STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010783	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC. (BELWOOD)	**5151 W SILVER SPRING DRIVE MILWAUKEE, WI 53218**

(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 09/12/2024, Surveyors concluded a standard survey, verification visit and 7 complaint investigations at Broadstep-Wisconsin, INC (Belwood). Thirteen deficiencies were identified. Six complaints were substantiated. One complaint was unsubstantiated. One of 13 deficiencies was a repeat violation. See Statement of Deficiency (SOD) WFG114, dated 11/02/2022 and MRK212, dated 02/19/2024. One of 13 deficiencies was cited for a third time. See SOD WFG112, dated 6/17/2021 and SOD WFG114, dated 11/02/2022. One of 13 deficiencies was cited for a fourth time. See SOD WFG111, dated 12/28/2020, SOD WFG112, dated 6/17/2021. SOD WFG113, dated 2/16/2022, and SOD WFG114, dated 11/02/2022. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 39	{N 000}		
N 163	83.12(4)(a) Reporting when resident's whereabouts unknown A CBRF shall send a written report to the department within 3 working days after any of the following occurs: Any time a resident ' s whereabouts are unknown, except those instances when a resident who is competent chooses not to disclose his or her whereabouts or location to the CBRF, the CBRF shall notify the local law enforcement authority immediately upon	N 163		

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

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N 163	Continued From page 1	N 163		

discovering that a resident is missing. This reporting requirement does not apply to residents under the jurisdiction of government correctional agencies or persons recovering from substance abuse.

This Rule is not met as evidenced by:
Based on record review and staff interview, the provider did not report to the department when Resident 2 eloped from the facility on 07/28/2024 and returned on 07/30/2024. The provider did not know where Resident 2 was.

Findings include:

On 08/06/2024. Surveyor reviewed Resident 2's record. Resident 2 was admitted to the facility on 01/21/2020, with a diagnosis including schizoaffective disorder, bipolar type. Resident 2 had a guardian.

Resident 2's record contained a nursing annual assessment dated 05/13/2024. Under psychosocial history, tobacco use read, "Yes", with type of tobacco handwritten in as, "Cigarettes, Crack, Marijuana." Surveyor observed a line through marijuana and the section titled, 'amount' read "error".

Resident 2's ISP required, "60-minute body checks for shift reporting, 60-minute bed checks for shift reporting and [Resident 2] is permitted 12 hours in the community between the hours of 8:00 a.m. and 8:00 p.m. due to medication passes occurring at this time period. If [Resident 2] is missing from his/her bed at 10:00 p.m. [sic] s/he should be considered AWOL (absent without leave) and missing person protocol should be followed."

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N 163	Continued From page 2 Client Notes -07/29/2024. "It was brought to my attention that [Resident 2] has been missing for approximately 72 (+) hours and a police report was being made." -07/30/2024. "missed [sic] all meds due to him/her being awol." -07/31/2024. "Received copy of police report for missing person filed on 7/29/24. Uploaded into CURSA (on-line record keeping database) documents. Supervisor notified." On 08/30/2024 at 11:45 a.m., Surveyor received and reviewed Milwaukee Police Department reports The reports identified: -07/29/2024 at 11:10 a.m., Operations Coordinator (OC) I filed a missing person certification report for Resident 2 with the Milwaukee Police Department. The document read, "Resident 2 was last seen on 07/28/2024 at 12:00 p.m. Reason for disappearance: went to store." -08/11/2024. Milwaukee Police Officer (PO) BB placed telephone call to OC I to check on Resident 2's status. OC I confirmed Resident 2 returned to facility on July 30th, 2024 and s/he forgot to call it in to police Department [sic]. OC I stated Resident 2 was not a victim of a crime. Interviews On 08/01/2024 at 11:11 a.m., Surveyor interviewed OC I, who stated, "[Resident 2] has been missing since Monday, July 29th. I filed a	N 163		

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police report on Monday, July 30th. S/He got his/her debit card and disappeared." Surveyor questioned if Resident 2 had done this before. OC I confirmed, "This isn't the first time."

On 08/23/2024 at 3:50 p.m., Surveyor interviewed Care Team Manager (CTM) T and Executive Team Member (ETM) R. CTM T confirmed Resident 2 was recently missing from the building for a week. CTM T stated, "The missing person's report was filed after s/he had already been gone for 72 hours. [Resident 2] saved her money, and we believe s/he went out on a cocaine binge." Surveyor asked what actions the facility took when they noted Resident 2 was missing. CTM T stated, "We call the family, filed a police report, and check his/her common hangouts." CTM T confirmed no other interventions were in place for Resident 12's elopement behaviors.

On 09/04/2024 at 3:30 p.m., Surveyor reviewed Department records for provider, including documentation of incidents self-reported. Surveyor located no evidence of elopements being reported to the Department for the incident on 07/28/2024.

On 09/12/2024 at 2:15 p.m., Surveyor interviewed Program Manager (PM) H regarding AWOL and missing person facility protocol. PM H stated when a resident did not come home between 8:00 p.m. and 10:00 p.m. for medications, the provider waits 24 hours, then files a police report. The provider also notifies the guardian and the county right away. Surveyor asked when the provider reported Resident 2's whereabouts were unknown to the Department? PM H stated, "We didn't report it to the Bureau of Assisted Living." Executive Team Member (ETM) R stated, "I know what code you are referring to. We should have

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N 163	Continued From page 4 reported him/her missing."	N 163		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview and record review, the licensee did not ensure that the provider and its operation were compliant with all laws governing a Community Based Residential Facility (CBRF). This had the potential to affect 39 of the 39 residents that resided at the facility. As a result of this survey, a total of 13 deficiencies were identified. One of 13 deficiencies was a repeat violation. See Statement of Deficiency (SOD) WFG114, dated 11/02/2022 and MRK212, dated 02/19/2024. One of 13 deficiencies was cited for a third time. See SOD WFG112, dated 6/17/2021 and SOD WFG114, dated 11/02/2022. One of 13 deficiencies was cited for a fourth time. See SOD WFG111, dated 12/28/2020, SOD WFG112, dated 6/17/2021. SOD WFG113, dated 2/16/2022, and SOD WFG114, dated 11/02/2022. Six of 7 complaints were substantiated. Findings include: The provider is licensed by the Department as a class CS (semi-ambulatory) CBRF able to serve up to 46 residents within the client groups of public funding, emotionally disturbed/mental	N 196		

