STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009565	A. BUILDING: _____ B. WING _____	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC. (FLORIST)	7401 W FLORIST AVE 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 08/15/2025, Surveyor conducted a standard survey at Broadstep-Wisconsin (Florist). Thirteen deficiencies were identified. Census: 06	N 000		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 3 residents reviewed had pre-admission or ongoing assessments. Resident 1 and Resident 2 did not have assessments in their records. Findings include: On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted 10/27/2023 with diagnoses including schizophrenia, diabetes mellitus, chronic pancreatitis, hepatitis C. There was no assessment in Resident 1's file.	N 381		

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

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N 381	Continued From page 1 On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 2's file. Resident 2 was admitted 06/20/2025, with diagnoses including schizophrenia, impacted cerumen, poor dentition, latent tuberculosis, and latent syphilis. There was no assessment in Resident 2's file. On 08/15/2025 at approximately 2:00 PM, Surveyor interviewed Program Manager (PM) A. PM A stated, "The Case Manger is responsible for doing assessments, I don't think they were done." Surveyor asked PM A about Chapter DHS 83 requirements for assessments. Program Manager A acknowledged that Chapter DHS 83 requires the facility to conduct assessments to assess abilities and needs of residents. PM A was unsure why the assessments were not completed.	N 381		
N 386	83.35(3)(a) Comprehensive Individualized Service Plan Comprehensive individual service plan. Scope. Within 30 days after admission and based on the assessment under sub. (1), the CBRF shall develop a comprehensive individual service plan for each resident. The individual service plan shall include all of the following: 1. Identify the resident ' s needs and desired outcomes. 2. Identify the program services, frequency and approaches under s. HFS 83.38(1) the CBRF will provide. 3. Establish measurable goals with specific time limits for attainment. 4. Specify methods for delivering needed care and who is responsible for delivering the care.	N 386		

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N 386	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident had a comprehensive individualized service plan which identified the methods for delivering needed cares for 1 of 1 resident. Resident 2's ISP was not developed. Staff had no written direction instructing how to deliver needed care. Findings include: On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 2's record. Resident 2 was admitted on 06/20/2025, with diagnoses including schizophrenia, impacted cerumen, poor dentition, latent tuberculosis, and latent syphilis. On 08/15/2025, at approximately 2:00 PM, Surveyor interviewed Direct Service Personnel (DSP) D. DSP D stated, "The Case Manger is responsible for doing the ISPs. They may have been completed but I don't know how to find them." DSP D reported staff were trained how to work with the residents by informing them of any changes and hands on training when they were hired. On 08/15/2025 at approximately 2:00 PM, Surveyor interviewed Program Manager A who confirmed the need to develop an ISP for each resident. Program Manager A stated, "I only have the face sheet. I guess the Case Manager [Case Manager C] has not done the Individual Service Plan or the Behavioral Support Plan."	N 386		
N 389	83.35(3)(d) Service plans updated annually or on changes	N 389		

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N 389	Continued From page 3	N 389		

Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure each resident's Individualized Service Plan (ISP) was updated annually for 1 of 1 resident reviewed. Resident 1's ISP was due to be updated in July 2024 and July 2025 and was not.

Findings include:

On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted 10/27/2023 with diagnoses that included but are not limited to: schizophrenia, diabetes mellitus, chronic pancreatitis, hepatitis C.

Resident 1's ISP was dated 07/07/2023. Resident 1 was listed as their own person and had signed the ISP but not dated it. Resident 1's ISP was due for a review by 07/07/2024 and 07/07/2025. Resident 1's record did not include ISPs from 2024 or 2025.

On 08/15/2025 at approximately 2:00 PM,

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N 389	Continued From page 4 Surveyor interviewed Program Manager (PM) A. Program Manager A stated, "The Case Manger is responsible for doing the ISP's. They may have been completed but I don't know how to find them." Surveyor advised Program Manager A on Chapter DHS 83 requirements for annual ISP's. Program Manager A acknowledged that Chapter DHS 83 requires the facility to do annual ISPs.	N 389		
N 391	83.35(3)(f) Staff access to assessment and ISP Availability. All employees who provide resident care and services shall have continual access to the resident ' s assessment and individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure all staff who provided resident care and services had continual access to the resident's assessment and Individual Service Plan (ISP) for 2 of 2 residents reviewed (Residents 1 and 2) who resided in the facility at the time of the survey. Findings include: On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted 10/27/2023 with diagnoses that included but are not limited to: schizophrenia, diabetes mellitus, chronic pancreatitis, hepatitis C. There was no assessment or current ISP available for staff to access. On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 2's file. Resident 2 was admitted 06/20/2025, with diagnoses that include but are	N 391		

