated	{N 389}		

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{N 389}	Continued From page 6 07/24/2025. Findings include: On 01/07/2026, at 10:00 AM, Surveyor reviewed resident records and identified the following: -Resident 1 was admitted on 11/27/2023. Resident 1's record contained an ISP dated 11/19/2024 with no required signatures. -Resident 3 was admitted on 10/27/2023. Resident 3's record contained an ISP dated 07/24/2025 with no required signatures. On 01/08/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager H and Administrator N. Program Manager H reported they were waiting to receive signed service plans from guardians of both residents. Cross Reference DHS N0391 83.35(3)(f) Staff Access to Assessment And ISP	{N 389}		
{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 staff providing resident care and services had continual access to each resident's individual service plan (ISP) for 1 of 4 residents reviewed (Resident 3). This requirement is being cited for a fourth time. See Statement of Deficiency (SOD) HVB511,	{N 391}		

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{N 391}	Continued From page 7 dated 01/20/2022, and SOD HVB512, dated 04/06/2023, and HBV513, dated 07/24/2025. Findings include: On 01/07/2026, at 10:15 AM, Surveyor reviewed resident records and identified the following: -Resident 3 was admitted on 10/27/2023. Resident 3's record contained a message that stated, "No ISP on file." On 01/08/2026, at approximately 2:30 PM, Surveyor interviewed Program Manager H. Program Manager H confirmed staff did not have access to Resident 3's service plan. Program Manager H reported there had been a problem with the computer system and a hard copy of the plan was not in the residents file on site. Cross Reference DHS N0389 83.35(3)(d) Service Plans Updated Annually or On Changes	{N 391}		
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 evaluate each resident's mental or physical capability to respond to a fire alarm at least annually for 1 of 1 resident reviewed (Resident 6) who required an annual review in 2024 and 2025.	N 394		

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N 394	Continued From page 8 Findings include: On 01/07/2025 at 10:00 AM, Surveyor reviewed Resident 6's record and identified the following: Resident 6 was admitted 10/27/2023 with diagnoses that included but are not limited to: schizophrenia, pervasive developmental disorder and depression. Resident 6's record contained no evidence an evacuation assessment was completed in 2024 or 2025. On 01/08/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager H and Administrator N. Program Manager H confirmed that there was no evacuation assessment for Resident 6. Administrator A confirmed understanding that all residents must be evaluated/assessed for evacuation limits annually.	N 394		
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	N 525		

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N 525	Continued From page 9 residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure a fire evacuation drill was conducted at least quarterly with both employees and residents. No fire evacuation drills were conducted between April 2024 to September 2024 (2nd and 3rd quarters). No fire drill was conducted between July 2025 to September 2025 (3rd quarter). Findings include: On 01/07/2026, Surveyor completed a safety code report review. Surveyor reviewed 8 "Disaster Incident Report" forms. Surveyor was not provided evidence that indicated fire drills were conducted between April 2024 to September 2024 (2nd and 3rd quarters). In addition, Surveyor did not observe evidence a fire drill was conducted between July 2025 to September 2025 (3rd quarter). On 01/08/2026 at approximately 2:00 PM, Surveyors interviewed Program Manager H and Administrator L. Program Manager H reported fire drills were conducted quarterly in 2024 and 2025. Operations Coordinator I emailed four additional "Disaster Incident Report" to Surveyor on 01/08/2026 at 2:27 PM. The email did not contain evidence that showed fire drills were conducted between April 2024 to September 2024 (2nd and 3rd quarters) and July 2025 to September 2025 (3rd quarter).	N 525		

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N 526	Continued From page 10	N 526		
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 a tornado, flooding, or other emergency or disaster evacuation drills were conducted at least semi-annually in 2024 and 2025. Findings include: On 01/07/2026, Surveyor completed a safety code report review. Surveyor reviewed 1 "Disaster Incident Report," with a date of 01/07/2025. The "Disaster Incident Report" indicated a "Blizzard Drill" was conducted. Surveyor did not observe evidence of a tornado, flooding, or other emergency or disaster evacuation drill was conducted semi-annually in 2024. Surveyor was not provided evidence of a tornado, flooding, or other emergency or disaster evacuation drill was conducted between July 2025 to December 2025. On 01/08/2026 at approximately 2:00 PM, Surveyors interviewed Program Manager H and Administrator L. Program Manager H reported other evacuation drills were conducted semi-annually in 2024 and 2025. Operations Coordinator I emailed four additional "Disaster Incident Report" forms to Surveyor on 01/08/2026 at 2:27 PM. The email did not contain evidence other emergency or disaster evacuation drills were conducted semi-annually in 2024 and between July 2025 to December 2025.	N 526		

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N 613	83.55(4)(a) Bath and toilet areas: privacy. Bath and toilet rooms shall have door locks to ensure privacy, except where the toilet, bath or shower room is accessed only from a resident room that is occupied by one person. All door locks shall be operable from both sides. This Rule is not met as evidenced by: Based on observation and staff interview, the provider did not ensure 1 of 2 bathroom doors had locks to ensure privacy. Findings include: On 01/07/2026, at approximately 10:00 AM, Surveyor toured the facility. Surveyor observed 1 of 2 bathrooms to be equipped with a lockable doorknob. Surveyor observed the bathroom located in the main hallway, leading to the residents' bedrooms were missing the thumb turn/button to lock the door. (Photo 1). On 01/08/2026 at approximately 2:00 PM, Surveyors interviewed Program Manager H and Administrator L. Program Manager H confirmed the thumb turn/button to lock the door was missing on the doorknob. Program Manager H was not aware of the missing thumbturn/button to lock the door. Program Manager H will work with maintenance to have the doorknob replaced.	N 613		
N 666	83.59(7)(a) Emergency egress lighting provided All exit passageways and stairways shall be provided with emergency egress lighting with a stand-by power source. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 666		

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N 666	Continued From page 12 did not ensure all exit passageways were provided with emergency egress lighting with a stand-by-power source for 2 of 3 emergency egress lighting fixtures within the facility. Findings include: On 01/07/2026 at approximately 10:00 AM, Surveyor toured the facility. Surveyor observed 3 emergency egress lighting: 1 in the basement and 2 on the main floor. Surveyor tested the egress lighting fixtures located in the basement and 2 of 2 lights did not turn on. Surveyor tested the egress lighting fixture located in the main floor hallway, leading to residents' bedrooms and 2 of 2 lights did not turn on. On 01/08/2026 at approximately 2:00 PM, Surveyors interviewed Program Manager H and Administrator L. Program Manager H denied staff tested the emergency egress lighting. Administrator L could not confirm if maintenance staff checked the emergency egress lighting. Administrator L reported a contracted fire safety company typically checks the emergency egress lighting fixtures on an annual basis. Administrator L stated he/she would call a contracted fire safety company to address the emergency egress lighting.	N 666		