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N 196	Continued From page 5 illness, alcohol/drug dependent and/or developmentally disabled. On 07/24/2024, Surveyors conducted a standard survey, verification visit and 7 complaint investigations. As a result of this survey, the following citations were issued: 83.12(4)(a) Reporting When Residents Whereabouts Unknown 83.14(2)(a) Licensee Ensures Facility Complies with Laws 83.31(3)(a) Notice Of Facility Initiated Discharges 83.37(1)(e) Medication Regimen, Administration Review 83.38(1)(a) Personal Care 83.38(1)(i) Behavior Management 83.43(2)(b) Clean, Comfortable Mattress and Pad 83.44(1)(c) Clothes Dryers Enclosed and Vented 83.44(2)(a) Rooms Clean And Free From Odors 83.47(2)(e) Other Evacuation Drills 83.54(3)(a) Bedrooms: No more Than 2 Residents 83.55(1)(a) One Toilet, Sink, And Bath Or Shower 83.59(4)(b) Delayed Egress: Locking Device Sign Posted On 09/12/2024, at 2:15 p.m., Surveyors interviewed Broadstep Executive Team Member (ETM) R regarding the above findings. ETM R indicated s/he felt corrections could be made to ensure compliance. They were already working on corrections.	N 196		
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	N 326		

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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 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 observation and interview, the provider did not ensure 22 of 22 residents were served a 30-day written advance notice of discharge (Residents 24, 25, 26, 14, 15, 27, 28, 29, 12, 5, 17, 13, 6, 8, 21, 18, 19, 20, 4, 22, 23, and 9). Residents were not provided a 30-day written notice of discharge, which explained to the residents the need for and possible alternatives to the discharge.

Findings include:

On 07/24/2024, at 9:14 a.m., Surveyor toured the facility. During the tour, Surveyor observed the occupied bedrooms. Bedroom #8 was occupied by 3 residents (Resident 6, Resident 8, and Resident 21). Bedroom #7 was occupied by 3 residents (Resident 18, Resident 19, and Resident 20). A bedroom, which did not have a room number, but was presumed to be bedroom #6 based on numbered order, was occupied by 4 residents (Resident 4, Resident 22, Resident 23, and Resident 9).

On 07/24/2024, at 2:03 p.m., Surveyor

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interviewed Program Manager (PM) H. PM H reported 22 residents (Residents 24, 25, 26, 14, 15, 27, 28, 29, 12, 5, 17, 13, 6, 8, 21, 18, 19, 20, 4, 22, 23, and 9) had been relocated from the west wing to the north wing of the facility, due to the fire which occurred on 03/14/2024.

Program Manager (PM) H reported the rooms in which these residents were relocated were prior offices, and not planned resident rooms. PM H reported the relocated residents were there temporarily while construction was going on in the west wing.

On 07/26/2024 at 11:10 a.m., Surveyor received an email from Executive Team Member (ETM) R, who stated, "Dates residents were moved to other part of building. 7/1/24."

On 08/01/2024 at 11:25 a.m., Surveyor interviewed Caregiver L, who stated the residents moved over to the new area, while the remodeling happened, at the beginning of July. S/He did not have to assist in the move.

On 08/01/2024 at 12:05 p.m., Surveyor interviewed Caregiver K, who stated the management moved the residents over to the new area around 07/04/2024. S/He did not have to assist in the move.

On 08/06/2024 at 4:48 p.m., Surveyor requested resident relocation plan from ETM R via email. On 08/06/2024 at 4:58 p.m., ETM R replied via email, "A relocation plan for what?"

On 08/07/2024 at 8:46 a.m., Surveyor received an email from Department of Health Services Relocation Coordinator (DHS RC) AA, "We have not received a resident relocation plan from

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N 326	Continued From page 8 Broadstep Wisconsin for Belwood CBRF. We have received no communication from the agency regarding resident relocations." On 08/07/2024 at 10:35 a.m., Surveyor interviewed ETM R, who stated they were not aware the office space of the facility was unlicensed, and not a part of their Community Based Residential Facility (CBRF). ETM R stated, "We assumed it was part of the license." ETM R confirmed a 30-day written advance notice of discharge had not been served to the residents. "We did not do a relocation plan because we were not aware we needed to. We will move the residents back immediately. The residents were not happy about the move in the first place." On 08/07/2024 at 10:27 a.m., Surveyor received an email from Department of Health Services Director of Contract Compliance (DCC) P who wrote, "We were not aware that clients had been moved to an unlicensed part of Belwood." On 08/08/2024 at 3:09 p.m., Surveyor received an email from ETM R, who stated, "Just wanted to let you know that all clients are back in their room and the moving [sic] went pretty well. No significant issues."	N 326		
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	N 404		

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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:
Based on interview and record review, the provider did not ensure that a physician, pharmacist, or registered nurse conducted an annual on-site review of the CBRFs medication administration and medication storage systems in 2023.

This deficiency is being cited for a fourth time. See Statement of Deficiency (SOD) WFG111 dated 12/28/2020, SOD WFG112, dated 06/17/2021, and SOD WFG114, dated 11/02/2022.

Findings include:

On 07/24/2024 at 9:45 a.m., Surveyor requested 2023 annual pharmacy review for the facility from Program Manager (PM) H.

On 07/24/2024 at 2:05 p.m., Surveyor interviewed

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N 404	Continued From page 10 facility Registered Nurse (RN) V, who stated a new pharmacy took over in March of 2023. They were looking for the 2023 annual pharmacy review for the facility survey. RN V stated s/he did not see in his/her records that anything was done for 2023. RN V stated. "I don't know when the last one was done." On 07/24/2024 at 3:30 p.m., RN V provided Surveyor a document titled, "Medication Storage and Security Checklist", dated 07/24/2024, RN V stated, "I just did this. Better late than never, right?" On 07/24/2024 at 4:10 p.m., Surveyor interviewed PM H who stated, "We did not do the 2023 medication administration review. I don't think we had the form. We are trying to get organized."	N 404		
N 425	83.38(1)(a) Personal care. 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: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence.	N 425		

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N 425	Continued From page 11 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 1 resident (Resident 11) was not taught the necessary skills to maintain his/her highest level of functioning with activities of daily living. Resident 11 did not have a 2023 assessment and the 2024 assessment did not address services with activities of daily living adequate to meet the needs of the resident. Resident 11 appeared dirty and disheveled upon survey. Findings include: On 04/23/2024, the department received a complaint alleging resident had a thick coat of black dirt on her/his legs and feet, which appeared the resident had not had a bath in a very long time. From 07/24/2024 to 09/12/2024, Surveyors reviewed the records for Resident 11. The following was identified: Resident 11 was admitted to the facility on 04/01/2015, with diagnoses including schizoaffective disorder, bipolar type, post-traumatic stress disorder, tobacco dependence and depression. Resident 11 was his/her own person. Resident 11's record contained a nursing annual assessment dated 05/08/2024. Resident 11's annual assessment did not identify Resident 11's needs and abilities concerning personal cares or activities of daily living. Wis. Admin. Code § DHS 83.02 (37) defines personal care as, "Assistance with activities of	N 425		

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daily living but does not include nursing care."