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N 391	Continued From page 5 not limited to: schizophrenia, impacted cerumen, poor dentition, latent tuberculosis, and latent syphilis. There were no documented assessments or ISPs in Resident 2's file for staff to access. On 08/15/2025, at approximately 10:30 AM, Surveyor interviewed Direct Services Personnel D (DSP D). DSP D stated, "I'm not sure where the resident records are kept. I just know their diagnosis listed on the MARs [Medication Administration Records]." On 08/15/2025 at approximately 2:00 PM, Surveyor interviewed Program Manager (PM) A regarding staff access to resident assessments and ISPs. Program Manager A stated, "The Case Manager is responsible for doing the ISPs and making them available to staff. They may have been completed in the electronic files, but I don't know how to find them." Surveyor advised Program Manager A on Chapter DHS 83 requirements for staff to have access to resident ISPs. Program Manager A acknowledged that Chapter DHS 83 requires the facility to make them available to staff.	N 391		
N 392	83.35(4) Resident satisfaction evaluation. Satisfaction evaluation. At least annually, the CBRF shall provide the resident and the resident ' s legal representative the opportunity to complete an evaluation of the resident ' s level of satisfaction with the CBRF ' s services. The evaluation shall be completed on either a department form or a form developed by the CBRF and approved by the department. This Rule is not met as evidenced by:	N 392		

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N 392	Continued From page 6 Based on record review and staff interview, the provider did not provide 1 of 1 resident reviewed (Residents1) and/or their legal representatives, an opportunity to complete an evaluation of the resident's level of satisfaction within the community-based residential facility (CBRF) services. Findings include: The facility is licensed as a class AA (ambulatory) facility for 8 residents with programs in advanced age, developmentally disabled and emotionally disturbed/mental illness. On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 1's record. Resident 1 was admitted 10/27/2023 and was his/her own person. Resident 1's record did not contain evidence of an annual satisfaction survey provided for calendar years 2024. On 08/15/2025 at approximately 2:00 PM, Surveyor interviewed Program Manager (PM) A regarding the resident satisfaction survey. PM A stated, " I didn't know we had to do those." Surveyor advised Program Manager A on Chapter DHS 83 requirements for annual satisfaction surveys for all residents. PM A stated, " I will look into that."	N 392		
N 393	83.35(5)(a) Initial evaluation of evacuation limitations. Initial evaluation. The CBRF shall evaluate each resident within 3 days of the resident ' s admission to determine whether the resident is able to evacuate the CBRF within 2 minutes in an unsprinklered CBRF and 4 minutes in a	N 393		

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N 393	Continued From page 7 sprinklered CBRF without any help or verbal or physical prompting, and what type of limitations that resident may have that prevent the resident from evacuating the CBRF within the applicable period of time. A form provided by the department shall be used for the evaluation. The resident ' s evaluation shall be retained in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate each resident within 3 days of their admission to identify any evacuation limitations the resident may have for 1 of 1 resident. Resident 2 was admitted on 06/20/2025 and did not have an evacuation assessment completed. Findings include: On 08/15/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted 06/20/2025. Resident 2's record contained no evidence an evacuation assessment was completed since moving into the facility. On 08/15/2025 at approximately 2:00 PM, Surveyor interviewed Program Manager (PM) A. PM A confirmed there were no evacuation assessments for Resident 2. PM A acknowledged all residents must be evaluated/assessed for evacuation limits annually.	N 393		
N 394	83.35(5)(b) Annual evaluation of evacuation limits Evaluation update. The CBRF shall evaluate each resident ' s mental or physical capability to respond to a fire alarm at least annually or when	N 394		

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N 394	Continued From page 8 there is a change in the resident ' s mental or physical capability to respond to a fire alarm. This Rule is not met as evidenced by: Based on record review and interview, the provider did not evaluate each resident's mental or physical capability to respond to a fire alarm at least annually for 1 of 1 resident reviewed (Resident 1) who required an annual review in 2023 and 2024. Findings include: On 08/15/2025 at 10:00 AM, Surveyor reviewed Resident 1's record and identified the following: Resident 1 was admitted 10/27/2023 with diagnoses that included but are not limited to: schizophrenia, diabetes mellitus, chronic pancreatitis, hepatitis C. Resident 1's record contained no evidence an evacuation assessment was completed in 2023 or 2024. On 08/15/2025 at approximately 2:00 PM, Surveyor interviewed Program Manager (PM) A. PM A confirmed that there were no evacuation assessment for Resident 1. Administrator A acknowledged all residents must be evaluated/assessed for evacuation limits annually.	N 394		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room.	N 481		

