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 _____	R-C 05/27/2026

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

(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 05/27/2026, Surveyor completed a verification visit and one complaint investigation at Broadstep - Wisconsin INC (Belwood VII Martin). Two of the previous 8 deficiencies were corrected. Seven deficiencies were identified. Five of the seven deficiencies were repeat violations, see Statement of Deficiency OCIK11, dated 04/27/2025. One complaint was substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 7	{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 diseases	{N 220}		

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

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{N 220}	Continued From page 1 including tuberculosis (TB), within 90 days before the start of employment for 1 of 2 caregivers reviewed (Caregiver I). Caregiver I's communicable disease screening and TB test were not signed by a physician, physician assistant (PA), or a licensed registered nurse (RN). This is a repeat deficiency, see Statement of Deficiency OCIK11, dated 04/27/2025 Findings include: On 05/27/2026, at approximately 11:20 AM, Surveyor reviewed Caregiver I's file. Caregiver I was hired on 01/05/2026. Caregiver I's record contained a communicable disease screening and the results of a TB skin test, dated 01/05/2026, signed by a medical assistant. The TB and communicable disease screening were not signed by a physician, PA, or an RN. On 05/27/2026, at approximately 1:15 PM, Surveyor interviewed House Manager F and Executive Team Member G. Executive Team Member G confirmed the code requirement. House Manager F and Executive Team Member G reported they were unaware Caregiver I's communicable disease screening and TB skin test were not signed by a physician, PA, or an RN. House Manager F and Executive Team Member G reported the facility would ensure future staff members communicable disease screening and TB test were signed off by a physician, PA, or RN.	{N 220}		
N 328	83.31(4)(c) Involuntary discharge notice requirements.	N 328		

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N 328	Continued From page 2 Discharge or transfer initiated by CBRF. Notice requirements. Every notice of involuntary discharge shall be in writing to the resident or resident ' s legal representative and shall include all of the following: 1. A statement setting forth the reason and justification for discharge listed under par. (b). 2. A statement that the resident or the resident ' s legal representative may ask the department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the department ' s regional office with a copy to the CBRF. The notice shall state that the request must provide an explanation why the discharge should not take place. 3. The name, address and telephone number of the department ' s regional office director. 4. The name, address and telephone number of the regional office of the board on aging and long term care ' s ombudsman program. For residents with developmental disability or mental illness, the notice shall include the name, address and telephone number of the protection and advocacy agency designated under s. 51.62(2)(a), Stats. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that an involuntary discharge notice provided to 1 of 1 resident (Resident 3), included all required information. The notice did not include a statement that the resident may ask the Department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the Department's regional office with a copy to the CBRF. The notice did not state that the request must provide an explanation why the discharge should not take place. The notice did	N 328		

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N 328	Continued From page 3	N 328		

not include the name, address and telephone number of the Department's regional office director or the name, address, and telephone number of the Wisconsin Board on Aging and Long-Term Care's ombudsman program.

Findings include:

On 04/22/2026, the Department received a complaint alleging a resident was being wrongfully discharged from the facility.

On 05/27/2026, at approximately 11:30 AM, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 02/16/2026 and discharged from the facility on 05/08/2026. Resident 3's file contained an involuntary discharge notice dated 04/08/2026. The notice stated, "...Dear [Resident 3] this letter serves formal notice that your participation in the CSH Program will end effective 05/08/2026. This decision has been made due to ongoing behavioral concerns that have negatively impacted program operations, staff, and/or other participants. Despite prior discussion, interventions, and attempts to address these concerns, the behaviors have continued. Behaviors Include:

- Repeated violation of program rules/policies
- Noncompliance with agreed upon behavior expectations
- Inability to remain clean and sober
-

During the next 30 days, we encourage you to work with your outside case management agency to develop an appropriate transition plan and identify alternative housing, services, or supports as needed. Program staff will remain available to assist with referrals and coordination during this

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N 328	Continued From page 4 transition period. Please understand that any immediate threats to safety, violence, illegal activity, or severe policy violations during this notice period may result in an accelerated discharge in accordance with program policies. If you would like to discuss this decision or need assistance with transition planning, please contact [House Manager F] at [phone number/email]. We appreciate the opportunity to have worked with you and wish you the best moving forward..." The notice did not include a statement that the resident may ask the Department to review the involuntary discharge by sending a written request within 10 days of receipt of the discharge statement to the Department's regional office with a copy to the CBRF. The notice did not state that the request must provide an explanation why the discharge should not take place. The notice did not include the name, address and telephone number of the Department's regional office director or the name, address, and telephone number of the Wisconsin Board on Aging and Long-Term Care's ombudsman program. On 05/27/2026, at approximately 1:15 PM, Surveyor interviewed House Manager F and Executive Team Member G. House Manager F reported s/he was unaware of the code requirement to ensure the involuntary notice contained the required documentation. House Manager F reported s/he would ensure future 30-day notices contained the required information.	N 328		

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{N 400}	Continued From page 5	{N 400}		
{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 1 of 2 resident records (Resident 4). This is a repeat deficiency. See Statement of Deficiency OCIK11, dated 04/27/2025. Findings include: On 05/27/2026, at approximately 9:15 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 the following: Resident 4's bin contained 1 over the counter (OTC) container of ibuprofen 200 milligram (mg), 1 OTC container Centrum multivitamins, 1 OTC container of Excedrin (acetaminophen 250mg, aspirin 250mg and caffeine 65mg) capsules, and 1 OTC container of Benadryl 25mg capsules. On 05/27/2026, at approximately 11:30 AM, Surveyor reviewed Resident 4's record. Resident	{N 400}		