Resident 11's Individual Service Plan (ISP) dated 05/17/2024, did not identify interventions or methods to reduce behaviors including, reminders to bathe/shower. Resident 11's ISP read, "[Resident 11] will go without bathing/showering for days or weeks if staff do not prompt and remind him/her. S/He exhibits poor hygiene and self-care without staff intervention. S/He has difficulty taking care of his/her oral health and needs prompts to brush his/her teeth as well as use mouthwash to minimize breath odors. Staff will need to encourage [Resident 11] to change his/her clothes daily." Resident 11's ISP was not signed by Resident 11.

Client Notes

-01/05/2024. " ...[Resident 11] refused to get into the shower. [Resident 11] needs to wash his/her feet."

-05/30/2024. " ...[Resident 11] appeared not well groomed. His/Her nails were quite long and black colored."

-06/18/2024. " ...[Resident 11] appeared in unwashed clothes and was in need of a shave."

-07/19/2024. " ...[Resident 11] looks like s/he could use a shower and some grooming, as his/her nails are quite dirty, and his/her toenails appear to be black in several areas."

On 08/01/2024 at 11:15 a.m., Surveyor observed Resident 11 in his/her room. Resident 11's hair appeared to be unwashed and uncombed. Resident 11 was not wearing shoes. Surveyor

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N 425	Continued From page 13 observed, what appeared to be dark, brown mud in between his/her toes. His/Her toenails were long and dirty. Surveyor observed Resident 11's fingernails to be long with dark matter underneath the nails. Resident 11 was dressed in a dirty sports team jersey and dirty sports team jacket. Resident 11 told Surveyor, "My clothes are in those bags. I'd change if I had clean clothes." On 08/01/2024 at 11:22 a.m., Surveyor interviewed Operations Coordinator (OC) I, who stated. "I don't know why his/her feet look like that. I have no idea why s/he looks so unkept." OC I explained Resident 11 did shower but always puts the same clothing on. Surveyor asked if staff documented Resident 11's showers. OC I stated they should and that s/he could print the documentation. Resident 11's shower documentation was not received.	N 425		
N 433	83.38(1)(i) Behavior management. 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: Behavior management. The CBRF shall provide services to manage resident ' s behaviors that may be harmful to themselves or others. This Rule is not met as evidenced by: Based on observation, interview, and record review the provider did not arrange or provide services adequate to meet the needs of 2 of 2	N 433		

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N 433	Continued From page 14 (Resident 2 and Resident 12) residents reviewed, around behavior management. Resident 2 had a known history of behaviors including property damage, verbal, and physical aggression, urinating/defecating on self and on floors, smoking in his/her room and leaving the facility for several days with drug seeking behavior. Resident 2 was not provided adequate supervision and services to meet her/his needs. Resident 12 had a known history of excessive fluid consumption (polydipsia). Resident 12 had a history of inappropriate behaviors including leaving the facility and going onto the neighbor's property to seek liquids, money, and/or cigarettes. Resident 12 received 1:1 staffing from Behavioral Health Services (BHS) from 07/06/2023 to 07/14/2024. Resident 12's was not provided adequate supervision and services to meet her/his needs. This deficiency is being cited for a third time. See Statement of Deficiency (SOD) WFG112 dated 6/17/2021 and SOD WFG114 dated 11/02/2022. Findings include: On 04/18/2024, the department received a complaint alleging, a resident was going into public and harassing people. The resident went over to neighboring restaurant multiple times and bothered customers. On 05/22/2024 the department received a complaint alleging a resident was given a mop bucket to urinate and defecate in. This bucket was kept in his/her room. Other residents complained the resident attacked them when s/he was out of his/her room.	N 433		

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N 433	Continued From page 15 From 07/24/2024 to 09/12/2024, Surveyors reviewed Resident 2's and Resident 12's records. The following was identified: Resident 2 Resident 2 was admitted to the facility on 01/21/2020, with diagnoses including schizoaffective disorder, bipolar type. Resident 2 had a Guardian. Resident 2's record contained a nursing annual assessment dated 05/13/2024. Resident 2's annual assessment did not identify the needs, abilities, and mental condition for 2024. Under psychosocial history, tobacco use read, "Yes", with Type of tobacco handwritten in as, "Cigarettes, Crack, Marijuana." Surveyor observed a line through Marijuana and the section titled, 'amount' read "error". Bowel Patterns read, "Normal." Urinary read, "No problems." The section titled 'other' read, "Will defecate and urinate in room." Resident 2's assessment did not identify Resident 2 needed a plan to address behaviors including property damage, verbal, and physical aggression, urinating/defecating on self and on floors, and leaving the facility for several days with drug seeking behavior. Resident 2's 2024 assessment did not identify Resident 2 needed a plan to address behaviors including, physical and verbal aggression, property damage, substance abuse or elopement. The assessment did not identify a plan for Resident 2's cigarette smoking. Resident 2's Individual Service Plan (ISP) dated 05/14/2024, did not identify interventions or	N 433		

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methods to reduce behaviors including, physical and verbal aggression, property damage, cigarette smoking, substance abuse or elopement. Resident 2's ISP was not signed by Guardian X.

Resident 2's ISP required, "60-minute body checks for shift reporting, 60-minute bed checks for shift reporting and [Resident 2] is permitted 12 hours in the community between the hours of 8:00 a.m. and 8:00 p.m. due to medication passes occurring at this time period. If [Resident 2] is missing from his/her bed at 10:00 p.m. [sic] s/he should be considered AWOL and missing person protocol should be followed."