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N 481	Continued From page 9	N 481		

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure 6 of 6 residents were provided a living environment that is safe, clean, comfortable, and homelike. The exterior of the home had cigarette butts on the steps to enter/exit the facility and in the grass and around the entries. Some bedrooms smelled of urine. Bedrooms had stains on flooring, walls, and on furniture which required cleaning and possibly repairs.

Findings include:

The provider is licensed to serve 8 residents who are developmentally disabled, advanced aged and/or emotionally disturbed/mental illness.

On 08/15/2025, Surveyor toured the facility and observed the following:

-Outside the facility at both front doors, cigarette butts were observed in the grass, on the steps, and around the front area.
-Outside the back door cigarette butts were observed around the foundation of the house and in the grass.

Kitchen:
-The oven contained a thick, black, flaky substance in the bottom consistent with burnt food.
-Six cabinet doors contained a thick, sticky, black substance on the edge of the cabinet doors. Surveyor was able to scratch off the substance with a fingernail.

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N 481	Continued From page 10 Bedrooms: Bedroom #3 -Had a very strong odor consistent with urine. -Surveyor observed dirty clothing throughout the room and in a wash-basket without a cover. -Resident bed had a plastic covered mattress and no sheets. There was one pillow with a soiled white pillowcase that had gray staining throughout 90% of the case. -The hardwood floor was stained with what appeared to be dirt and debris across 50% of the open space. Floor fan with protective grates was 70% covered in approximately ¼ inch of what appeared to be dust and dirt. -Cold air return was covered with 1/8-inch-thick gray substance, consistent with dust. -Light switch plate contained thick, black and brown sticky substance across 50% of the surface. Bedroom #4 -Doorknob had a gold-colored plate that was covered in fingerprints and sticky to the touch. -Resident bed had a plastic covering over the mattress with no sheets. There was one pillow with no pillowcase. The bed had a cigarette butt, a crumpled up soiled paper towel and dirt and debris covered 25% of the exposed area. -Open area of bed frame had 1/4 inch of what appeared to be dust and dirt accumulating in edge of the bed frame. -Walls around the bed were discolored with what appeared to be dirt. -The hardwood floor was stained with what appeared to be dirt and debris across 25% of the open space. -Light switch plate contained thick, black and brown sticky substance across 50% of the surface.	N 481		

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N 481	Continued From page 11 Bedroom #6 -Had a very strong odor consistent with urine and dirty laundry. -One large laundry basket overflowing with dirty clothes. -The hardwood floor was stained with what appeared to be dirt and debris across 75% of the open space. -Resident bed had a plastic covering over the mattress with no sheets. There was one pillow with no pillowcase. -Open area of bed frame had 1/4 inch of what appeared to be dust and dirt accumulating in edge of the bed frame. -Bedside table measuring approximately 3 feet wide by 3 feet deep was 100% covered in food containers, water bottles, laundry soap, tennis balls, fingernail polish, 1 pound bag of loose tobacco, 1 rotting apple, partially eaten bag of Doritos, lighter, cigarette butt, 1 squashed bag of Hostess twinkies, and single serving of chocolate cake which had what appeared to be mold growing inside the plastic wrapper. Two speakers sat on the table with 5 burnt cigarette butts and several pairs of what appeared to be dirty socks laying beside 1 box of opened popcorn. Beneath the table was a mound of what appeared to be a combination of garbage and personal supplies. -Light switch plate contained thick, black and brown sticky substance across 50% of the surface. Interviews On 08/15/2025, at approximately 9:30 AM, Surveyor interviewed Direct Services Personnel D (DSP D) regarding housekeeping duties. DSP D stated, "I'm pretty sure the 3rd shift staff is responsible for all housekeeping."	N 481		