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{N 400}	Continued From page 6 4 was admitted on 01/02/2026. Surveyor reviewed Resident 4's May 2026 medication administration record (MAR). The MAR indicated ibuprofen 800mg Sig: take 1 tablet by mouth three times a day as needed for pain. The MAR did not indicate ibuprofen 200mg tablets for her/his ibuprofen order. The MAR did not include Centrum multivitamins, Excedrin, or Benadryl 25mg. Resident 4's record did not contain evidence of a written physician order for the OTC medications in Resident 4's medication bin. On 05/27/2026, at approximately 1:15 PM, Surveyor interviewed House Manager F, Executive Team Member G, and Registered Nurse (RN) H. House Manger F confirmed staff administer medications to Resident 4. House Manager F reported Resident 4 obtains her/his medications from a local pharmacy and provides them to facility staff. Surveyor inquired if House Manager F was aware Resident 4's ibuprofen in her/his mediation drawer was an OTC container and did not come from a pharmacy or match the physician order. House Manager F reported s/he was not aware. House Manager F reported s/he believed Resident 4 obtained the OTC medication and provided it to staff who did not verify the medication with the physician order before accepting it. RN H confirmed Resident 4's ibuprofen needed to be filled at a pharmacy and not filled with OTC medications. RN H confirmed if residents take OTC medications the facility needs to obtain a physician order for the medications so staff can administer the medications. Cross Reference DHS N0401 83.37(1)(b) Medication Label Permanently Attached	{N 400}		

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{N 401}	Continued From page 7	{N 401}		
{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 over the counter (OTC) medications were labeled with resident information for 1 of 2 residents (Resident 4). This is a repeat deficiency. See Statement of Deficiency OCIK11, dated 04/27/2025. Findings include: On 05/27/2026, at approximately 9:15 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 the following: Resident 4's bin contained 1 over the counter (OTC) container of ibuprofen 200 milligram (mg), 1 OTC container of Centrum multivitamins, 1 OTC container of Excedrin (acetaminophen 250mg, aspirin 250mg and caffeine 65mg) capsules, and 1 OTC container of Benadryl 25mg capsules. Surveyor did not observe a label with Resident 4's name on her/his ibuprofen,	{N 401}		

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{N 401}	Continued From page 8 multivitamin, Excedrin, or Benadryl medications. On 05/27/2026, at approximately 11:30 AM, Surveyor reviewed Resident 4's record. Resident 4 was admitted on 01/02/2026. Surveyor reviewed Resident 4's May 2026 medication administration record (MAR). The MAR indicated ibuprofen 800mg Sig: take 1 tablet by mouth three times a day as needed for pain. The MAR did not indicate ibuprofen 200mg tablets for her/his ibuprofen order. The MAR did not include Centrum multivitamins, Excedrin, or Benadryl 25mg. Resident 4's record did not contain evidence of a written physican order for Resident 4's OTC medications. On 05/27/2026, at approximately 1:15 PM, Surveyor interviewed House Manager F, Executive Team Member G, and Registered Nurse (RN) H. House Manger F confirmed staff administer medications to Resident 4. House Manager F reported Resident 4 obtains her/his medications from a local pharmacy and provides them to facility staff. Surveyor inquired if House Manager F was aware Resident 4's ibuprofen in her/his mediation drawer was an OTC container and did not come from a pharmacy or make the provider order. House Manager F reported s/he was not aware. House Manager F reported s/he believed Resident 4 obtained the OTC medication and provided it to staff who did not verify the medication with the physician order before accepting it. RN H confirmed Resident 4's ibuprofen needed to be filled at a pharmacy and not filled with OTC medications. RN H confirmed if residents take OTC medications the facility needs to obtain a physician order for the medications so staff can administer the medications. RN H acknowledged the medications should be labeled.	{N 401}		

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{N 401}	Continued From page 9 Cross Reference DHS N0400 83.37(1)(a) Written Order for Medications, Supplements	{N 401}		
{N 499}	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were securely stored in 1 of 2 areas. Cleaning compounds and toxic substances were not securely stored in the kitchenette areas. This is a repeat deficiency. See Statement of Deficiency OCIK11, dated 04/27/2025. Findings include: The facility is license to serve up to 8 residents in client group emotionally disturbed/mental illness. On 05/27/2026, at approximately 9:00 AM, Surveyor toured the kitchen and observed the following. In a cabinet under the sink was a bottle of AJAX Bleach powder and a gallon bottle of Pure Bright ultra bleach. There was no locking mechanism on the cupboard door. On 05/27/2026, at approximately 1:15 PM, Surveyor interviewed House Manager F and Executive Team Member G. House Manager F and Executive Team Member G confirmed the cleaning supplies were to be securely stored.	{N 499}		

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{N 499}	Continued From page 10 House Manager F had cleaning supplies locked/secured by a staff member during the exit conference. House Manager F reported s/he would ensure cleaning supplies remained locked.	{N 499}		
{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 1 of 2 years. There were no other emergency or disaster drills conducted in 2025. This is a repeat deficiency. See Statement of Deficiency OCIK11, dated 04/27/2025. Findings include: On 05/27/2026 at approximately 10:45 AM, Surveyor reviewed facility safety files. Surveyor did not locate, or review evidence of tornado, flooding, or other emergency or disaster drills conducted semi-annually in 2025 in the facility safety files. On 05/27/2026, at approximately 1:15 PM, Surveyor interviewed House Manager F and Executive Team Member G. House Manager F and Executive Team Member G confirmed the code requirement. Executive Team Member G reported the facility did conduct other drills in 2025. Executive Team Member G could not	{N 526}		

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{N 526}	Continued From page 11 locate and did not provide Surveyor with proof of other drills conducted in 2025.	{N 526}		