Client Notes

-04/01/2024. "[Resident 2] had already attacked several of his/her peers here at Bellwood. One of the DSP (direct support professionals) called Crisis, [sic] Crisis told the staff to call the police because it wasn't anything they could do if they wanted his/her taken to MHEC (mental health emergency center). Police squad showed up as [Resident 2] continue [sic] to attack his/her peers [sic] clawing at one of his/her her peers face as the [sic] Police was walking in the door. S/He then continued to threaten his/her peers, throw water, and smoke in the building [sic] all in front of the police. The police then called [sic] Cart (crisis assessment response team) to assess [Resident 2]. They came and spent about 10 minutes with [Resident 2] and finally said s/he was "systematic" and "it's OK to be angry [sic] but not enough to take him/her. [S/He] was being homicidal or suicidal to be taken. CART said [sic] get the case manager involved and get him/her chaptered is the only way they could take him/her in. They said continue to call if s/he is being

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N 433	Continued From page 17 problematic." -04/02/2024. "[Resident 2] went outside to smoke and another resident was outside with him/her [sic] I was watching them and s/he attempted to try and light [Resident 16] on fire and then s/he swung on him/her and kept hitting him/her which resulted in them fighting." -04/26/2024: "I checked in on [Resident 2] for a weekly check in and immediately noticed a urine stain on his/her lower part of his/her shirt along with a strong urine smell. I asked how s/he was doing, s/he mentioned that s/he was in need of some clothes. As I started to take notes, I inquired if s/he had a moment to discuss his/her needs. S/He declined and mentioned that s/he would just keep on the same clothes and walked off." -05/03/2024. "[Resident 2] has been in the activity area since this morning sleeping in there [sic] staff told him/her s/he needs to go in his/her room, s/he refused, s/he brought his/her breakfast, and lunch in there [sic] through the plates and papers all on the floor [sic] I gave him/her time to decide when s/he was going to pick up, [sic] 1:30pm [sic] I asked him/her was s/he going to pick up [sic] s/he got up [sic] very rude [sic] cursing at staff [sic] etc." -05/20/2024. "[Caregiver M] did her hourly room checks & seen [sic] there was droppings in front of [Resident 2] bed with tissues on it. [Resident 2] didn't want to get up to clean it up and told me to get out [sic] his/her room." -05/20/2024. "[Resident 2] have 4 lighters in his/her pocket and matches s/he are [sic] refusing to give up [sic]"	N 433		

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N 433	Continued From page 18 -05/20/2024. "[Resident 2] was observed outside the store on 60th and Silver Spring, panhandling. S/he tried entering the store with [Direct Personal Support (DPS) G] but the worker/owner kicked him/her outstating s/he [sic] not allowed in the store because s/he steals." -06/12/2024. "[Resident 2] continuously urinates on the bedroom floor and other places as well [sic] we ask him/her to/tell him/her to make better decisions but s/he does not listen [sic] it's becoming a habit for him/her." - 06/28/2024. "[Resident 2] allowed [DPS G] to assist with getting him/her in the shower. [DPS G] put together his/her clean clothes, towels, body soap, and allowed [DPS G] to wash a load of his/her clothes. S/He was reward [sic] by [DPS G] with cigarettes and a soda [sic] s/he was in good mood afterwards." -07/01/2024. "[Resident 2] was smoking in room and not following smoke policy." -07/19/2024. " ...It was evident that s/he could benefit from a bath, as there was a strong smell of urine present." -07/16/2024. "There were [sic] feces found on the floor from [Resident 2] [sic] so I asked [Resident 2] can they help clean up with the mess [sic] we cleaned it up and told him/her next time ask staff to let him/her in the bathroom. Then I reported it and told the OC (operations coordinator) on duty. -07/24/2024. "I was doing my rooms when I noticed that it where [sic] a big pill [sic] of feces (poop) on the side of his/her bed. I asked [Resident 2] to help me clean it up [sic] s/he	N 433		

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replied no in [sic] put the cover over his/her head. I explained to him/her where the restroom was at [sic] in the building [sic] that s/he can use."

-07/29/2024. "It was brought to my attention that [Resident 2] has been missing for approximately 72 (+) hours and a police report was being made."

-07/30/2024. "missed [sic] all meds due to her being awol."
-
07/31/2024. "Received copy of police report for missing person filed on 7/29/24. Uploaded into CURSA (on-line database) documents. Supervisor notified."

Surveyor received and reviewed Milwaukee police department reports on 08/30/2024 at 11:45 a.m. The reports identified:

-07/29/2024 at 11:10 a.m., Operations Coordinator (OC) I filed a missing person certification report for Resident 2 with the Milwaukee Police Department. The document read, "Resident 2 was last seen on 07/28/2024 at 12:00 p.m. Reason for disappearance: went to store."

-08/11/2024. Milwaukee Police Officer (PO) BB placed telephone call to OC I to check on Resident 2's status. OC I confirmed Resident 2 returned to facility on July 30th, 2024 and s/he forgot to call it in to police Department. OC I stated Resident 2 was not a victim of a crime.

Interviews

On 07/24/2024 at 10:28 a.m., Surveyor interviewed Program Manager (PM) H, who

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stated Resident 2 had behaviors including property damage, verbal, and physical aggression, not taking showers, and urinated/defecated on his/her bedroom floor. "It happens every day."

On 07/24/2024 at approximately 12:30 p.m., Surveyors interviewed Housekeeping Specialist (HS) U, who stated s/he was the only housekeeping staff in May 2024, when s/he witnessed a bucket with urine and feces in Resident 2's room. HS U stated s/he reported his/her findings to PM H or Operations Coordinator (OC) I. HS U could not confirm how long Resident 2 had a bucket in his/her room or who gave the bucket to him/her.

On 07/24/2024 at 4:10 p.m., Surveyor interviewed Program Manager (PM) H, who stated Resident 2 urinated/defecated on his/her bedroom floor daily. Surveyor asked PM H what interventions were in place for his/her behaviors. PM H stated, "Interventions don't work. We ask [Resident 2] to tell us if [s/he] needs to go to the bathroom, but [s/he] doesn't tell staff. We are currently trying to get more staff and eventually relocate [him/her]."

On 08/01/2024 at 11:11 a.m., Surveyor interviewed OC I, who stated, "[Resident 2] has been missing since Monday, July 29th. I filed a police report on Monday, July 30th. S/He got his/her debit card and disappeared." Surveyor questioned if Resident 2 had done this before. OC I confirmed, "This isn't the first time."

On 08/01/2024 at 11:25 a.m., Surveyor interviewed Caregiver L, who described where Resident 2 smoked his/her cigarettes. Caregiver L stated staff yelled out 'smoke break', every hour. Staff gave the residents who were smokers,

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one cigarette per hour. Caregiver L described an electric lighter on the wall outside so no residents needed matches or a lighter. Caregiver L stated, "They did not want residents to have matches or a lighter in their personal possession...I don't know if it's in their ISP. I don't know if they agreed. We just do it."

