STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	310134	A. BUILDING: _____ B. WING _____	C 04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC (BELWOOD VII	1141 N 46TH ST MILWAUKEE, WI 53208

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N 000	Initial Comments On 04/10/2025, Surveyor completed a standard survey and 2 complaint investigations at Broadstep-Wisconsin Belwood VIII Martin. As a result, 8 deficiencies were identified, and 2 complaints were unsubstantiated. Census: 6	N 000		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis (TB), within 90 days before the start of employment for 1 of 2 caregivers reviewed (Caregiver D). Findings include:	N 220		

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

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N 220	Continued From page 1 On 04/04/2025, at 11:45 AM, Surveyor reviewed Caregiver D's file. Caregiver D was hired on 05/16/2023. Caregiver D's record did not contain evidence Caregiver D was screened for communicable diseases including TB. On 03/31/2025, at 3:30 PM, Surveyor interviewed Operational Director A. Operational Director A confirmed the code requirement. Operational Director A reported s/he was unable to locate the communicable disease screening or TB test in Caregiver D's file.	N 220		
N 400	83.37(1)(a) Written order for medications, supplements. Practitioner ' s order. There shall be a written practitioner ' s order in the resident ' s record for any prescription medication, over-the-counter medication or dietary supplements administered to a resident. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure a written practitioner's order was in 2 of 2 resident records (Resident 1 and Resident 2). Findings include: On 04/04/2025, at 10:56 AM, Surveyor observed resident medications. Resident medications were stored in a locked filing cabinet. Each resident had their own plastic container. Inside the plastic	N 400		

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N 400	Continued From page 2 containers, Surveyor observed the following: Resident 1 had a bottle of aspirin 325 milligram (mg) and a bottle of ibuprofen 200 mg. Resident 2 had a bottle of fluticasone propionate/salmeterol nasal spray. On 04/04/2025, at 11:30 AM, Surveyor reviewed resident records and identified the following: Resident 1 was admitted on 03/24/2025. Surveyor reviewed Resident 1's April 2025 medication administration record (MAR). Surveyor did not review aspirin or ibuprofen on the MAR. Resident 1's record did not contain evidence of a written practitioner's order for Resident 1's medications. Resident 2 was admitted on 03/24/2025. Surveyor reviewed Resident 2's April 2025 MAR. Surveyor reviewed fluticasone propionate/salmeterol nasal spray was on Resident 2's MAR as a PRN. Resident 2's MAR did not indicate how Resident 2 should be administered the medication. Resident 2's record did not contain evidence of a written practitioner's order for Resident 2's medications. On 04/04/2025, at 12:25 PM, Surveyor interviewed Clinical Director B. Clinical Director B reported all residents required staff administration with medications and no residents self-administer their medications. Clinical Director B reported residents either come with their medications or they pick them up from the pharmacy. Clinical Director B reported they did not have physician orders. Cross Reference DHS N0401 83.37(1)(b)	N 400		

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N 400	Continued From page 3 Medication Label Permanently Attached	N 400		
N 401	83.37(1)(b) Medication label permanently attached. Medications. Prescription medications shall come from a licensed pharmacy or a physician and shall have a label permanently attached to the outside of the container. Over-the-counter medications maintained in the manufacturer ' s container shall be labeled with the resident ' s name. Over-the-counter medications not maintained in the manufacturer ' s container shall be labeled by a pharmacist. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure medications were labeled to ensure proper and safe usage for 1 of 1 resident (Resident 2). Findings include: On 04/04/2025, at 10:56 AM, Surveyor observed resident medications. Resident medications were stored in a locked filing cabinet. Each resident had their own plastic container. Inside the plastic containers, Surveyor observed a bag with Resident 2's name, date of birth and "PRN" [as needed] written in black marker. Inside the bag was a bottle of fluticasone propionate/salmeterol nasal spray. Surveyor did not observe label on the bottle or directions of use listed on the bag. On 04/04/2025, at 11:30 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 03/24/2025. Surveyor reviewed Resident 2's April 2025 MAR. Surveyor reviewed fluticasone propionate/salmeterol nasal spray was on	N 401		