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N 481	Continued From page 12 On 08/15/2025 at approximately 2:15 PM, Surveyor interviewed Program Manager (PM) A. PM A confirmed the home needed a thorough cleaning. PM A confirmed the House Manager was responsible to oversee all cleaning assignments and stated, " I will let them know." On 8/18/2025 at 4:46 PM Surveyor interviewed Licensee F who viewed photographs of the homes condition. Licensee F replied, " I agree. This is shocking and unacceptable. I will urgently meet with my managers tomorrow, hold them accountable, and implement immediate corrective action."	N 481		
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 did not ensure residents had a comfortable mattress covered with a mattress pad on 5 of 6 residents' (Resident 1, Resident 2, Resident 3, Resident 4 and Resident 5) beds. The beds observed were covered in plastic without a mattress pad. Findings include: On 08/15/2025, at approximately 9:30 AM, Surveyor toured facility accompanied by Direct Service Personnel (DSP) D and observed	N 483		

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N 483	Continued From page 13 Residents 1's, 2's, 3's, 4's, and 5's mattresses were each covered in plastic with no mattress pad covering the plastic. On 08/15/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager (PM) A. PM A confirmed there were no mattress pads covering the plastic covered mattresses. PM A stated, "I'm not sure everyone is aware of this requirement. It's hard because the residents always take them off. I will let staff know."	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 1 of 1 clothes dryer in the residential laundry room had vent tubing which was maintained. The facility's vent tubing was not attached to the dryer. Findings include: On 08/15/2025 at approximately 10:30 AM, Surveyors toured the facility accompanied by Direct Service Personnel (DSP) D. The laundry area was in the basement and contained one clothes dryer. The clothes dryer was equipped with vent tubing, which had become unattached from the dryer and was venting inside the facility	N 488		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009565	A. BUILDING: _____ B. WING _____	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADSTEP-WISCONSIN, INC. (FLORIST)	7401 W FLORIST AVE 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 488	Continued From page 14 laundry room. On 08/15/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager (PM) A. PM A was unaware of the detached dryer vent and stated, "I will have it repaired immediately."	N 488		
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 fire drills were conducted quarterly for 4 of 4 quarters in 2023. The provider did not fire drills were conducted quarterly for 3 of 4 quarters in 2024. There were no fire drills conducted to date in 2025. The provider did not ensure at least one drill in 2023, 2024, and to date in 2025, simulated the conditions during	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009565	A. BUILDING: _____ B. WING _____	08/15/2025

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N 525	Continued From page 15 usual sleeping hours. Findings include: On 08/15/2025, Surveyor reviewed safety records and identified the following: -There were no documented fire drills during 2023. -Two fire drills were completed during the first quarter of 2024. There were no additional fire drills completed during the remaining 3 quarters of the year. -There were no documented fire drills for 2025. On 08/15/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager (PM) A regarding the missing fire drills. PM A confirmed that there were no additional fire drills to review. PM A stated, "I will add this to my list of concerns for the manager." Cross Reference N0526 DHS 83.47(2)(e) Other Evacuation Drills Cross Reference N0530 DHS 83.47 (3) Fire Inspection	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	N 526		

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	0009565	A. BUILDING: _____ B. WING _____	08/15/2025

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N 526	Continued From page 16 other emergency or disaster drills conducted in 2023, 2024, or to date in 2025. Findings include: On 08/15/2025, Surveyor reviewed safety records. The safety files did not contain evidence of other emergency or disaster drills for 2023, 2024 or to date in 2025. On 08/15/2025 at approximately 2:30 PM, Surveyor interviewed Program Manager (PM) A regarding the missing drills. PM A confirmed the code requirement and confirmed that there were no additional drills to review. Stating, "I will add this to my list of concerns for the manager." Cross Reference N0530 DHS 83.47(3) Fire Inspection Cross Reference N0525 DHS 83.47(2)(d) Fire Drills	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 inspection by the local fire authority or certified fire inspector and retain the report for 3 of 3 years requested for review (2023, 2024, and to date in 2025). Findings include:	N 530		

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	0009565	A. BUILDING: _____ B. WING _____	08/15/2025

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N 530	Continued From page 17 On 08/15/2025, Surveyor reviewed safety records for the facility. There were no fire inspections included in the records for 2023, 2024, and to date in 2025. On 08/15/2025 at approximately 2:30 PM Surveyor requested fire inspections for 2023 to present day from Program Manager (PM) A. PM A stated they would find them and send to Surveyor's e-mail by end of business day 08/15/2025. As of 08/18/2025 at 3:45 PM no additional fire inspection documentation has been received. Cross Reference N0526 DHS 83.47(2)(e) Other Evacuation Drills Cross Reference N0525 DHS 83.47(2)(d) Fire Drills	N 530		