On 08/01/2024 at 1:27 p.m., Surveyor interviewed PM H who stated, "[Resident 2] has schizoaffective disorder and is a cocaine user." PM H could not confirm if cocaine use was recognized as one of Resident 2's diagnosis.

On 08/01/2024 at 12:05 p.m., Surveyor interviewed Caregiver K, who stated Resident 2 just disappears sometimes. "Were just supposed to report it to management. It's not normal that s/he just disappears. S/He needs care." CG K explained Resident 2 needed assistance with toileting and showering. "We try to assist him/her with toileting by checking in hourly and reminding him/her to use the bathroom. When we come back in an hour, there usually is 'feces' on the floor." Caregiver K stated the interventions provided by management were to redirect the resident. "If we cannot redirect [Resident 2], we are to get the managers." Caregiver K stated there was no written plan on 'how' to redirect [Resident 2]. Caregiver K stated, "We mostly just go on instinct." Caregiver K stated, "It would be nice to have other interventions, to know how to serve these residents better."

On 08/01/2024 at 12:45 p.m., Surveyor interviewed Caregiver Z, who stated Resident 2 had been gone from the facility since Friday, July 26th, 2024. Caregiver Z stated it was in Resident 2's ISP that s/he could come and go, as s/he pleased, from the facility. Caregiver Z stated, "It

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seems to be her routine S/he does this once a week." Caregiver Z explained every Friday, residents get money. "I think s/he saved his/her money up and went out on a cocaine binge. S/He does that sometimes."

On 08/07/2024 at 10:35 a.m., Surveyor interviewed ETM R, who stated, "Our care managers do consultations, levels of care, behaviors and behavior management and ISPs." ETM R stated, "Behavior management should be in residents ISPs."

On 08/23/2024 at 3:50 p.m., Surveyor interviewed Care Team Manager (CTM) T and Executive Team Member (ETM) R. CTM T stated Resident 2 was aggressive with throwing things in common areas. The staff tried to keep common areas free of items s/he could throw. CTM T confirmed Resident 2 would have aggressive outbursts in common areas that are directed at both staff and residents.

Surveyor asked CTM T to identify what services were in place to meet Resident 2's behaviors including property damage, verbal, and physical aggression, urinating/defecating on self and on floors, and leaving the facility for several days with drug seeking behavior. CTM T stated, "I oversee [Resident 2's] care manager. I am not his/her care manager. However, it looks like we probably need to update [Resident 2's] ISP to reflect the code."

CTM T confirmed Resident 2 was recently missing from the building for a week. CTM T stated, "A missing person's report was filed after s/he had already been gone for 72 hours. [Resident 2] saved her money, and we believe s/he went out on a cocaine binge." Surveyor

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asked what actions the facility took when they noted Resident 2 was missing. CTM T stated, "We call the family, filed a police report, and check his/her common hangouts." CTM T confirmed no other interventions were in place for Resident 12's elopement behaviors.

Resident 12

Resident 12 was admitted to the facility on 08/29/2019, with diagnoses including schizoaffective disorder. Resident 12 had a Guardian.

Resident 12's record contained an annual nursing assessment dated 05/07/2024. The annual assessment did not identify the needs, abilities, mental condition, and level of supervision required in the home and community for 2024. The nursing assessment did not address Resident 12's excessive fluid consumption (polydipsia), behaviors in the community and smoking preferences. Under psychosocial history, tobacco use read, "Yes", with Type of tobacco handwritten in as, "Cigarettes." The section titled 'amount' was left blank.

Resident 12's ISP, dated 05/17/2024, did not identify interventions or methods to reduce behaviors including, physical and verbal aggression, property damage, substance abuse or elopement. Resident 2's ISP was not signed by Guardian Y.

Residents 12's ISP did not include program service frequency, approaches to be provided, established measurable goals with specific time limits for attainment, specified methods for delivering needed care or who was responsible for delivering his/her 1:1 care. Residents 12's ISP

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N 433	Continued From page 24 did not address his/her need for 1:1 oversight or interventions for caregivers when behaviors occurred. Client Notes -01/12/2024. "[Resident 12] came to see CM (care manager). [Resident 12] was not attended by his/her 1:1. [Resident 12] was wondering around the building unattended." -07/17/2024. "[Resident 12] was with his 1-on-1 DSP (direct support worker)." -07/18/2024. "[Resident 12] was walking with his/her 1-on-1 DSP staff. [Resident 12] asked if s/he could have my coffee. I stated, 'No'." General event reports -On 07/08/2024 at 1:30 p.m., Caregiver K wrote, "Doorbell ring [sic] and I open [sic] the door and the owner of the [restaurant next door] came over and told me to keep [Resident 12] from (coming) over there." -On 07/18/2024 at 9:51 p.m., Caregiver K wrote, "[Resident 12] was outside smoking when writer notice [sic] s/he was going [sic] writer went across the street to the [restaurant next door] where s/he was , [sic] talking to and [sic] his/her kids asked for a soda. [Resident 12] tried going over there a couple times , [sic] at 6pm [sic] 7pm and 7:40pm [sic] with [Resident 12] being a line of sight [sic] we have to know where [sic] is at all time , [sic] It's getting to point s/he his (is)[sic] leaving out the back gate , [sic] and leaving out the side door by his/her room . [sic] it is starting to become a safety problem. [sic] each time s/he tried to go over there [sic] writer stopped him/her."	N 433		

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N 433	Continued From page 25 Interviews On 07/24/2024 at 10:40 a.m., Surveyors interviewed Program Manager (PM) H, who stated Resident 12 was diagnosed with polydipsia, which made him/her want to drink all the time. PM H stated s/he would grab anything to drink. Resident 12 had behavior in the facility and community. Resident 12 had a history of leaving the facility and going onto the neighbor's property asking for soda and cigarettes. Resident 12 smoked cigarettes. Resident 12 was incontinent of urine. Surveyor asked about any recent incidents in the facility or in the community. PM H explained Resident 12 went to [restaurant next door]. Resident 12 did not have 1:1 caregiver, however, staff still followed him/her. PM H stated Resident 12 did not have 1:1 supervision at that time. Resident 12 took a child's drink from him/her. The parent assaulted Resident 12. There was not police involvement as far as PM H knew. Surveyor asked PM H how provider responded to Resident 12's behavior and what behavior management was put in place after the incident. PM H told Surveyor, "We called County and told them we needed more help. We requested a 1:1 staff." PM H confirmed no other interventions were put in place to manage Resident 12's behaviors. PM H stated, "I don't think the 1:1 staffing is in [Resident 12's] individualized service plan (ISP)." On 07/25/2024 at 2:00 p.m., Surveyor interviewed Utilization Review Manager of Milwaukee County (URMC) O, who stated on 04/22/2024, BHS conducted an announced utilization review at	N 433		

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N 433	Continued From page 26	N 433		

Broadstep WI- Bellwood. BHS gave provider a list of files that would be evaluated. The resident files BHS evaluated did not have updated assessments or ISP's. URMC O stated s/he went back and forth with ETM R and discussed resident goals.