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N 401	Continued From page 4 Resident 2's MAR as a PRN. Resident 2's MAR did not indicate how Resident 2 should be administered the medication. Resident 2's record did not contain evidence of a written practitioner's order for Resident 2's medications. On 04/10/2025, at 2:45 PM, Surveyor interviewed Administrator D. Administrator D acknowledged the medications should be labeled. Cross Reference DHS N0400 83.37(1)(a) Written Order for Medications, Supplements	N 401		
N 404	83.37(1)(e) Medication regimen, administration review. Medication Regimen Review. 1. If residents ' medications are administered by a CBRF employee, the CBRF shall arrange for a pharmacist or a physician to review each resident ' s medication regimen. This review shall occur within 30 days before or 30 days after the resident ' s admission, whenever there is a significant change in medication, and at least every 12 months. 2. At least annually, the CBRF shall have a physician, pharmacist, or registered nurse conduct an on-site review of the CBRF ' s medication administration and medication storage systems. 3. The CBRF shall obtain a written report of findings under subds. 1. and 2., and address any irregularities for appropriate action. When the review is done by someone other than the prescribing practitioner, the prescribing practitioner shall receive a copy of the report when there are irregularities identified with the resident's medication regimen, which may need physician involvement to address.	N 404		

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N 404	Continued From page 5 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 04/04/2025, at 11:15 AM, Surveyor requested the review of the provider's medication administration and storage system for 2023 and 2024. On 04/04/2025, at 11:25 AM, Surveyor interviewed Operational Director A, Clinical Director B and Nurse C. Nurse C reported s/he would need to see where the reviews were. Clinical Director B reported they switched programing to a crisis unit and had not been in the facility for a year, so they would not be responsible for the medication review until after 1 year. Surveyor relayed the facility had maintained a CBRF license and the codes were still required to be followed. Operational Director A confirmed there were residents in the facility prior to the programming being changed and reported they would reach out to the other program nurse. As of 04/10/2025, at 2:00 PM, no documentation was sent to Surveyor.	N 404		
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	N 499		

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N 499	Continued From page 6 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 in the kitchenette areas. Findings include: The facility is license to serve up to 8 residents in client group emotionally disturbed/mental illness. On 04/04/2025, at 1:25 PM, Surveyor toured the facility and observed the following: Basement There was no door to the basement. On a shelf in the basement was 4 bottles of Purbright germicide bleach, a bottle of Microban sanitizing spray and 3 containers of Amazon disinfecting wipes. Kitchen In a cabinet under the sink was a bottle of Zep disinfectant spray, 2 bottles of Pledge, and a container of Amazon disinfecting wipes. There was no locking mechanism on the cupboard door. On 04/04/2025, at 1:30 PM, Surveyor interviewed Operational Director A. Operational Director A reported the cleaning supplies in the basement was supposed to be put in a locked closet area in the basement. Operational Director A reported the cleaning supplies just came in and staff had not had an opportunity to put the items in the locked closet. Operational Director A confirmed the cleaning supplies were to be securely stored.	N 499		

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N 499	Continued From page 7 Operational Director A reported there was not to be cleaning supplies under the sink.	N 499		
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 residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure quarterly fire drills were conducted for 1 of 2 years reviewed. There were no drills conducted in 2023. The drills conducted in 2024 did not include a time the drill was conducted. Findings include: On 04/04/2025, at 11:15 AM, Surveyor requested to review safety files.	N 525		

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N 525	Continued From page 8 On 04/04/2025, at 4:14 PM, Surveyor reviewed the safety files sent via fax sent by Manager A. The documentation of the drills conducted in 2024 did not indicate a time the fire drills were conducted. Surveyor did not review any evidence of fire drills conducted in 2023. On 04/07/2025 at 10:50 AM Surveyor received an email from Operational Director A. Operational Director A reported s/he was unable to locate 2023 fire drills.	N 525		
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 semi-annually for 2 of 2 years. There were no other emergency or disaster drills conducted in 2023 or 2024. Findings include: On 04/04/2025, at 11:15 AM, Surveyor requested to review safety files. On 04/04/2025, at 4:14 PM, Surveyor reviewed the safety files sent via fax sent by Manager A. The safety files did not contain evidence of other emergency or disaster drills for 2023 and 2024. On 04/10/2025, at 2:45 PM, Surveyor interviewed Administrator D. Administrator D confirmed the	N 526		

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N 526	Continued From page 9 code requirement. Administrator D reported they complete tornado drills twice a year. Administrator D did not report where the documentation was.	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 1 of 2 years reviewed. Findings include: On 04/04/2025, at 11:15 AM, Surveyor requested to review safety files. The documentation indicated a fire inspection was conducted on 11/09/2023. Surveyor did not review evidence of a fire inspection conducted in 2024. On 04/10/2025, at 2:45 PM, Surveyor interviewed Administrator D. Administrator D confirmed the code requirement. Administrator D reported s/he thought the fire inspection was in an email sent to Surveyor.	N 530		