URMC O stated, "For example, if the resident wanted to get a job goal how were the providers helping the resident? What was the facility's interventions to assist the resident in meeting their goals. We spent a lot of time going back and forth assisting the facility in completing assessments and ISP's."

On 08/01/2024 at 11:25 a.m., Surveyor interviewed Caregiver L, who stated Resident 12 needed assistance with changing his/her bedsheets and clothing because s/he was incontinent of bladder. Resident 12 is supposed to shower daily. When s/he does not want to shower, Caregiver L stated, "I attempt to redirect him/her or tell him/her I'll give him/her a soda."

Caregiver L stated Resident 12 used to elope. "[Resident 12] eloped to the restaurant next door several times looking for soda. We would have to offer his/her a cigarette to come back to the facility." Caregiver L stated s/he did not know any other interventions on assisting resident back to the facility except offering him/her a soda or a cigarette. Caregiver L stated, "I don't know if there are any interventions in [Resident 12's ISP]."

On 08/07/2024 at 10:35 a.m., Surveyor interviewed ETM R, who stated, "Our care managers do consultations, levels of care, behaviors and behavior management and ISPs." ETM R stated, "Behavior management should be in residents ISPs."

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N 433	Continued From page 27 On 08/23/2024 at 4:00 p.m., Surveyor interviewed Care Team Manager (CTM) T and Executive Team Member (ETM) R. CTM T stated Resident 12's Nurse Practitioner requested a renewal of his/her 1:1 staffing of 16 hours on 04/01/2024. Surveyor asked CTM T to identify where staff would find their 1:1 staffing expectations. CTM T confirmed Resident 12 did not have behavioral management for his/her history of excessive fluid consumption (polydipsia). CTM T confirmed Resident 12 did not have behavioral management for his/her history of inappropriate behaviors including leaving the facility and going onto the neighbor's property to seek liquids, money, or cigarettes. Surveyor asked CTM T to identify in Resident 12's service plan: where his/her 1:1 oversight and interventions for caregivers were outlined, what specific program strategies and approaches were to be provided, what were the established measurable goals with specific time limits for attainment, what were the specified methods for delivering needed care and who was responsible for Residents 12. CMT stated, "That information is not part of [his/her] plan. I didn't know that was part of the code." On 08/29/2024 at 10:41 a.m., Surveyor received and email from URMC O, who stated, "I was able to look into the billing history for 1:1 services (I went back to 1/1/2020 until today's date) and can see that [Resident 12] was approved for and billed every day (16 units aka 16 hours) from 7/6/2023 to 7/14/2024 at Belwood so that coincides exactly with what you see. I do not see any other incidences of 1:1 service at Belwood for him/her before or after."	N 433		

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N 433	Continued From page 28 On 08/30/2024 at 8:20 a.m., Surveyor interviewed Guardian Y, who described Resident 12 as difficult to engage. "I think they try to get him/her to do his/her ADL's (Activities of Daily Living). His/her biggest challenge is the behavior where s/he wants to drink excessively. I have no idea what the facility is doing for that." On 08/30/2024 at 8:20 a.m., Surveyor interviewed Guardian Y who stated, a former co-worker told him/her that Resident 12 was at the restaurant next to the facility, asking people for money and cigarettes. "The facility never called me to inform me of this incident. They should have called me." Guardian Y stated, "[Resident 12] is very persistent. S/He could be taken wrong in the community It's very difficult to redirect him/her, if you don't know what you're doing, especially when s/he wants something." Cross reference N0381 DHS 83.35(1)(a) Preadmission And Ongoing Assessment Cross reference N0388 DHS 83.35(3)(a)2 Comprehensive Individual	N 433		
N 483	83.43(2)(b) Clean, comfortable mattress and pad. Bedroom furnishings. If a resident does not provide the resident ' s own bedroom furnishings, the CBRF shall provide all of the following: A clean, comfortable mattress covered with a mattress pad and when necessary, waterproof covering. This Rule is not met as evidenced by: Based on observation and interview, the provider	N 483		

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N 483	Continued From page 29 did not ensure a clean, comfortable mattress covered with a mattress pad and when necessary, waterproof covering, for 9 of 9 residents' beds observed (Resident 14, Resident 15, Resident 13, Resident 17, Resident 18, Resident 19, Resident 20, and 2 unidentified residents). Findings include: On 07/24/2024, at 9:14 a.m., Surveyor toured the facility with Program Manager (PM) F and observed the following: - Resident 14's and Resident 15's beds had pillows with a thick exterior waterproof material and no pillowcases. - Resident 13's and Resident 17's beds had pillows without pillowcases. Their mattresses had a thick exterior waterproof material, which was covered with 1 fitted sheet. - Resident 18, Resident 19, and Resident 20 shared a bedroom. Two of 3 beds, within the shared bedroom, had mattresses with a thick exterior waterproof material, which were covered with 1 fitted sheet, and the beds did not contain pillows. One mattress did not have a fitted sheet or covering, and the pillow did not contain a pillowcase. - Room #18 had 2 beds; 1 of 2 had a pillow, which did not contain a pillowcase. - Many bedrooms throughout the facility contained mattresses and pillows with a thick exterior waterproof material and were missing coverings. - Mattress pads were not observed on any residents' mattresses. - Many of the mattresses, pillows, and linens were stained.	N 483		

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N 483	Continued From page 30 On 07/24/2024, between 9:14 a.m. and 10:15 a.m., while touring the facility, Surveyor interviewed PM F. Surveyor inquired why many of the residents did not have pillows or had pillows without coverings. PM F reported staff may not be completing their rounds. PM F reported caregivers are responsible for making sure residents had beds that were clean and had the proper linens. PM F stated, "If you get the residents into it, they'll do it, they just have to be guided." On 07/24/2024, at 11:15 a.m., Surveyor interviewed Operations Coordinator (OC) I. OC I was unaware a mattress pad was required by code. OC I reported beds should be made with a plastic mattress, fitted sheet, sheet, blanket, and a pillow with a pillowcase. OC I reported s/he issued these items to each resident, but did not keep a log. S/He reported many of the residents take off pillowcases and other bed coverings.	N 483		
N 488	83.44(1)(c) Clothes dryers enclosed and vented Clothes dryers. The CBRF shall enclose any clothes dryer having a rated capacity of more than 37,000 Btu/hour in a one-hour fire resistive rated enclosure. If the clothes dryer requires a vent, the CBRF shall use dryer vent tubing that is of rigid material with a fire rating that exceeds the temperature rating of the dryer. The dryer vent tubing shall be clean and maintained. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the dryer vent tubing was clean and maintained for 2 of 3 dryers. The dryer vent tubing was disconnected on 2 of 2 dryers, and the laundry room was covered in lint.	N 488		

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N 488	Continued From page 31 Findings include: On 07/24/2024, at 9:14 a.m., Surveyor toured the facility with Program Manager (PM) F and observed the following: The laundry room on the east wing had 3 dryers. The dryer venting went up through the ceiling. The ceiling was covered in grayish fuzzy material, consistent with lint. The wall behind the dryer vent was also covered with lint. The dryer vent was disconnected from 2 of 3 dryers and lint covered the back of the dryers, the wall behind the dryers, the venting, and the electrical outlet behind the dryers. The laundry room had a ceiling vent fan, which was covered with lint, as well as the ceiling around the vent. The laundry room on the west wing had laundry piled on top of the dryers, in baskets, and on the floor. Some clothing items had fallen behind the dryers and were piled up between the dryer and the venting. On 07/24/2024, at 10:15 a.m., Surveyor interviewed PM F. PM F reported when s/he was a caregiver, s/he recalls the dryer venting in the east wing disconnecting often and having to shift it back into place. On 07/24/2024, at 10:45 a.m., Surveyor interviewed PM H. PM H reported both laundry rooms in the facility were used, but the west wing laundry room was used by staff and the east wing laundry room was used by staff and residents. PM H reported approximately 11 residents utilized the east wing laundry room to do their own laundry.	N 488		

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{N 489}	Continued From page 32	{N 489}		
{N 489}	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all rooms were kept clean and free from odors, which had the potential to affect 39 of 39 residents residing at the facility. This is a repeat deficiency. See Statement of Deficiency MRK212, dated 02/19/2024. Findings include: On 07/24/2024, at 9:14 a.m., Surveyor toured the facility with Program Manager F and observed the following: Resident 14 and Resident 15's shared room: - The room had an odor of urine masked with room freshening spray. - Resident 14's bed had a mattress covered in thick plastic material with a fitted sheet over it. Her/His bed also contained a pillow covered in a thick plastic material, without a pillowcase cover. - Resident 15's mattress covered in thick plastic material was covered with a fitted sheet and contained no other bedding or pillow. - Resident 14's and Resident 15's bedroom contained no personal items or clothing. - The clothes dresser in the room had 5 drawers. One of 5 drawer handles were broken and 1 of 5 drawers were off track and broken. - Three box style mouse traps were in the room. Resident 13 and Resident 17's shared room:	{N 489}		

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{N 489}	Continued From page 33 - Resident 13's bed had a mattress covered in thick plastic material with a fitted waterproof fitted sheet over it. Her/His bed also contained a pillow without a pillowcase cover. - Resident 17's bed had a mattress covered in thick plastic material with a fitted sheet. The frame of the bed had a thick layer of a blackish/gray substance built up in the corner, which was consistent with dirt and dust. Her/His bed also contained a pillow without a pillowcase cover. - The closet was filled with paper, wrappers, plastic bags, 3-4 pieces of clothing, and remnants consistent with food items. - The closet wall contained a thick brownish/black substance, approximately the size of nickel, which was consistent with feces. Resident 4, Resident 22, Resident 23 and Resident 9's shared room: - The room had an odor of stale/unclean laundry and urine. - The floor was tiled and contained more than 11 separate areas with brownish stains, ranging from approximately 1 inch in diameter, to over 12 inches in diameter. - An area on the floor contained a brownish pooled liquid, approximately 24 inches in diameter. Inside the pool of liquid were 2 pennies and over 30 dead flying insects. - Multiple pennies were on the floor and around the room. - Four of 5 pillows did not contain pillowcases and contained large amounts of brownish staining. - A tissue was wedged into the opening of a doorknob. - A bolt inside the hinge on a door was sticking out of the hinge approximately 1/2 inch and was propped with a pair of pliers. - The thermostat cover had been removed from a	{N 489}		

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{N 489}	Continued From page 34 thermostat and a corner of the cover was charred black. A wire from the thermostat was also removed; both were laying on the windowsill near Resident 4's bed. - The room contained 2 thermostats, one was missing the face and had exposed wires. A clear plastic box covered the thermostat and was cracked and not completely enclosing the thermostat. - An outlet was covered with a pink waxy-like substance. - The wall contained a golf ball sized circular spot of the same pink waxy-like substance, and a penny stuck to the wall in the substance. - There was dried staining of a liquid that dripped down along the wall around the outlet cover. - A grayish round putty-like substance was on the wall, consistent with a balled-up piece of gum. Resident 18, Resident 19, and Resident 20's shared room: - The room had a odor of stale/unclean laundry. - Two of 3 mattresses were covered in thick plastic material with a fitted sheet over. - One of 3 mattresses were covered in thick plastic material with a fleece blanket over it. - Two of 3 beds did not have pillows. One of the two beds had 2-3 coats rolled up, which appeared to be used as a pillow. - One of 3 beds had a heavily stained pillow, which did not contain a pillowcase. On 07/24/2024, between 9:14 a.m. and 10:15 a.m., Surveyor interviewed Program Manager (PM) F. Surveyor inquired why Resident 14 and Resident 15 appeared to have no personal belongings. PM F reported their case managers had been working with them to obtain donated clothing.	{N 489}		

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{N 489}	Continued From page 35 PM F reported Resident 13 had behaviors where s/he would attack people, take things from others, and hoard garbage and items in her/his room. Surveyor inquired about the pillows in resident rooms. PM F reported staff may not have been completing their rounds. S/He reported caregivers were required to complete hourly checks of the residents and were responsible for cleaning or picking things up the residents made a mess of. PM F and Surveyor observed the pooled liquid in Resident 4, Resident 22, Resident 23, and Resident 9's shared room. PM F bent down to smell the area of the liquid and confirmed it was urine. S/He reported Resident 4 had schizophrenia and s/he had behaviors which resulted in the staining, tampered items, and other things observed within the room. PM F reported if the caregivers guided the residents, most would have made their beds and taken care of other daily tasks.	{N 489}		
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 document evacuation drills, such as tornado, flooding or other emergency or disaster, were completed at least semi-annually for 1 of 1 year reviewed (2023). Findings include: On 07/24/2024 at approximately 3:30 p.m.,	N 526		

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N 526	Continued From page 36 Surveyor reviewed the provider's documentation of evacuation drills, including tornado, flooding or other emergency or disaster for 2023. Surveyor observed no documented evidence of other emergency or evacuation drills for 2023. On 07/24/2024, at approximately 4:03 p.m., Surveyor interviewed Program Manager (PM) H regarding the evacuation drill documentation. Surveyor asked PM H if other evacuation drills were conducted. PM H verified s/he was aware of the requirements to conduct other evacuation drills. PM H stated s/he could not verify the drills were done. PM H acknowledged that evacuation drills, such as tornado, flooding or other emergency or disaster, should have been completed at least semi-annually.	N 526		
N 601	83.54(3)(a) Bedrooms: no more than 2 residents. Resident bedrooms shall accommodate no more than 2 residents per room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident bedrooms did not accommodate more than two residents per room. Three rooms within the facility were accommodating more than 2 residents, which had the potential to affect 10 residents (Resident 6, Resident 8, Resident 21, Resident 18, Resident 19, Resident 20, Resident 4, Resident 22, Resident 23, and Resident 9). Findings include: On 07/24/2024, at 9:14 a.m., surveyor toured the facility. During the tour Surveyor observed the	N 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0010783	A. BUILDING: _____ B. WING _____	R-C 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC. (BELWOOD)	5151 W SILVER SPRING DRIVE MILWAUKEE, WI 53218

(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 601	Continued From page 37 occupied bedrooms. Bedroom #8 was occupied by 3 residents. Bedroom #7 was occupied by 3 residents. A bedroom, which did not have a room number, but was presumed to be bedroom #6 based on numbered order, was occupied by 4 residents. Resident 6, Resident 8, Resident 21, Resident 18, Resident 19, Resident 20, Resident 4, Resident 22, Resident 23, and Resident 9 were in shared bedrooms with more than 2 residents. On 07/24/2024, at 2:03 p.m., Surveyor interviewed Program Manager (PM) H. PM H reported 22 residents (Residents 24, 25, 26, 14, 15, 27, 28, 29, 12, 5, 17, 13, 6, 8, 21, 18, 19, 20, 4, 22, 23, and 9) had been relocated from the west wing to the north wing of the facility, due to the fire which occurred on 03/14/2024. The rooms in which these residents were relocated were prior offices, and not planned resident rooms. PM H reported the relocated residents were there temporarily while construction was going on in the west wing.	N 601		
N 608	83.55(1)(a) One toilet, sink, and bath or shower The CBRF shall provide at least one toilet, one sink and one bath or shower for every 10 residents and other occupants or fraction thereof. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the facility had one sink, and bath or shower to every 8 residents. The facility's census was 39, and the facility had a total of 4 sinks and 2 showers accessible to all residents. This had the potential to affect 39 of 39 residents. Findings include:	N 608		

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BROADSTEP-WISCONSIN, INC. (BELWOOD)	5151 W SILVER SPRING DRIVE MILWAUKEE, WI 53218

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N 608	Continued From page 38 On 07/24/2024, at 9:14 a.m., Surveyor toured the facility and observed the following: North Wing - 1 women's bathroom with 3 toilets and 2 sinks (The women's bathroom was locked and not freely accessible to residents.) - 1 men's bathroom with 2 toilets, 1 urinal, and 2 sinks - 1 individual bathroom with 1 toilet and 1 sink East Wing - 2 individual bathrooms within resident rooms, with 1 toilet and 1 sink each - 2 shower rooms, with 1 shower each - 1 individual bathroom with 1 toilet and 1 sink West Wing - The west wing was under construction due to a fire, and not accessible to residents. In total, the facility had 5 toilets, 4 sinks, and 2 showers available for all resident use. The census at the time of the survey was 39, and required a minimum of 4.875 toilets, sinks, and bath/showers to meet code requirements. The facility did not have enough sinks or bath/showers to meet the code requirements. Thirty-nine residents were sharing 4 sinks and 2 showers. Two of the 5 toilets were available for the female residents at the facility to utilize, which were also shared with the male residents, as they were in individual bathrooms, not gender specific bathrooms. On 07/24/2024, at approximately 10:00 a.m., Surveyor interviewed Program Manager (PM) F. PM F reported the women's bathroom on the north wing was kept locked; staff had a key to open it on the request of a resident. This bathroom was kept locked due to its location in	N 608		

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N 608	Continued From page 39 the north wing, where one female resident resided. The rest of the female residents resided in the east wing, which was within the same hallway as the north wing. It was kept locked to prevent the males from utilizing the women's bathroom.	N 608		
N 650	83.59(4)(b) Delayed egress: locking device sign posted Delayed egress door locks are permitted with department approval only in facilities with a supervised automatic fire sprinkler system and a supervised interconnected automatic fire detection system and shall comply with all of the following: A sign shall be posted adjacent to the locking device indicating how the door may be opened. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a sign was posted adjacent to the locking device indicating how the door may be opened for 6 of 6 delayed egress doors. Findings include: The provider is licensed to care for up to 46 residents within the client groups of developmentally disabled, emotionally disturbed/mental illness, and alcohol/drug dependent. On 07/24/2024, at 9:14 a.m., Surveyor toured the facility with Program Manager (PM) F. Surveyor observed 6 exits which were equipped with delayed egress locking devices. None of the exits	N 650		

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N 650	Continued From page 40 had a sign which indicated an individual must push on the door for 15 seconds in order for the lock to release and the door to open. On 07/24/2024, at 2:20 p.m., Surveyor interviewed Program Manager (PM) H. PM H reported the facility had signs for the delayed egress, but they were not posted. PM H stated, "Some residents can't read, and some residents won't read." PM H reported s/he was unaware it was a code requirement for the signs to be posted. PM H reported s/he would locate the signs and have maintenance post them adjacent to the delayed egress doors. Prior to Surveyor exiting the facility, the signs were posted at the delayed egress exits.	N 650		